Overview Report

PREPARED FOR THE DOMESTIC HOMICIDE REVIEW PANEL REGARDING THE DEATH OF

AB

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INDEX

CONTENTS	PAGE
PREFACE	3
1. INTRODUCTION	4
2. TERMS OF REFERENCE	8
3. METHODOLOGY	11
4. DETAILS OF PARALLEL PROCESSES	13
5. THE FACTS /SUMMARY OF AGENCY INVOLVEMENT	13
6. ANALYSIS OF KEY ISSUES	70
7. CONCLUSIONS	82
8. KEY RECOMMENDATIONS	90
APPENDIX 1 – Abridged Chronology	95
APPENDIX 2 – Glossary	100
APPENDIX 3 - Extract Police and Criminal Evidence Act 1984 Code G	101
APPENDIX 4 - Extract of MAPPA Guidance	104
APPENDIX 5 – CV, Independent Overview Report Writer	105
APPENDIX 6 – Explanation of MARAC and DASH	106

Preface

This review has been amended at the request of the Home Office Domestic Homicide Review Quality Assurance Panel.

The suggested amendments highlighted by the Panel have been incorporated into the report, which remains the work of the original author.

The additional work has been undertaken by Jon Chapman.

Within the report any comment attributed to the 'Overview Writer' remains the view of the original author.

1. INTRODUCTION

1.1 In September 2012, AB was fatally stabbed. The injuries that caused her death were multiple stab wounds (16).

1.2 The following day, DE attended Wembley Police Station, where he was arrested on suspicion of murder. He was later charged with the murder of AB and additionally with the rape and attempted murder of another woman earlier that same day. He was convicted of the murder in 2013 and later sentenced to serve a minimum period of 33 years.

1.3 The relationship between AB and DE is recorded as far back as March 2007. The first domestic disputes and violence were recorded in early 2008. Between then and the time of AB's death, incidents of domestic violence were recorded within Bedfordshire, Hertfordshire and the Metropolitan Police Service (MPS) Area. DE had a number of criminal convictions with a significant number involving violence. Over the review period both AB and DE had extended contact with a number of local authorities and in particular their Children's Social Care (CSC) Departments. For the purpose of the review this has encompassed Brent, Enfield, Luton and Hertfordshire. There was some limited contact with other local authorities but this was not significant in terms of the delivery of services to AB or her children. Similarly AB and DE had contact with a range of health and support services and these are listed in section 3 with all those providing a chronology and Individual Management Reviews (IMR) identified. All others listed provided detailed chronologies.

1.4 AB was the third child of a sibling group of five. Her mother and father separated in 1985 when she was 5 years old. She lived in the Midlands area and London when she was growing up.
Her first child HB was born in 1998.
In 2000 she met and lived with DD. The relationship was initially described as good but within a year there were allegations of domestic abuse, they married in 2005. Her two children BD and ED were as a result of that relationship.
HB throughout that period lived for substantial periods with his maternal family members rather than AB. In 2007 he was made subject of a Child Protection Plan in Brent.
In 2007 AB met DE and by early 2008 they lived together.
In August 2008 formal arrangements were made with the Courts for HB to live with his maternal grandmother and for BD and ED to live with their father DD.
AB was recorded shortly before her death in an assessment for court prepared by a Hertfordshire Local Authority Social Worker as being articulate and able to express her feelings and opinions clearly.

1.5 Listed below are the significant persons in the life of AB;

Name	Relationship	Recorded Ethnicity	Address at time of AB's death
(AB)	Subject	Mixed White and Black Caribbean	WATFORD
(DE)	Partner/separated	Black or Black British Caribbean	LONDON
(CE)	Son	Mixed any other mixed background	WATFORD
(HB)	Son	Mixed any other mixed background	WATFORD
(GH)	Mother and had Residence Order re: HB	Not noted on ICS	LONDON
(BD)	Daughter	Not noted on ICS	LONDON
(ED)	Daughter	Not noted on ICS	LONDON
(DD)	Previous partner, father, and has Residence Order re: BD and ED	Not noted on ICS	LONDON,
(BB)	Maternal aunt	Not noted on ICS	ENFIELD, Middlesex,
(HE)	Paternal Grandmother to DE	Not noted on ICS	LONDON,

1.6 The MPS murder investigation and contact with the family has identified the following information that is relevant to the DHR:

1.7 Family's relationship: AB had a mixed relationship with her mother and sisters. They mainly disagreed about the way AB was bringing up the children which caused some family tensions and as a result they would on occasions not see her for months at a time. The family members had seen her more in the period proximate to her murder, as in the last two years of her life she had been diagnosed with Crohn's disease and would return to her mother's home when she was feeling unwell.
The family did not know the detail of the treatment she was receiving at the time.

1.8 Employment: The family stated that AB mostly worked as a nanny, a personal assistant and in administration. She changed her job regularly and tended to stay no more than a couple of months in a job.

1.9 Relationship of AB and DE: AB and DE met in 2007 through her work in an agency for ex-offenders and started going out with one another. By Christmas 2007 she had left DD and was living in a bed and breakfast. AB and DE began living together in 2008. When interviewed as part of the assessment process prior to his conviction for murder DE described his relationship with AB as being the first and only significant relationship he had with a woman.
The family described the relationship as, '*very volatile*', that they kept splitting up and would then get back together: the reasons for the apparent reconciliations are explored within the report.
It is the family view that AB changed her address frequently in order to get away from DE and to evade social services when she thought they were trying to take her children into care. The family opinion was that whilst she would move address to get away from DE, she would continue to tell him where she was living at a later date, but then maintain to others, including family members, that there was limited or no contact with DE.

Focus of the Overview Report and child protection concerns

1.10 In order to focus on the issues that are relevant to the DHR some of contact with the various children's services has been subject to limited analysis within the Overview Report. The IMRs reflect frequent contact with children's services in Brent, Enfield, Hertfordshire and Luton around all four of AB's children. Contact for the most part is focused around the children and the IMRs record that.
It is arguable that the IMRs do offer evidence, in varying degrees, that the children were left at considerable risk from both AB and DE but this was not the focus of the DHR. This is reflected on within the Overview Report when it is directly relevant to the domestic abuse issues.

1.11 The Overview Report attempts to reflect the child safeguarding issues fairly across the various agencies, with the intention that both the Overview Report and the anonymised merged chronology are shared with the appropriate Local Safeguarding Children Boards (LSCB) to promote learning and any necessary action in relation to both the DHR learning and also the child safeguarding issues identified.

1.12 The vast majority of the incidents examined within the Review relate to DE although there are a number that relate to DD, her previous partner and the father of two of her children, BD and ED. There are also a small number of incidents that relate to her son HB. They were not recorded by the police as domestic incidents due to his age. These have been included in order to fully reflect the level of contact agencies had with AB and DE and the complex nature of that involvement.

1.13 In order to assist the examination and analysis a full chronology is provided at Appendix 1.

1.14 DE has a criminal history dating back to 1994 with 15 recorded convictions for 50 offences (not including those committed which initiated this review) His early offending history was for theft related offences escalating to robbery in 1999. In 2002 DE was convicted of the more serious offences of conspiracy to rob, possession of an offensive weapon and wounding with intent, among others. These offences involved his stabbing the victim 5 times, for these offences he received a 6 year term of imprisonment at Young Offender institute. There was also intelligence held by the

MPS which linked DE to Operation Trident (an Operation focusing on knife and gun crime)

Was the death of AB avoidable?

1.15 Given the totality of the information available to all of the agencies at the point of the murder of AB it is reasonable to assert that the outcome of her, or one of her children, receiving some level of extremely serious injury or harm from DE was predictable but not necessarily preventable. That outcome had been judged as a potential high risk on a number of occasions over a number of years by a range of agencies. The potential to have avoided the death of AB is reflected upon within the Report at length.

1.16 It is true that AB herself presented the agencies trying to protect her and her children with real difficulties through her repeated disguised compliance and non cooperation, and failure to access some of the support offered. To quote the MPS IMR, '*her engagement with professionals appears to have been most effective while the children were subject of Child Protection Plans' (CPP*) and this reflects the view of her family; that this was the only thing that AB was likely to respond to positively. This may, of course been due to the coercive behaviour of DE, and the existence of a Child Protection Plan enabled her to justify her engagement. The question for this Review in the view of the Overview Report Writer is whether given the frequent disguised compliance or non-cooperation (which may have been at the behest and direction of DE) could agencies have found additional or alternative means of protecting AB and her children?
The analysis and conclusions attempt to answer that question in so far as is possible on an objective basis avoiding the benefit of hindsight. The conclusions have been based around four significant themes which have arisen through the Review process: 1. Disguised compliance or non compliance, 2.Significant health issues, 3. Arrest policy, 4. Focus on the offender.

1.17. It is always a matter of judgment as to whether this or similar incidents could have ended less tragically, but it is reasonable to conclude that there would have been a greater chance of avoiding significant harm to AB and her children if those issues had been addressed in parallel across agencies. The detail of the available information and the extensive work and support provided by agencies is outlined within the respective sections of the Report. It should also be noted that overall there was a great deal of work that was carried out by the agencies to support and protect AB and her children.

Consideration has been given to cultural/diversity issues and issues surrounding Human Rights.

1.18 AB was a dual heritage (white and Black Caribbean) female, born in the UK. At the time of her death she was 32 years of age. According to records she had lived in Luton, Bedfordshire, at various addresses within the London area, and at the time of her death was living in Watford, Hertfordshire.

1.19 DE was a dual heritage male, also born in the UK. At the time of AB's death he was 31 years of age. DE had also lived at numerous addresses within the Greater London area and in Luton, Bedfordshire.

2. TERMS OF REFERENCE

2.1 The TOR for this review are referred to throughout the analysis They are as follows:-

Scope

The agreed dates between which the DHR is considering agency involvement with the victim and family – and therefore the period for which agencies were required to provide information - is **1 March 2008 to the date of AB's death in 2012**.

Purpose of the review is to:

- Gain an understanding of what domestic violence there was between AB and DE.
- Establish the appropriateness of agency responses to both AB and DE - both historically and immediately prior to AB's death.
- If and how agencies assessed risks to AB and her children.
- Establish whether single agency and inter-agency responses to any concerns about domestic violence were appropriate.
- Identify, on the basis of the evidence available to the review, whether the deaths were predictable and preventable, with the purpose of improving policy and procedures within the various agencies areas of responsibility.
- To identify good practice that was in place.
- To establish how well agencies worked together and to identify how inter-agency practice could be strengthened to improve the identification of, and safeguarding of, vulnerable adults where domestic violence is a feature.

The Review will exclude consideration of who was culpable for the death of AB as this is a matter for the Criminal courts to determine..

2.2 Key issues

Information: Did the agencies comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

Did the agency have policies and procedures for (DASH[1]) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used?

Was the victim subject to MARAC[2]?

2.3 Contact and support from agencies: Were practitioners sensitive to the needs of the victim and perpetrator?

Did actions and risk management plans fit with the assessment and decisions made?

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[1] DASH - *The Domestic Abuse, Stalking, Harassment and Honour Based Violence Risk Identification, Assessment and Management Model (DASH 2009)*

[2] MARAC – *A MARAC is a multi-agency meeting which has the safety of high-risk victims of domestic abuse as its focus. See appendix 6 for more information.*

Were appropriate services offered or provided?

2.4 **Any additional information considered relevant:** If any additional information becomes available that informs the review this should be discussed and agreed by the independent chair and the review panel and confirmed by the chair of the Domestic Violence Strategic Prevention Board (DVSPB).

2.5 **Key Lines of Enquiry**:

The Panel for this DHR has determined broad aims, which can be amended as information is gathered.

Specifically, the Panel wish to determine:

1. What disclosures AB made to agencies and the circumstances behind them coming into contact with her.

2. If and how agencies assessed risks to AB and her children.

3. Were the agencies' responses good practice and proportionate considering their knowledge?

4. Whether relevant agencies discharged their duties properly?

5. Could this homicide have been prevented?

6. Lessons to be learned for the future?

7. Good practices that were in place.

8. The effectiveness of inter-agency communication.

9. Any difficulties agencies encountered when working with AB and her family that impact on the case.

10. The accuracy of records and information imparted.

11. An understanding of the nature of the behaviours and triggers exhibited by AB.

<u>Agencies Involved:</u>

<u>The following agencies provided an IMR</u>

Metropolitan Police (IMR)
Hertfordshire Constabulary (IMR)
Bedfordshire Constabulary (IMR)
Hertfordshire Children's Services (IMR)
Hertfordshire Community Trust - Health Visitor services (IMR)
West Hertfordshire Hospital Trust (IMR)
Victim Support – Hertfordshire IDVA Service (IMR)
General Practice, NHS Hertfordshire (IMR)
North Middlesex University Hospital (IMR)
Bedfordshire Probation Trust (IMR)
London Probation Trust (IMR)

Children's Safeguarding – Enfield (IMR)
Children's Safeguarding – Brent (IMR)
NHS Enfield – GP (IMR)
Luton Children Services (IMR)

The following agencies provided a chronology

NHS Brent
Ealing Social Services
Luton Social Services
Brent Housing
Enfield Housing
Luton Housing
Ealing Housing
Crown Prosecution Service
Children's Safeguarding - Central Beds
NHS Beds
NHS Luton
Essex County Council (Housing)
Paradigm Housing
Redbridge Social Services
Brent and Enfield Mental Health Services
NHS Hertfordshire
Hertfordshire Probation Trust
Watford Community Housing
Hertfordshire Partnership NHS foundation Trust
Luton & Dunstable Hospital

2.6 Family Involvement:

The panel recognised the importance of the contributions of the victim's family to the review outcomes, and that of the alleged perpetrator.

The approach to either was initiated with the agreement of Panel members in conjunction with the Overview Report writer, and with the assistance of the Family Liaison Officer and Senior Investigating Officer.

The Chair of the DHR Panel together with the Overview Report Writer and the police Family Liaison Officer met with the mother and two sisters of AB on the 19th November 2013.

The family raised the following specific issues that they wanted the Review to seek to examine and will be addressed specifically within the Conclusions of the Report at Section 7 below;

The level and quality of the liaison and information sharing between agencies and in particular children's social care, the police and probation

The focus that was placed on protecting the children of AB and in particular in relation to CE and HB

To what extent the information relating to DE and his history of crime and violence was shared across agencies and used to manage the risks he presented to AB and the children?

Whether AB would have been fully aware of all the information relating to DE and his offending behaviour that was available to agencies and therefore in a position to judge the level of risk to herself and the children?

A draft of the full Overview Report was shared with family members on the 13th February 2014 at a further meeting. The family expressed their thanks for the Report and the work around it, and agreed with the various Recommendations and Conclusions. They made no request for any amendment or addition.

3. METHODOLOGY

3.1 The DHR Panel set up following the death of AB to established that a wide range of agencies had contact with AB and DE over the period within the Terms of Reference (ToR) of this Review, March 2008 to the dates of AB's death in 2012. The agencies with the most significant contact were children's social care services (both within a number of London Boroughs and outside London), the police in London, Hertfordshire and Bedfordshire, Health, most significantly in the form the GPs, and various domestic violence support agencies. Most of the agencies sustained some form of contact over the period under review as services overlapped on a number of occasions.
Each of the identified agencies was asked to provide an initial chronology or confirmation of their level of contact with those subject to the ToR. If it was established there was significant contact an Individual Management Report (IMR) was requested.

3.2 Those agencies which provided an IMR have been identified below and in each of the IMRs the methodology section outlines the process each of the IMR authors undertook. Essentially this involved the examination of relevant papers, electronic recording, and interviews with relevant staff, and records have been secured and remain available. Each followed the Home Office Guidance (2011) in terms of format and content.

3.3 The various IMRs also record the analysis undertaken by the individual authors, much of which is directly reflected within the Overview Report. In Section 5 (The Facts), the Overview Report Writer has included an element of analysis and comment where that is directly relevant in relation to the specific incident or information recorded.

3.4 The Overview Report Writer followed up directly with a number of agencies as agreed with the Panel Chair.

3.5 The following agencies confirmed directly to the Panel that they had no contact with AB and DE over the review period;

Central Bedfordshire Children's Services
Hertfordshire Partnership Foundation Trust

East of England Ambulance
Director of Housing, Ealing

3.6 Sources of material will be reflected at the relevant point within the document. Copies of the original records have been retained by the respective organisations and can be accessed by the various report writers and the Overview Report Writer.

3.7 The overview Report Writer wrote to DE in prison via the police providing the ToR of the DHR seeking his assistance in relation to the process of the Review. No response was received. The Police Senior Investigating Officer (SIO) however did make available some of the Reports that were provided for the Court. These give some insight into the level of drug and alcohol use of DE and the relationship with AB that is explored within the Overview Report.
DE appears to have had little clear recollection of what specifically triggered the offences but he did confirm that he routinely carried knives, heard voices in his head and consumed substantial amounts of alcohol and drugs at the time and prior to the offences.

3.8 PANEL MEMBERS OF AB DHR

Khatun Sapnara QC	Chair, Barrister at Coram Chambers
Manny Lewis	Managing Director, Watford Borough Council and Chair of Community Safety Partnership
DCI Elizabeth Hanlon	Deputy Director of Force Intelligence, Hertfordshire Constabulary
Sarah Taylor	Programme Manager, Domestic Abuse/Hate Crime County Community Safety Unit (Hertfordshire County Council)
Alan Postawa	Report Writer, Hertfordshire Constabulary
Dave Wickens	Review Officers, Metropolitan Police Services
DI Natalie Cowland	Metropolitan Police Services
DI Simon Pickford	SIO, Metropolitan Police Services
DI Steve Lane	Metropolitan Police Services
Mayank Joshi	Service Head of Safeguarding Locality Family Support, Children's Services, Hertfordshire County Council
Jodie Keen	IDVA Manager, Victim Support, Sunflower Centre, The Lodge, Police Headquarters
Dawn Morrish	Health Improvement Manager- Offender Health and Community Safety, Public Health
Samantha Mee	Designated Named Nurse for Safeguarding Children, NHS, Hertfordshire
Susan Pleasants	Victim Manager, Hertfordshire Probation Trust
Kerry Biggadike	Observer, Programme Support Officer, Vulnerable People, CCSU
Sue Jacobs	(Minute Taker) County Community Safety Unit, Hertfordshire County Council
Tim Beach	Independent Overview Report Writer

4. DETAILS OF PARALLEL PROCESSES

4.1 The circumstances surrounding the death of AB were the subject of a murder investigation conducted by the Metropolitan Police Service. DE was convicted of the murder of AB in 2013 at the Central Criminal Court following a trial at which he entered a plea of not guilty on the grounds of diminished responsibility. He was sentenced to serve a minimum of 33 years imprisonment.

5. THE FACTS/ SUMMARY OF AGENCY INVOLVEMENT

This section is intended to provide details of the key events in the period covered by this review in chronological order. Each event has been the subject of examination by the review officers responsible for the respective IMR and then the Overview Report Writer, who has conducted an objective reflection on the incidents. It does not detail all contact with key individuals and therefore does not reflect the entirety of the work carried out by all the agencies but it does represent the contacts regarded as being significant.
The focus of the review has been around incidents that are regarded as relating to the issues of Domestic Abuse rather than the child protection concerns, but where judged relevant to the DHR they have been included.

Recorded Information 2007 – Prior to Review period. Brent Children's Social Care (CSC)

5.1 The records indicated that a decision to proceed to an initial child protection conference (ICPC) for HB was taken in August 2007, and following an unexplained delay in the organisation of the conference, HB's name was placed on a child protection plan (CPP) for physical abuse in October 2007. A decision for the step siblings was deferred until the first review case conference as no concerns were raised about their care. These concerns did not relate to DE.

Recorded Information – 3rd March 2008. Brent CSC

5.2 The family moved to a new address in Enfield (2 days prior) whilst subject to CPP for HB. Recording confirms that HB was placed on Enfield's temporary register. An allocated senior social worker had discussion with the victims sisters and mother–

there were concerns about the children's welfare now that they believed that AB's new partner had recently been released from prison for armed robbery and AB had kept this information from CSC and the family. DE was caring for the children as AB has returned to work. HB had told his maternal grandmother that he was still being beaten by his mother and stepfather, and DE threatened him. AB stated that if social care did not want her friend to look after the children then they should arrange child care until they entered school and nursery. AB was recorded as refusing to give any details of her friend.

Recorded Information – 4th March 2008. Brent CSC

5.3 A single agency child protection visit was carried out by a senior social worker following a strategy discussion with police - DE was the only adult present. HB was seen alone and made allegations of physical and emotional abuse by his mother and threats of violence by his new step father DE.

Comment: *By this point it is clear that DE was resident with the family and that professionals had shared concerns about DE.*

Recorded Information - 7th March 2008. Brent CSC

5.4 HB was staying with his Aunt. He was collected from there for his Child Protection (CP) medical. HB was recorded as having provided '*a vivid picture*', of the emotional abuse he had suffered while in the care of his mother together with a picture of the physical abuse he was subject to; he also identified that his sister BD had also been hit on occasion.

Comment*: Following this the recording showed HB was resident with both his aunts', his maternal grandmother (MGM) and for a brief period with foster carers after he was subject of police powers when found wandering the streets at night. There were clear recorded allegations of abuse made by HB, showing a repeat of historical allegations which related to his mother AB, primarily. No risk assessment was evident on file and the other children remained at home. There are recordings of concern about the violent history of DE but other than discussion with the police it does not trigger action and does not appear to have prompted a referral relating to BD and to Enfield CSC where they were both resident with AB and DE. There is extended recording around the formal joint interview of HB which eventually takes place on the 2nd April, well outside appropriate timescales. HB discloses DE had threatened him but this is not proceeded with on the basis of insufficient disclosure.*

Recorded information – 30th April 2008. Brent and Enfield CSC

5.6 Enfield CSC invited Brent CSC to a transfer in conference, which is the mechanism to allow the moving of a child subject to child protection to move from one area to another. Having spoken to all parties the conference chair advised them that they could not proceed to '*transfer in*' the case as currently HB did not live in Enfield. AB's mother advised the senior social worker that AB was about to be

evicted for non payment of rent, and BD and ED '*were watching music TV all day',* and their behaviour was causing serious concern. After the conference HB followed his mother out to the car which arrived to pick her up. It was being driven by DE. HB was recorded as having photographed the pick up, and AB's mother informed the senior social worker that DE had neither driving licence nor insurance. Further the girls were not strapped in.

Comment*: DE had a number of convictions relating to motoring offences and was convicted of further relevant offences in 2010*

Recorded Information – 2nd May 2008. Brent CSC

5.7 A referral was made to Enfield children's social care by Brent for BD and ED, outlining the situation and concerns.

Comment*: A follow up discussion was not recorded as taking place between the respective CSC departments.*

Recorded Information – 6th May 2008. Brent CSC

5.8 During discussions between Brent probation and a social worker, it became clear that probation had not been involved as the Offender Manager (OM) had changed and social care had not been informed and the wrong person had been invited to attend. The OM advised that AB had given a completely different picture to her leaving her previous partner, saying he had trashed all her belongings. The OM did not know that social care had supported AB's move to Enfield or that she was living with DE. The OM agreed to make contact with AB's employer and evaluate the current situation and let the Senior Social Worker know the outcome.
The record explains that a core group should have taken place by the 7th May 2008 but that due to non co operation by AB it had not been arranged.

Comment*: HB remained on Brent's child protection plan (CPP), but the procedures and timescales were not adhered to.*

Recorded Information – 28th May 2008. Brent CSC

5.9 Brent CSC record the police as having arranged to interview AB *'next week'* in relation to the allegations made by HB

Recorded Information – 2nd June 2008. Brent and Enfield CSC

5.10 Enfield social care refused to '*pick up'* the referral on BD and ED, as they argued that Brent had not completed their assessments prior to the referral and must do so before referral would be accepted.

Comment: *BD and ED had not been the focus of any assessment or plan since March and their welfare remained unknown at this point in time.*

Recorded Incident Barnet and Enfield and Haringey Mental Health Trust (BEHMT) – 5th June 2008.

5.11 AB attended the Crisis Resolution Team (CRT) following advice from paramedics after they had attended her address on the 3rd June after a suicide attempt when she had taken substantial numbers of pain killers. AB was seen by a Social Work member of the team and advised to go to A and E and to change her GP as she had moved to an Enfield address. No further action and case closed to CRT.

Comment: *This does appear to be followed up by the GP and with BEHMHT attending a CPP meeting on the 11th August at which the GP is agreed as the appropriate lead.*

Recorded information – 18th June 2008. Probation and Brent CSC

5.12 A call is recorded from an Offender Manager (OM) to a Senior Social Worker to update on contact with AB. The OM had seen AB a few days prior and she was distressed. She told her OM that she had taken an overdose as she feared the family would be homeless due to unpaid rent. The OM called Enfield social care that were recorded as refusing to take the referral as the case was open to Brent, but the OM insisted that they take the referral for children of concern living in their area.

Recorded Domestic Disturbance – 20th June 2008. Probation and Brent CSC

5.13 An Offender Manager at Brent Probation and Brent CSC were contacted by a sister of AB who stated that AB had stabbed her partner, wounding him in the hand and had tried to attack him with a hammer. Probation recorded that police had been contacted.
The sister was recorded as being on the way to the address.
AB was seen on the 23rd June 2008 by Offender Manager who was informed by AB that her boyfriend had not pressed charges. It was agreed with CSC that the Offender Manager would make an urgent CP referral to Enfield CSC.

Comment: *It is not clear at any point if this is DE as an alleged victim and the incident is not recorded within the police records but is recorded as above by probation and confirmed by the family. Additional checks were made by the MPS but no records could be found of the incident. This is not significant given that the available information was shared between agencies later in any case.*

Recorded Domestic Incident – 24th June 2008. MPS

5.14 On 24th June, AB telephoned the Metropolitan Police Service (MPS) stating she had been threatened by DE who had brandished a knife and was still nearby.

5.15 At the scene, DE alleged he had woken to find AB on top of him with a knife stating she knew of his affair with another woman (*he confirmed to officers he had started another relationship*). DE told officers he could no longer '*put up with her*' and said she was depressed and her behaviour was erratic. She had apparently

threatened to take her own life and would not let him go. He had locked her outside so he could pack his case to leave. AB's sister was also present and is recorded as having concerns about her sister's behaviour. She added that prior to the incident AB had asked to be committed at Chase Farm Hospital, where when seen, she was declared medically fit and advised to see her GP. DE was driven home by AB's sister to help diffuse the situation. Police records at the time revealed DE was known for violence but they were not known for previous domestic violence reports and the address was known to the local Child Abuse Investigation Team. No offences were alleged to the officers and a Domestic Violence Incident report was completed. The risk assessment was graded as standard risk. An appropriate notification was made for the children BD and ED.
A conversation recorded by the OM for AB from the following day revealed the following, *'she mentioned that DE had threatened to petrol bomb her house during the incident and he has taken her passport'.*

Comment: *This is reflective of the pattern of allegations; the initial call records an allegation of a criminal offence that is later recorded as being withdrawn or minimized by AB. DE also alleged offences against AB which was also a repeated pattern. The comments recorded from the following day by probation should have raised additional concerns and there was agreement by the 23rd June to hold a CPC.*

Recorded Information – 30th June 2008. Brent Probation and Enfield CSC

5.16 An Offender Manager (OM) recorded on the Brent Probation records that AB, "*is wearing very short shorts which show numerous bruising on her legs which AB says are due to her arguments with DE".*

Comment*: It is not clear that this information was shared by probation*
Enfield CSC record the completion of the delayed Initial Assessment (IA) on BD and ED at this point

Recorded Information – 7th July 2008. Enfield CSC

5.17 AB' s mother is recorded as having contacted CSC to clarify why she had returned HB to his mother's care. She cited lack of support, financial and accommodation difficulties, along with problems managing his behaviour.

Recorded Domestic Incident – 14th July 2008. MPS

5.18 On 14th July, police were called by an anonymous male to an argument between DE and AB in the street outside their address in Enfield. The anonymous caller refused details, called twice and alleged that the male was attacking the female with children present.

5.19 At the scene police officers described the couple as volatile and they were apparently making counter allegations (no details). The police were able to establish they were known for the previous reported domestic violence incident and the address was known to the Child Abuse Investigation Team as HB was subject to a Child Protection Plan. They were apparently arguing about their relationship and him

wanting to leave. The police initially recorded that there were allegations by both parties but the final remarks state that no allegations were made and DE left with his belongings. An MPS form recording contact with a child or young person was completed for ED and BD who were shown as living at the address with AB. No address was recorded for DE who is shown as an '*ex-partner*' on the records
No further action was taken by police at the scene.

5.20 This incident was referred to the Community Safety Unit to be reviewed, which occurred on 21st July and a notification was sent to Enfield CSC.
There is no reason shown for the apparent delay in this being shared.

5.21 On 15th July 2008, the police received a written referral from the Duty Manager, Enfield Children's Services expressing concerns over the previous day's incident and requesting further information and checks. The information also notes that both AB and DE alleged the other had caused a hand injury. This injury appears to have been the result of a tussle over a pair of scissors and DE had walked away from police so the alleged injury was not seen by officers. The incident raised concerns as the children witnessed the incident and should there be further incidents they could get caught up in the violence. A telephone strategy discussion took place between the police Referrals Manager and Enfield CSC. It was agreed this would be a single agency investigation with Children Services who would undertake an initial assessment and then feed back to police once complete. AB's mother provided additional information in a separate telephone contact. She described the relationship between AB and DE as, '*volatile and harmful to the children. Said there had been another incident the night before during which DE had allegedly stabbed AB and slashed her car tyres. She claimed DE was taking steroids and AB had issues with alcohol'.*

5.22 Brent Probation also recorded a detailed account to them in which AB alleged that DE had in fact been cutting up her clothes when he cut himself, that DE was dropped off by police at the station and had not been arrested. Enfield CSC recording reflects that as a consequence of the police referral and the information from AB's mother an initial CPP meeting was arranged for 29th July.

Comment: *There is substantial information received across a number of agencies which paints a more complex picture than that recorded by police initially following their immediate response, and agencies were clearly beginning to share the complex picture by this point. The initial information (albeit anonymous) to police appears to allege an offence, that DE is the offender and the presence of children at the incident.*

Attached as Appendix 5 to the Report is Code G of the Police and Criminal Evidence Act 1984, which outlines police powers for an arrest.
Given the initial information of an assault, the history of violence was known and child protection issues were identified, officers could have had grounds to suspect an offence had been committed and that DE had been the offender. The initial allegation amounted to more than a minor domestic incident and alleged an assault by DE.
It is accepted that the exercise of the power of arrest is an individual decision for an officer but arrest is accepted as a positive means of managing an alleged offender in cases of domestic abuse.

MPS current policy (updated September 2012) requires that officers arrest all perpetrators where evidence of a criminal offence exists, which challenges and holds

them accountable for their actions. It is the officer's decision to arrest and it is not reliant on the victim's willingness to support a prosecution.
This positive action requires enhanced levels of victim care and the MPS aims to ensure that the safety of victims is paramount, particularly where children are involved. Effective intervention to support victims through the criminal justice process and referral to independent advocates is provided.
The police service nationally has similar policies.

A and E – 15th July 2008. North Middlesex Hospital

5.23 AB attended the hospital reporting abdominal pains following a fall, during triage it was recorded that she was pregnant. Records show that AB was seen by the Nurse Practitioner but left before treatment by a doctor
***Comment**: The GP was notified of the attendance at the Hospital but it appears that other agencies were unaware*

Recorded Information – 29th July 2008. Enfield and Brent CSC

5.24 CSC record a CPC took place in Enfield at which police attended and Brent provided information. All three children were placed on a CPP on the basis of the perceived threat to them from Domestic Violence and the inability of AB to protect them.

***Comment**: It is clear professionals recognized by this point the level of risk of Domestic Abuse to both the children and AB and the totality of the information was available to the CPC. The CPC requested a referral to MARAC and Multi Agency Public Protection Arrangements (MAPPA)*

Recorded Information – 8th August 2008. Enfield CSC

5.25 An interview with AB took place during which the issue of the impact of domestic violence on her children was discussed by a social worker. AB was adamant that her children were not being hurt.

Recorded Information – 11th August 2008. Enfield CSC

5.26 AB's mother came to the office with HB. HB described incidents of violence at home. He described DE, '*as nasty and horrid and his mother as messed up and crazy. He described a man bringing weed to the house for DE to smoke. He said there were knives in the bedroom which had been used in the fights but they were also there in case anyone came looking for DE*'. She raised concerns that the children were living with AB and DE and that DE sometimes looked after the children alone. Other information shared by AB's mother without HB present was that DE had also threatened AB's sister, as she had been supporting her during some of the domestic violence incidents, he told her to keep quiet or her house would be firebombed by his crew. She also claimed that AB knew where there were guns. She regretted taking HB back to them and was going to a solicitor the following day. AB's

mother also reported that DE had no driving licence and had had one crash with the children in the car.

Comment: *It is not recorded what prompted the attendance by AB's mother with HB but there is already by this point a substantial body of information reflecting the level of violence that was known to professionals from various sources. The reference to firearms corroborates the intelligence recorded through the MPS, (Operation Trident)*

Recorded Domestic Information – 12th August 2008. Brent Probation

5.27 The OM recorded a meeting with AB where there was extended discussion about Domestic Abuse and violence by both parties when the children are present at the premises. The OM recorded that he/she had tried on 6 occasions to obtain domestic violence information from the police.

***Comment**: It is not clear if this issue was resolved but the MPS have no record of the request.*

Recorded Information – 19th August 2008. Edmonton County Court/ Herts CSC

5.28 Edmonton County Court made an Interim Residence Order relating to all three of the children of AB, with HB to live with his maternal grandmother and the sisters BD and ED to live with their father DD. The court specifically ordered on that date that AB did not allow any of the three children to have **any contact** with DE and that AB was not to have any unsupervised contact with HB, her son.

Comment: *It is clear that the court recognized a significant level of risk linked to DE and an inability on the part of AB to protect them and active steps were being taken by the Court to protect the children. It is not clear what account the Court took of the fact that two of the children were being placed with DD who had been the subject of domestic abuse allegations whilst in the relationship with AB.*

Recorded Domestic Incident – 23rd August 2008. MPS

5.29 On 23rd August, DD (ex partner) called police to his address stating he had a court order against AB and she had attended the location in order to take the children to a carnival, which he disagreed with. Police attended and spoke with BD and ED, who both appeared in good health. DD produced correspondence indicating he had a Residency Order for the children; however, visiting rights were unclear. Both were advised to seek clarification and AB left as she stated she did not wish to argue any further. No offences were apparent and the appropriate forms completed. The risk assessment was graded as standard risk. A domestic violence incident report was completed and the officers also completed a child referral for BD and ED.

5.30 The risk assessment and research were completed and recorded, which confirmed the risk as standard risk. The police Community Safety Unit (CSU) later attempted to contact both parents by telephone by way of follow up, but got no response. Letters were sent to both asking them to contact the CSU but as there was no response after 10 days the report was closed.

Recorded Information – 3rd September 2008. Brent Probation

5.31 The OM recorded that AB had a badly swollen lip. AB stated that it was as a result of her falling as she came down from the attic. The OM recorded that, AB *'appears to be putting her relationship over her children'.*

Comment: *There is no recording of sharing of the information but the OM appeared to be drawing a conclusion that the injury was as a result of domestic abuse and the potential impact on the children.*

Recorded Information – 22nd September 2008. BEHMHT

5.32 Information recorded by BEHMHT staff that police were called to the address of AB following a complaint from a neighbour of AB setting fires in the garden. Recorded as the second incident in a week and that she was taken to A and E previously. AB was reported as reluctant to attend Crisis Team and was therefore brought by police under S 136 Mental Health Act[3]. A social worker attended and recorded AB as '*having grip marks on her arms',* and AB gave an account of DE punching her and using a knife. She said that her current partner (DE) told her that she would never get her children back which resulted in a fight with him '*hitting her with a coat hanger punching her, putting a knife between her mouth and throwing her to the floor'.*
AB stated that she had responded by taking her clothing into the garden and throwing them into what would be a bonfire. She had a miscarriage 4-5 days ago; the baby was at 8 weeks and said that this was a significant factor in causing her distress.

Comment*: The incident was dealt with by way of two appointments with the Crisis Resolution Team (CRT), which do appear to have been attended by AB*
The incident is not recorded in the MPS chronology but the allegations of serious assault are clearly recorded by mental health staff. Further research was carried out by the MPS but no record found of the incident..
Both mental health staff and a social worker are involved in initially assessing and then supporting AB.
BEHMHT record that they provided information to CSC on the progress that AB has made with the CRT and that the case is recorded as closed. It is recorded that domestic abuse issues ***had not*** *been discussed with AB by mental health staff.*

Recorded Information – 2nd October 2008. Enfield Probation

5.33 AB attended her first meeting with her offender manager in Enfield

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[3] Section 136 Mental Health Act 1983 - This section allows a constable to remove an apparently mentally disordered person from a public place to a place of safety for up to 72 hours.

Recorded Information – 3rd October 2008. Enfield CSC

5.34 An office interview by social worker took place with AB and DE. AB claimed she did not to know what the allegations from Brent were. DE claimed to have a good relationship with all 3 children.

Recorded Domestic Incident – 11th October 2008. MPS

5.35 On 11th October, AB called police and stated she was at Enfield near the railway station and her boyfriend (DE) had just assaulted her. She added that he had attacked her in the house and he had been in possession of a knife, but she did not know if he still had it. (*There is no mention of the children throughout this incident so it is unclear where they were at this time*). On police arrival DE had left the area. AB was found with bruising to her left eye and a large lump on the left side of her head. She refused any first aid or hospital treatment. She alleged it started when DE took her cash card. When she asked for it back he became aggressive, took a knife from the kitchen and threatened to stab her. He then grabbed her by the throat and lifted her off her feet and punched her. She ran out of the house and called police. She said his behaviour was becoming more and more erratic and she no longer wanted to be with him. A police Domestic Abuse report and a crime report for domestic related assault occasioning actual bodily harm was completed with the incident graded as medium. **The first line supervisor was concerned about the level of violence** and ensured initial arrest enquiries were made (*but DE could not be found*) and created a record for further arrest enquiries. A report was created to ensure that future calls to the family home were treated as urgent. The following morning (*12th October*) before the CSU took over the investigation a supervisor rang AB to ensure she was alright and that DE had not returned.
The CSU Detective Sergeant agreed with the need to arrest DE '*as a matter of urgency'* and set out a detailed investigative plan for the investigating officer. The risk assessment was confirmed as medium risk by the investigating officer and DE was circulated as wanted on the Police National Computer (PNC) by the end of the day. On 13th October, DE handed himself into police and was **arrested**. In interview, he denied they argued over the credit card; stated when he tried to leave she held onto his clothing to stop him; accepted there was pushing and pulling and that he did push her away and she fell; he denied punching her or having a knife, adding it was often her who picks up knives during arguments; he did not see her hurt her head and when he left she followed him and he saw her call police. They argued again before he left the scene. He concluded by saying they had spoken since the incident and were now back together.

5.36 At the same time, AB had attended the police station and insisted on providing a withdrawal statement. She retracted the allegation that she had been punched, grabbed by the throat or been threatened with a knife. She said she had slipped on the wet floor which caused the injury and it was her who had grabbed the knife and this is what she does when they argue. She had made the complaint as she was angry at him as he said he was leaving her. She disclosed she was under a lot of stress as she was going through the courts about her children (*although she did not elaborate on this*) and had recently been sectioned under the Mental Health Act and was now a patient at Chase Farm Hospital and receiving help.
The officers consulted a Crown Prosecution Service (CPS) lawyer who advised no further action should be taken. The officer attempted to speak again with AB but got

no reply when he rang her and the investigation was subsequently closed. DE was released and no further action taken.
As her two daughters were in the care of their father and HB was living with AB's mother the incident did not reach the threshold for officers to complete a child referral.

Comment: *The police reaction to this was positive, in that they recognize the potential level of violence, clearly record it and respond to it. They can corroborate the injuries to the head of AB; although she subsequently asserted that the injuries were caused by a slip on the floor. The consultation with CPS was good practice and reflects a genuine desire to prosecute if possible.*
The fact that she was receiving treatment for mental health problems could also have flagged some additional vulnerability.

Given the multi agency involvement at this relatively early stage, and the information available across agencies, a Multi Agency Risk Assessment Conference (MARAC) should have been considered legitimately from this point on.

Recorded Information – 13th October 2008. Enfield CSC

5.37 Telephone contact is recorded between and Enfield SW and Brent SW. Background information regarding physical abuse of HB, CP registration in Brent and incidences of Domestic Violence is exchanged including that support services were offered to AB, but were declined.

Recorded Domestic Incident – 16th October 2008. MPS

5.38 On 16th October, police received an abandoned call from a mobile phone number previously used by AB, to her address at Enfield. Police were aware of the previous domestic violence incident to the address prior to attending. DE was seen but was unwilling to speak to police, but did state that he accidentally called police. A female at the scene (*not named*) said she did not realise police had been called. There is nothing recorded which identifies the female as being AB, that this was a domestic violence incident or whether any children were present. Police took no further action.

Comment: *There appears little doubt that the incident did relate to AB*

Recorded Domestic Incident – 18th October 2008. MPS

5.39 On 18th October, DD called police to report that AB was trying to force BD and ED into her car. The court order recorded AB as apparently allowed to see the children between 10am and 6pm, but if she was aggressive (*which he alleged she was*) he could refuse her access. At the time of this incident DE was waiting outside in the car. When officers arrived AB was described as '*…upset and angry*' at being unable to see her children. Following discussion, and due to her manner and behaviour, it was considered in the best interests of the children that she did not have them this day. They were apparently due back at court on 20th October, to discuss the children. No offences were disclosed.

The risk assessment was graded as medium risk.
A Domestic Violence incident report was completed. The officers also completed a child referrral for BD and ED which was shared with Brent Children's Services.
The police Community Safety Unit (CSU) amended the risk assessment to standard risk having completed research on the subjects.

5.40 The CSU later discussed the situation with DD before closure of the investigation. DD stated he had not heard from AB since the civil court case (*20th October*) and stated she was not allowed to see the children until she had been visited by social services, which was expected to take place on the 4th November.

***Comment**: The recording by police was comprehensive but no rationale was given for this revised risk assessment.*

Recorded Domestic Incident – 20th October 2008. MPS

5.41 On 20th October, police were called by AB who alleged DE had kicked and punched her, and held a knife to her throat. At the time of her call they were still together in the house but in separate rooms.
At the scene officers considered AB may have mental health issues and as a result the London Ambulance Service (LAS) were asked to attend. While with officers she further alleged DE had ripped up items of her clothing and caused bruising to her arm. She told police she was suicidal and that DE had threatened to kill her. It would appear that prior to police attendance AB had set fire to the stairs but had promptly put it out. In order to provide her with family support her mother was contacted by police and attended. She was taken to her mother's home with most of her belongings. It would appear AB and DE were in the process of being evicted (*no details*). She stated that access to her children had been reduced to '*supervised access*', due to violence from DE. DE was **arrested** at the scene for assault (ABH) and criminal damage. The officers completed a Domestic Violence report, assessing the incident as medium risk and completed a crime report for the assault.

5.42 The CSU interviewed DE who gave a no comment interview. AB attended the police station and refused to be seen by the Forensic Medical Examiner. She gave a different account of her injuries and stated they were caused when DE tried to stop her setting fire in the house. At the station she was introduced to an Independent Domestic Violence Advisor (IDVA). AB made a withdrawal statement, would not discuss her domestic situation and would not support a prosecution.
The incident was reviewed by the CPS who advised NFA due to insufficient evidence, as AB was not supportive of police action and had withdrawn her account of events. DE was released on 21st October 2008. Prior to the closure of the investigation, the CSU investigator attempted to contact AB by telephone but got no response.

***Comment:** It was good practice at this point to introduce the IDVA as a means of trying to support AB; unfortunately AB did not feel able to avail of the opportunity. Arrest powers were exercised positively.*

5.43 At a Review Child Protection Conference (RCPC) on the 21st October 2008 consideration was given to attempt to address the previous Domestic Violence between DE and AB. The key worker had been asked to follow up a referral for AB to mental health services. AB had been seen on 22nd September 2008 at Chase Farm Hospital in the Mental Health Unit and admitted for assessment. It was concluded

that she was not suffering from any mental disorder and was discharged (see above entry for 22nd September), as Children Services were working with her. Information about the MARAC system had been provided to AB by her key-worker and she had apparently made enquiries with Enfield Woman's Aid regarding their Domestic Violence services. The Conference Chair noted the case had **still not been referred to MARAC by the key-worker**. A decision was again made to refer the matter as soon as possible. The key worker had previously been asked to establish if DE was the subject of local MAPPA but had not yet had a response. This on-going action is not reflected in the decision sheet for this meeting. The next review was planned for 5th February 2009.

Comment: *This appears to be the only point at which there was follow up to consideration of MAPPA but there is no evidence of this being followed up again. A MARAC referral was by this point being actively considered but this is 9 days after the referral for the previous incident, MARAC is for high risk cases and the referral should have taken place in a more timely fashion as a re-occurrence of the violence suggests*

Recorded Domestic Incident – 25th October 2008. MPS

5.44 On 25th October, police were called by the sister of DD regarding a Domestic Violence incident in London NW10. DD and AB were arguing over access to the children, BD and ED.

At the scene it was established AB wished to take the children to DE's mother's house and DD stated this was not allowed under the terms of the court order. Neither had the court paperwork and so police were unable to confirm this. The children expressed a wish to go with their father, which was allowed. No offences were disclosed, the police completed a Domestic Violence risk assessment putting the incident at Standard risk and completed an appropriate child referral which was shared with Brent Children's Services by MPS (PPD).

The CSU researched the couple and identified the previous Domestic Violence matters and based on this confirmed the risk assessment as standard risk. The investigating officer made a number of attempts to contact both AB and DD by telephone, but got no response. The officer sent letters asking them to contact the CSU should they wish to discuss the matter further. Following no response the investigation was closed.

Recorded information – 11th November 2008. Enfield CSC

5.45 A further referral to domestic violence services for assessment and support was made. The Child Protection Chair was concerned to ensure that AB was offered support despite her previous resistance to accessing services. AB phoned the following day to say that she was OK about referral to domestic violence services and that she was on a waiting list for mental health services and for GP counselling.

Recorded Domestic Incident – 19th December 2008. Bedfordshire Police

5.46 At 11:29 hours on Friday 19th December 2008, Bedfordshire Police received an emergency (999) call from DE reporting a disturbance at a Luton address. DE stated

that his partner had locked herself in the flat with him and that things were going to get very violent. **This was the first recorded incident in Bedfordshire.**
The response was graded as 'prompt' and officers were sent to the scene at 11:33 hours, arriving four minutes later.
Prior to the arrival of officers at the scene, a check for previous incidents at the address was made and a Police National Computer (PNC) check was carried out on a female occupant, although the details obtained by the call handler were wrong.

5.47 When the officers arrived the door was answered by AB. It would appear that there had been a verbal argument over money, but no complaints were made by either party. Both parties were advised by the officers and AB left the location to get a bus. The officers completed a non-crime domestic report and left the incident at 11:54 hours.

5.48 At 17:08 hours the same day, DE made a further call to Bedfordshire Police stating that AB was back with her brother and they were trying to get through the door. DE made a further call at 17:31 hours stating that he was very concerned.
Officers arrived at 17:50 hours. According to the incident log, there was no further breach of the peace, the female had returned to collect her belongings.

Comment: *This incident was regarded at the time as a minor domestic situation that was unlikely to develop into anything more serious than a verbal dispute.*
The recording does not reflect whether officers attending on each occasion were aware of the previous history with regard to AB and DE but given the intervention of specialist officers a few days later it is apparent that there was follow up. Given the previous history this was potentially arguably more than a minor domestic incident. By this point there had already been consideration of referral to MARAC and the involvement of domestic abuse services in the MPS area.

5.49 Both persons were checked against the PNC, and although DE had warning signals for weapons, violence and drugs, no offences appeared to have been committed by either party and there was no suggestion on this occasion that there had been any previous domestic incidents. In accordance with Force policy, a non-crime report was completed. Force procedures would not allow for the completion of a 'Domestic report' without a SPECCS Risk Assessment being completed.

Comment: *Officers followed the required procedure.*

5.50 On the 24th December 2008 the Public Protection Support Team, reviewed the incident and background history. The report did not identify a victim. It merely identified the individuals concerned as 'Party 1' and 'Party 2'. This would probably account for the reason that no other detailed information was recorded on the SPECCS form. There was no mention by the officers that any children were involved or present.

5.51The Support Team then conducted a more in-depth intelligence check on AB and DE. The officer arranged for more information to be obtained from the Metropolitan Police due to the PNC record indicating that AB had been arrested in July 2008 for assault on her son, but where no further action had been taken. Due to there being very little additional information regarding domestic incidents involving AB, the risk assessment was graded as 'medium'. A referral was made to Luton CSC.

Comment: *This should be regarded as good practice and provides evidence of good follow up research. This example highlights the fact that on some occasions, even*

incidents that could be regarded as relatively minor were treated with a recognition of their potential to indicate underlying serious threats. This was the first domestic incident involving AB and DE in Bedfordshire. In order to evaluate an accurate assessment of the risks to AB further historical information was gathered from other sources.

Recorded Domestic Incident – 6th January 2009. Bedfordshire Police

5.52 At 21:24 hours on Tuesday 6th January 2009, Bedfordshire Police received an emergency telephone call from AB (name spelt incorrectly) at her home in Luton, stating that her boyfriend, DE, was trying to attack her with a knife. The Police response was graded as 'Immediate'.

5.53 The Police call handler maintained a conversation with the caller up to the point the Police arrived and was therefore able to constantly reassess the gravity of the incident. The Force Information Room Inspector was committed with another incident but agreed to deploy firearms officers with full authority to arm. The Firearms Officers were directed to go straight to the scene.

Comment: *The action taken by Bedfordshire Police Operations Room staff in relation to this incident was positive. On receipt of the call, the graded response was correct and an officer was deployed quickly, arriving within eleven minutes. Whilst the officers were en-route, checks were made against the address and a PNC check was carried out on DE in anticipation of there being any valuable intelligence that may be of assistance to the officers on arrival.*

5.54 Two minutes after the above telephone call, DE also contacted Bedfordshire Police via the emergency phone line stating that his ex-partner was at the address in Luton, and if officers did not attend, it would get bad.
DE did not provide any additional information, and the incident was matched with the call made by AB, which police were already attending.

Comment: *This telephone call from DE was virtually identical to the call he made on the previous incident on the 19th December 2008, where it would seem DE tried to take the moral high ground and give the appearance that he was the potential victim rather than the potential offender.*

5.55 On arrival officers found AB huddled in a foetal position in the corner of a room. She was crying uncontrollably and shaking violently. The officers established that DE had assaulted AB by threatening her with a knife and trying to remove her trousers, he had also struck her around the head with a belt. DE was arrested on suspicion of indecent assault. A female officer was asked to attend the address.

5.56 AB was taken to Luton Police Station where she was interviewed by a trained Victim Liaison Officer.

5.57 AB provided the DVLO with information relating to the incident. This included allegations of assault, sexual assault, false imprisonment and threats to kill. AB stated that DE was regularly violent towards her, although only two previous complaints had been made to the Police, and these had been withdrawn prior to any prosecution taking place. AB also disclosed that DE had raped her a few months previously. AB showed the Officer an injury allegedly caused by a belt buckle on the 5th January 2009 and an injured finger which she was unable to straighten. She also

complained of a pain in the back of her neck but there were no visible injuries. AB was returned to her home address with a view to her providing a full statement in the morning.

5.58 The Victim Liaison Officer also completed a Crime Report and a Risk Assessment which provides information on the victim, the offender, and children. AB gave her contact address as an Enfield address and a contact number. AB informed the officer that alcohol and drugs were regularly taken by the suspect, that AB had attempted suicide previously by taking an overdose, **and that abuse was a daily occurrence.**

Comment: *Making arrangements for a trained Victim Liaison Officer to interview AB was good practice and provided a good quality service to the victim. The officer would have had special training in providing support and interviewing victims of domestic violence. The officer was better placed to devote more time in obtaining evidence and thereby securing the confidence and cooperation of the victim. The recording of this level of information being passed seems to reflect at this point a high level of trust in the Victim Liaison Officer and AB provides significant information about the level and frequency of abuse. This reflects the value of specialist staff being involved with interviewing and supporting victims. Although it is often difficult to take a formal witness statement too soon after an incident of this nature consideration could have been given to achieving a short statement of complaint which would allow referral of the incident to the CPS. If this was not achievable to record the reasons why this did not occur.*

5.59 Officers tried to make contact with AB the following day. Initially her phone was switched off, but contact was made with her later. AB stated that she was waiting for her sister from London to take her to Enfield where she would be safe and would speak in about one hour.

5.60 DE was interviewed at 11:25 hours the day after his arrest. The interview lasted ninety minutes, and resulted in a search taking place at the Luton address. The reason for the search it appears was to seize some pills which formed part of his account of what happened.
When the officers arrived, AB was inside the premises. She obstructed the officers in carrying out the search to such an extent that she had to be arrested.

5.61 She was subsequently given a 'Caution' for the offence of Obstruction and released from custody at 01:29 hours on the 8th January 2009. A statement had not been taken from her by that point.

5.62 At 19:00 hours on the 7th January 2009, DE was released on conditional bail to return to Luton Police Station on the 21st January 2009. His conditions of bail were that he was not to communicate or interfere either directly or indirectly with AB, either through any third party or via any electronic means. His bail address was in London.

5.63 Following AB's release from custody, numerous attempts were made to contact her over the following days, with the intention of taking a formal statement. Letters were also sent to her address. On the 21st January 2009, an officer spoke to AB who stated that she did not wish to make a statement against DE. A referral was made to CSC on the 13th January 2009, and due to the allegations being made at the time of the incident, the risk assessment was considered to be 'High'. The case was referred to the MARAC co-ordinator.

Comment: *There was no recorded reason why a statement was not taken from AB on the evening of the incident. Comprehensive notes were taken and AB appeared supportive of police action at the time. The police had clearly built a good rapport with AB initially and a signed witness statement together with the evidence provided by officers attending the scene should have been sufficient to charge DE with an offence. Bearing in mind Bedfordshire Police's policy of taking robust action against perpetrators of domestic violence, had the Crown Prosecution Service agreed, consideration could then have been given to placing DE before court the following day. It was unfortunate that the subsequent search of the premises on the 7th January 2009 resulted in the arrest of AB for obstruction. There may well have been little alternative but it is not clear what the relevance of the "pills" was at the time and whether it was being alleged that they were prescribed medicine or otherwise. It is reasonable to reflect that the arrest of AB is unlikely to have increased her willingness to support a prosecution on that occasion or into the future.*

5.64 On the 27th January 2009, the case was reviewed. The Domestic Abuse Incident Report states the following: "*On the face of this, it appears to be a serious case; however IP (Injured Party) has admitted lying to officers about the incident. IP now in London. She was cautioned for Obstruction and the perp(sic) was bailed now until 4th Feb with conditions not to contact IP.* **Not for MARAC at this time** – *further incidents should be brought to the attention of a supervisor".*

Comment: *The Police IMR Writer could find no reference to the fact that AB had admitted lying to officers regarding this incident, although there was evidence that she had frustrated the investigation, firstly by obstructing officers during the search of the scene, and secondly, by failing to engage with the Domestic Violence Investigation Unit (DVIU). It is recognised that the reasons people sometimes fail to engage is out of fear of retribution from the perpetrator or that they have no confidence in the agencies concerned.*

MARAC only have the capacity to deal with the 'very high risk' category of victims, and unless the victim does engage any initiatives to help mitigate further abuse will inevitably be less productive. This could be the reason why the MARAC co-ordinator has made the decision that this case would not be referred. It would have been helpful if the rationale for this decision was more explicit on the 'Domestic Abuse Incident Report'. It is difficult to see why this case would not have been referred MARAC the reluctance of the victim to pursue a criminal prosecution should not have had a bearing on this. This alleged offence appears to have been formally discontinued on or around 5th June 2009 on the grounds of AB refusing to assist the prosecution despite police attempting to prosecute.

Recorded Domestic Incident – 31st January 2009. MPS

5.65 On 31st January, AB called police (MPS) stating DE had assaulted her and had a gun. At this time she was living in Luton.
Police were unable to contact her by telephone after the call, but made enquiries and traced her to DE's mother's address in London, NW10. Police spoke with AB and DE's mother outside the address. AB admitted she had not been assaulted or abused by DE. She stated that seeing him earlier in the street she had shouted at him after saying hello; he told her to '*get lost*' and in response she said she would get him arrested. Officers noted she was in an emotional state and fluctuated from being fine one minute and not the next. DE's mother told police that AB and DE were not

friends, that AB was harassing her son and had mental health issues. DE was not seen by police.

5.66 In view of AB's apparent mental health issues which raised concerns over the validity of her account and surrounding circumstances, the investigating officers decided to give her a warning for the behaviour and wasting police time. She apologized to the officers and police took NFA. The officers recorded their actions on an intelligence report.

***Comment**: There is insufficient information as regards the interaction between AB and DE to decide if the matter reached the threshold to be reported as a Domestic Violence Incident.*

Information from Probation Enfield 5th February 2009.

5.67 Enfield Probation was informed that AB had moved to Luton and later that day made contact with her. AB stated that she was low and suicidal and needed to make a fresh start. The OM was recorded as attempting to pass the information to Luton (Bedfordshire) Probation later that day and again on the 11th and 17th February without success.
On the 18th February an e mail was sent to progress the issue and an appointment made for AB for the 23rd February. That appointment was not kept and a further appointment for the 3rd of March was made and notification sent to AB with a warning letter by Bedfordshire Probation. AB attended the appointment on the 3rd March 2009.

***Comment:** The liaison between the respective Probation Offices seems at this point to be less than ideal although there is no evidence that the delay in response had any negative outcomes for AB.*

Emergency attendance at A and E – 2nd March 2009. Health

5.68 AB presented to Luton and Dunstable Hospital 4 to 6 weeks pregnant with abdominal pain and bleeding reporting that she had fallen onto a pile of clothes. Appointments were made for her to attend the early pregnancy clinic and to contact the community mid wife and GP.

***Comment:** There is no recording of the previous domestic abuse history*

Recorded Information - 9th March 2009. Enfield CSC

5.69 A Review Child Protection Case Conference took place in relation to the children

***Comment:** Records show all three children were removed from a CPP at this point*

Information from Probation Beds - 10th March 2009. Luton CSC

5.70 OM met with AB on 3rd March where AB disclosed the previous history of attempted suicide and "*volatile relationship*", with her fingers having been broken. Concerns regarding the unborn child were recorded. Luton CSC were contacted by an OM to inform them that AB, who had three children not living with her but living in Enfield and who were subject to a Child Protection Plan, was in a volatile relationship, was pregnant and had previously attempted suicide. A management decision was made to undertake a Pre-Birth Assessment in regard to the risks to the unborn child.

Comment: *The case was recorded as being open with Enfield CSC and the OM also shared the information with Enfield directly the following day.*
The pre birth assessment was actually completed as a parenting assessment on 23rd November 2009. The Pre-Birth Assessment, described on the documentation as "A Parenting Assessment/Core Assessment", started on 17th August 2009 and was completed on 23rd November 2009 and is recorded by Luton as being delayed because of the issues in obtaining information from Enfield and Brent.This delay would seem to be significant.

Abandoned phone call – 15th March 2009. Bedfordshire Police

5.71 At 20:10 hours on Sunday 15th March 2009, Bedfordshire Police received an emergency telephone call (999) from a female requesting the Police. According to the call taker, the female sounded distressed and was screaming at someone to get out or get back. The caller did not leave a name or an address, but the number of the phone making the call was recorded. An attempt was made to return the call, but the phone automatically went to 'voicemail'. A Bedfordshire Intelligence check was carried out on the number with a negative result. Enquiries were made with the phone company and at 20:15 hours Bedfordshire Police Control were advised that the phone belonged to a Lisa Brown in Enfield.
Arrangements were made with the Metropolitan Police to attend the address. The Bedfordshire incident log was closed at 20:43 hours.

5.72 Although Bedfordshire Police do not have a record of the result of the Metropolitan Police's, the review officer learnt that the address appeared to be unoccupied.

Comment: *Although Bedfordshire Police Control Room staff carried out an intelligence check on the phone number, had they carried out a similar check on the Enfield address, they would have found the incident involving AB and DE that had occurred in Luton on the 6th January 2009. Bearing in mind a 999 call on a mobile phone would automatically go to the Force area from where the call was made, it would have reasonable to assume that the call was made from within Bedfordshire, and possibly from the known Luton address. This was an error by Bedfordshire Police.*

Information from Probation Beds 16th March 2009.

5.73 AB informed OM that she had moved to Brent intending to move on to Lambeth and had no intention of returning, as the frequency of the domestic abuse had increased and that over the weekend she had been thrown to the floor cut and bruised. AB had stated that she tried to call the police but her partner had removed

her phone and money. She had fled to her ex husband for safety. The OM informed CSC in both Luton and Brent and is recorded as transferring the case back to Enfield Probation. The OM also made a referral to Luton CSC regarding AB's unborn child.

Comment: *This information confirms that AB was resident in Luton at the time and was responsible for the call for assistance above, 15th March. This contact does not appear to be recorded by Luton or Enfield CSC , the Luton Probation OM does record that there was an exchange of information regarding AB's partner but there does not appear be any consideration of the new disclosure of escalating domestic abuse at the weekend.*

Concern for safety - Adult at risk – 15th April 2009. Bedfordshire Police and Probation Luton

5.74 At 13:28 hours on Wednesday 15th April 2009, Luton Probation contacted Bedfordshire Police Force Information Room, concerned for the safety of AB**.** The caller stated that AB was 4 months pregnant and may be staying with the unborn child's father, DE, in Luton.
It was stated that Enfield Probation had contacted Luton Probation and were concerned for the safety of AB and the unborn child and Luton Probation believed that AB may be staying at the Luton address.
There is no information on the police incident log to suggest why AB was thought to be at risk or whether the risk was immediate.

5.75 The response to the call was graded as 'routine' and an officer was allocated to deal at 18:42 hours. However the officer was unable to make the visit so it was reallocated at 23:36 hours and an officer arrived at 23:46 hours. A female, presumably AB, was spoken to and it was confirmed that she was safe and well.

Comment*: It is clear from the recording in the IMRs at this point that there is genuine confusion as to the location of AB and for some of the agencies trying to maintain as to which CSC or Probation Office had responsibility. It appears that the visit was prompted through discussions between various CSC staff and Probation staff attempting to locate AB. The check therefore was arguably not a core police responsibility and police officers powers under these circumstances would not have extended any further than those of the probation officers. It may have been appropriate for a probation staff to have visited the address in the first instance.*
The information appears to confirm that AB was again resident in Luton. Probation also contacted Luton CSC that day and were informed by Luton CSC that they had not referred this case forward and would take no action as AB was no longer in their area. The duty officer is recorded as having told the OM she now held all responsibility.
The actions over this time period reflects a high degree of confusion between the agencies, including CSC in Luton and Enfield, as to the management of the risks that all had identified by this stage.

Domestic Incident – 5th June 2009. Bedfordshire Police and Luton CSC

5.76 At 11:42 hours on Friday 5th June 2009, AB contacted Bedfordshire Police via the emergency telephone line reporting that she had been assaulted overnight by her partner, DE. She stated that she had managed to get to a telephone kiosk, but he was now with her again. She was 4 months pregnant. The incident was graded as requiring an immediate response, and officers were dispatched to the scene within two minutes, arriving at 11:49 hours. On arrival the officers carried out a PNC check on DE and were made aware of his warning markers for weapons, drugs and violence and also that he was an escaper.

5.77 An officer stated that on arrival AB looked quite upset although there was no shouting going on at the time. It was recorded that all AB wanted were her car keys. The officers took her back to the flat to discover she had packed some items and they assisted her in taking them to her car. It is recorded that AB did not give the impression that she was frightened of DE.; all she wanted to do was leave. After AB had left, the officers remained with DE for a short period of time. He seemed quite amicable according to the officers. A Domestic Violence report was made.

5.78 The officer could not remember if she asked the Force Control Room if any previous incidents had occurred at the address, or if there was a marker for Domestic Abuse on the address.

5.79 On the 8th June 2009, the police public protection team reviewed the incident and background history. The risk assessment highlighted that AB was pregnant and she was therefore a high risk victim and assessed as such. A referral was made to Social Services and the case was allocated to the Domestic Abuse Investigation Unit for a specialist Domestic Abuse Advisor to make contact with AB to complete a more detailed risk assessment (DASH 2009) in order to assess and manage the risk appropriately. Records show that a specialist officer was tasked with this on the 16th June 2009. There are no entries to suggest that any attempt was made to contact AB until the log entry on the 3rd July 2009.

5.80 There is no evidence on record that the referral was assessed by CSC and therefore, in response to the referral, joint investigation discussion or the need for a Child Protection Conference was considered at that time, despite the fact that AB was by then five months into her pregnancy with a significant history of domestic violence incidents with two partners and three children having been removed from her care. No further action was taken by CSC.

Comment: *The length of time it took to task a specialist officer and secondly the apparent lack of urgency in trying to contact the victim is concerning. If the log is correct and there had been no contact with AB it was not surprising that AB was unwilling to engage with the police on this occasion. If, on the other hand, attempts had been made to contact AB, this should have been recorded on the log. A referral was made to Victim Support. The initial response appears to have been focused on dealing with AB's desire for the return of her keys rather than the recorded allegation of her being assaulted overnight. Officers who responded appear to have negotiated with DE. It is arguable that this was an opportunity to take positive action in relation to DE by arresting him on initial attendance. There is an initial allegation of a criminal offence of assault, and AB had reported that she was pregnant flagging both her vulnerability and that of the unborn child. It would appear that DE had followed AB to the telephone kiosk and was either present or proximate when AB was spoken to. As previously referred to at 5.22 the officers should have considered arrest at this stage.*

5.81 The log entry on the Domestic Abuse Incident Report dated the 3rd July 2009 records the fact that an officer tried unsuccessfully to make contact with AB. There is an entry dated the 26th August 2009 which refers to a Planning Meeting to be held on the 4th September 2009. This entry is dated after the next domestic incident between AB and DE on the 23rd August 2009.
The officer when interviewed for the police IMR stated that due to high work load she was unable to attend that meeting. She also stated that these meetings were more to do with CSC and how they were going to work with the family and support them.

Comment: *Police should attend planning meetings, certainly for 'High Risk' victims, unless there is no useful purpose in doing so. By attending these meetings the Police may be able to offer advice and strategies that would assist in protecting vulnerable people.*
It would have been feasible at this point to raise the potential of focusing on the management of DE either through MAPPA or non MAPPA arrangements.
Similarly the lack of any joint investigation by Luton CSC and the police was a missed opportunity to organise a structured multi agency response.
Recording by Victim Support shows that a referral was made but as their information was that this related to a verbal dispute it was not progressed by them.

Domestic Incident – 23rd August 2009. Bedfordshire Police

5.82 At 18:23 hours on Sunday 23rd August 2009, an emergency telephone call (999) was received by Bedfordshire Police Control Room. The callers name was recorded as C (but believed now to be AB) and she lived at a Luton address. The caller was alleging that she was 32 weeks pregnant and had been assaulted by the baby's father. She was suffering pains. The incident log recorded that the offenders name was MD (incorrect) who was still believed to be inside the flat, but the caller had run to a nearby Residential Home. The response was graded as 'Immediate' and the Ambulance Service was informed by the Police. Additional information appeared to have been provided to the Police, including the offender's date of birth. A PNC check was carried out, with a negative result.

5.83 It is not known if the caller gave the wrong name of the offender or the control room operator misheard. A PNC check carried out on the correct details would have highlighted how dangerous the alleged offender was and more urgency may have been given to deploying officers to the scene. There had been no previous incidents recorded at this address. It was therefore not until the response officers were furnished with the correct details of DE that they became aware of the issues and history of domestic abuse between these two individuals.

5.84 The Force Information Room did have the facility to check intelligence and crime report data on the victim, but this would have been dependent on various factors including the immediacy of the incident, the information they were provided with by the caller, but more importantly, by ensuring the information they received was correct.

5.85 Although the Ambulance crew had arrived by 18:38 hours, Police Officers were not despatched until 18:54 hours, 31 minutes after receipt of the emergency call. According to the incident log, officers arrived at 18:59 hours. The delay in officers arriving at the scene prevented the ambulance crew from removing the complainant to hospital due to the flat being insecure. It may also have meant that the alleged offender had time to leave without being detained. Force and national policy is that

units should arrive at the scene of an immediate response call within ten minutes. Bedfordshire Police failed in this respect.

5.86 The officers checked the address to discover there was nobody present then made their way to the Luton and Dunstable Hospital to gain more information from AB.

5.87 By 19:24 hours a PNC check revealed that the officers had obtained the correct details of the alleged assailant and his last known address in Luton. The PNC record also provided the officers with the assailant's criminal history, highlighting his propensity to use violence. The officers informed the Control room that they were going to attend the address with a view to arrest the male. This attempt was unsuccessful.

5.88 A nine page witness statement was taken from AB which commenced at 21:30 hours. This statement was detailed and provided a good summary of AB's relationship with DE, a good detailed account of the incident, including words used, and a brief summary of five previous incidents of domestic abuse perpetrated by DE against AB. A referral was made to Victim Support

5.89 At the time of this incident in 2009, an appropriate risk assessment was completed by the attending officer, which provided details of three children, none of whom were present at the time of the incident. On the 28th August 2009 (5 days after the incident), the Public Protection Support Team (PPST) reviewed the incident and background history and assessed AB as being at "High risk". The case was allocated to the Domestic Abuse Investigation unit for a specialist Domestic Abuse advisor to make contact with AB to complete a more detailed risk assessment using the Domestic Abuse, Stalking, Harassment and Honour Based Violence Risk assessment (DASH 2009) in order to assess and manage the risk to AB appropriately. A referral was made to social services and a marker was placed on AB's address in Luton

5.90 At 22:05 hours the officers were given an address at London NW10 as the offenders address. The incident was recorded as a crime of Domestic Common Assault. The incident log also indicates that the officer dealing, asked for the incident to be deferred until 07:00 hours on the 26th August 2009, when he would be placing the assailant's details on PNC as being 'Wanted'. At 03:37 hours on the 25th August 2009 an officer recorded on the incident log that he had sent an arrest request to the Metropolitan Police for the suspect to be arrested. Additionally, the log indicated that an officer would attempt the arrest at the Luton address.

5.91 The incident log indicates that the MPS attended the address in London at 04:34 hours but there was no answer. They indicated that they would try again later. However at 09:23 hours, the MPS contacted Bedfordshire Police stating that due to a heavy workload they would be unable to attend the address again. A decision was made to keep the Bedfordshire incident log 'open' for 14 days in order for the offender to be arrested.

Comment: *This is good practice as all 'open' incident logs are reviewed by supervisors regularly.*

5.92 The following day, electronic records show that AB attended the CSC office for an initial meeting together with the midwife and the person undertaking the Parenting Assessment. At this meeting, it was agreed that a Planning Meeting/Strategy would

be held on 04/09/2009 to address the imminent concerns posed to the unborn baby following the incident.

***Comment**: Another opportunity to commence joint investigation was missed at this point. A decision was made at this meeting to proceed to Child Protection Conference. There was no evidence that a Strategy discussion took place which is concerning as police had a great deal to input to such a meeting. They were invited but were unable to attend. However, this meeting was later described as a Planning/Strategy Meeting. The case had by now been open for six months to CSC but there is no evidence that a Core Assessment had been started. The date given on the Core Assessment was that it started on 30th April 2009. The social worker was not able to give a reason as to why the Core Assessment was delayed when interviewed.*

5.93 The police investigation log shows that various officers had been tasked to arrest DE on six occasions between the 25th August and the 1st September 2009. On this last occasion the officers were advised by the occupants that DE had moved out two weeks previously. This prompted Bedfordshire Police to place DE on PNC as wanted.

***Comment:** The fact that officers had been tasked to arrest DE on numerous occasions indicates that offences of this nature were taken seriously by the police. However, consideration could have been given to placing DE on PNC earlier. The officers knew that DE sometimes lived in London and was proving elusive.*

The criteria required before a person can be recorded as 'wanted' on PNC have changed. In 2009 an officer was required to exhaust all possible enquiries before a person could be placed on PNC as being 'Wanted'. That is not now the case and wanted persons are placed on PNC as soon as it becomes obvious that they may not be readily located.

5.94 On the 1st September 2009, AB attended Luton Police Station and handed in a handwritten letter stating that the incident on the 22nd August 2009 did not take place and that she wished to withdraw her complaint. It is unclear what information AB gave to the Police Station staff, but it would seem that she stated it was written in the presence of a Miss SH, the implication being that this was AB's solicitor. In fact the crime report indicates that the officers, wrongly, made the assumption that the letter had been countersigned by a solicitor.

***Comment:** Bearing in mind the detailed account given by AB at the time of the incident the veracity of the letter is questionable. It is possible that AB was coerced into making this withdrawal letter and the police Review Officer was of the view that it is improbable that such a letter would have been condoned or supported by a solicitor. There are no solicitors of that name on the Law Society website.*

This letter was arguably indicative of the lengths AB would go to in order to disengage with the Police or alternatively the level of control being exercised by DE.

5.95 In spite of this letter from AB the Police considered that DE should still remain on PNC as wanted and be arrested for the offence. The rationale for this decision was that AB was still deemed to be at 'high' risk. Furthermore, due to the fact that AB refused to make a formal withdrawal statement, there was nothing to confirm that AB had in fact written the letter.

Comment: *This was the correct course of action in that positive action should be taken on each and every occasion, and is consistent with national policies relating to Domestic Abuse. There was also a referral to Victim Support and contact appears to have been made but there is no additional information.*

5.96 Even though AB was reluctant to engage with the Police, officers from the Domestic Violence Unit continued in their attempts to contact her. AB eventually returned their calls on the 21st September 2009, one month after the incident, and arrangements were made to complete a further risk assessment (RA) the following day. The case was also referred for MARAC consideration. The entry on the police system states: '*Considered for MARAC as 10 ticks on RA. However SSD involved and all children are subject to CP Orders and do not reside with this client. SSD currently involved in this case and have unborn child on register under 'neglect'. Client has support services with Women's Aid and social workers. Offender still to be arrested but client is not supporting prosecution**. Not for MARAC'.***

5.97 At the meeting between AB and an officer on the 22nd September 2009, AB gave a brief history of her relationship with DE. She also provided details of her three children and stated that she was due to have a caesarean on the 7th October 2009. She had a non-molestation order against DE and was attending the FREEDOM[4] project. AB was at this time living in a privately rented accommodation in Luton. Two of her children lived with her estranged husband, DD, in London, and the third child lived with the child's grandmother in Enfield.

Comment: *It seems from this meeting that although AB was not going to pursue a criminal complaint against DE, either through intimidation or otherwise, she was using her own initiative and resourcefulness to keep away from DE and protect herself from him.* ***It is not clear what the rationale was for the non referral to MARAC other than the children were already on CPP and she was in contact with a range of agencies. Arguably a MARAC at this point could have offered the opportunity to ensure the coordination of this work at a time that AB was working with a range of agencies and the birth of CE was imminent. Again there was arguably an opportunity to focus agency attention on DE through MAPPA or non MAPPA processes.***

5.98 A meeting between AB, DE and CSC on the 23rd September 2009 created an issue that could have had significant consequences for AB. Unfortunately CSC had inadvertently provided DE with AB's new address. This potentially not only placed AB at risk of further abuse but also possibly undermined AB's trust in an agency that could have provided her with support.

5.99 At 17:13 hours on the 23rd September 2009, an officer arranged for a 'Police Watch' to be placed on her address in Luton, as a consequence of AB's address being divulged. This instigated an incident log on the Bedfordshire Police Command and Control system and would remain on the 'Open' list until such time other measures had been put in place to reduce that risk.

Comment*: It appears that the information was passed inadvertently in a copy of a report provided to DE as part of the CPP process.*

[4] Freedom Project – Programme For women who want to learn more about the reality of domestic violence and abuse.

5.100 Arrangements were then made for a 'Sanctuary Room' and 'Panic Alarm' to be installed at the location. This work was completed on the 5th October 2009 and the 'Police Watch' incident log was closed.

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Comment:*. CSC would not move AB as she was in private accommodation.* ***It appears that at the time DE was circulated as wanted by police that he attended the meeting on the 23rd September 2009 with SD and CSC and police staff. It is unclear why the police did not move to deal with the arrest or at least investigate whether the wanted maker on DE needed to remain in place.***

By the 28th February 2010, DE had still not been arrested for this offence. He was still recorded on PNC as being wanted. This case was by then six months old and therefore was beyond the date that a complaint could be laid before a court. A supervising officer therefore filed the crime as undetected with no further action to be taken. Attempts were made to contact AB with a negative result.

Common Assault is a summary only offence and therefore attracts a limitation of proceedings of six months. This means that in accordance with Section 127 of the Magistrates Courts act 1980, summary only offences can only be tried if the information or complaint is laid within six months of the offence being committed. Whilst it appears that attempts were made to locate DE the incident on the 23rd September indicates that at least some members of the agencies engaged with the family were in contact with DE and there was an opportunity on that date to arrest him which would have been within the relevant 6 month period. The fact that this was not dealt with or at least addressed in a timely fashion has to be seen as poor practice, particularly as at least one opportunity had been presented when DE attended a meeting with police.

Recorded Information – 26th August 2009. Luton CSC

5.101 AB applied for a Non-Molestation Order on 26th August 2009 and this was granted following 5 recorded incidents of domestic violence between AB and DE.

Recorded Information – 4th September 2009. Luton CSC

5.102 A Planning Meeting was convened and took place on 4th September. AB informed the meeting that she was attending a group at Women's Aid every Wednesday and was due to start one to one counselling sessions with the Freedom Project. This was due to commence on 17th September 2009 but there is not known whether AB attended this. A ten point plan emerged from the meeting; a review was set for 1st October 2009 dependent upon whether a Child Protection Conference had taken place by then.

Initial Child Protection Conference – 23rd September 2009. Luton CSC

5.103 An IPCC was held by Luton CSC with what is recorded as good attendance to discuss unborn CE. Both AB and DE are recorded as being present as are Bedfordshire police and that previous allegations and withdrawals and counter allegations were discussed, including AB's apparent reluctance to prosecute (with DE present).

It would appear that intelligence regarding DE's links to Operation Trident were shared.
Because of the inappropriate disclosure of her address the police put in place additional protective arrangements for AB as outlined above.

Comment: *As noted above DE appears to have attended the meeting at a time he was being sought by police. It would have placed AB in an extremely uncomfortable position explaining her reluctance to prosecute or otherwise with the alleged offender present who was also subject of a non-molestation order granted on the 26th August and wanted at the time.*
The following day the police were recorded as saying that they had considered referral to MARAC but had decided not to and that DE was still to be arrested for the assault. There was no clear recorded rationale for the non-referral to MARAC as noted above. The MARAC may have allowed greater coordination of the work to protect AB and arrest DE.

Information – 29th September 2009. Bedfordshire Police

5.104 Bedfordshire Police record police and fire safety measures had been put in place and completed for the address AB was residing at as understandably she did not want to move.

Comment: *AB has heavily pregnant and CSC had already declined assistance with moving as she was in private accommodation.*

Recorded information Birth of CS – 7th October 2009.

5.105 Baby CE was born at Luton Hospital. DE was barred from the hospital and was at the time subject of the non-molestation order. The Hospital was recorded as being aware of the domestic abuse issues.

Recorded information – 13th October 2009. Enfield CSC

5.106 Information was recorded raising concerns about HB's situation now that AB and new born baby were living with AB's mother and AB was being left in charge of HB when her mother went to work. There were concerns about DE knowing where AB was.
The following day a social worker visited the home address of AB's mother and the risks associated with DE knowing AB's whereabouts were discussed and the mother agreed to a Community Safety alarm being installed

Recorded information – 15th October 2009. Enfield CSC

5.107 No further action was proposed in relation to Enfield CSC involvement with BD, ED and HB. All were removed from CP Plans in March 2009 and recorded as living in safe situations in other local authorities with referrals made to appropriate services. Case Closed recorded.

Review Child Protection Conference – 15th December 2009. Luton CSC

5.108 AB attended the Review Conference and informed those present that although there were safety measures in place she was not safe. AB confirmed that DE has been to the address since the birth of CE and that further domestic abuse had taken place including when she had been holding CE. AB also stated that DE had been to some of her friends' houses and had threatened them and that she was now very scared of him.

5.109 The mother of AB stated that AB has been concealing the presence of DE at the house even from her. AB stated that she has not contacted police as DE had removed her mobile phone and she did not have confidence in the police being able to attend any incident quickly enough. The recording states that there was good multi-agency attendance but there was no police officer due to sickness and an apology from the probation officer - no reports from either. AB confirmed that the Police had, since the last review, put a Marker on the address and put some safety measures into the home but she did not feel these had worked. AB admitted that she had had contact with DE during the review period at her home and that he had been violent towards her. **AB agreed to take up a refuge place at this point as part of the CPP and part of the contingency planning was that should AB leave the refuge a legal planning meeting should be considered**.

Comment*: The recording reflects extremely high levels of concern at this point with Women's Aid expressing their concern. This was the second multi-agency meeting in Luton which the police had not attended. Perhaps at this stage some arrangements' should have been put in place for DE to have controlled contact with CE as this would have limited the ability for DE to control the situation.*

Breach of Non-Molestation Order 17th December 2009 Bedfordshire Police

5.110 At 14:29 hours on Thursday 17th December 2009, Luton's Woman's Refuge contacted Luton Police Station stating that there had been a breach of the non-molestation order obtained by AB who was currently living in a refuge. The Refuge was attempting to book an appointment for a statement to be taken from AB.
The officer who received the telephone call recorded the incident and also recorded that AB had been suffering from domestic violence from ex-partner DE and that positive action was to be taken. Furthermore, that DE may have access to firearms. The victim would be available on Friday 18th December. The Sergeant on the Investigation Management Team was advised who spoke to the Refuge later the same day.

5.111 The Refuge stated that they were not now in contact with AB but would try and make an appointment for the following day. It would appear from the incident log that no appointment was made and the incident was closed at 08:03 hours on the following day.

Comment:

This breach of a molestation order was never dealt with and the incident was closed. There is no record of any feedback to the refuge staff member who made the report. This has to be viewed as poor practice and service to a victim and reporting person.

A and E attendance – 9th March 2010. NMUHT

5.112 On the 9th of March AB attended A&E at NMUHT via GP referral with a past medical history of diarrhea and vomiting for the previous two weeks.
AB also complained of not eating or drinking. No verbal or physical evidence of domestic violence was indicated. AB explained she was not happy to stay unless her 5 month old child stayed with her due to child minder problems. The doctor and staff nurse on duty explained that this would not be possible due to the infection risk to the child, but suggested they could get in touch with social services to assist with the situation. AB refused to have any involvement with social services and threatened to self-discharge.
Staff were unable to persuade AB to stay and let them help. Subsequently, she self-discharged herself and left with the child and her '*step father*'

A and E attendance – 12th March 2010. NMUHT and Enfield NHS

5.113 On 12th of March 2010 at 18.30, AB attended A&E at NMUHT with a past medical history of diarrhea and vomiting for the previous two weeks after leaving the department previously and being seen earlier in the day after a collapse at home. AB was then seen by the A&E Doctor who obtained a full medical history and carried out a full physical examination. From the evidence in these case notes shows, this physical examination indicated that she had sepsis; she was still suffering from diarrhea. AB was admitted for intravenous antibiotics, fluids and further investigations. CE was being cared for by '*stepfather',* at home. Investigations during this admission confirmed AB was suffering from flare up of Crohn's disease. Symptoms settled after the next few days. There was no indication within the notes of any evidence of verbal or physical abuse or domestic violence. AB remained an inpatient until 19th March 2010, discharged home with '*gastro follow up'* for 30th March 2010. A discharge letter was sent to the Enfield GP regarding this admission and subsequent treatment. AB was registered with the Enfield GP from 6th April. During this period the practice had little involvement with the family other than a GP who saw AB for the treatment of Crohn's. Although registered from 15/03/2011 – 31/05/2011 child HB was not seen by the GP surgery.
Thereafter AB was in regular contact with specialist support at NMUHT for treatment of Crohn's until November 2011 when treatment was transferred to Watford.

Recorded Information - 28th May 2010. Luton CSC

5.114 A Review Child Protection Conference Summary & Actions were recorded – *a decision was made to remove CE from a Child Protection Plan and move to a Child in Need Plan. The Core Assessment concluded on 28/05/2010 and recommended that Baby CE is removed from a Child Protection Plan as AB had continued to have a good working relationship with professionals; contact between CE and his father was taking place in paternal grand-mother's home; the home AB now shares with her mother is in good order and well presented. AB did access the Refuge before moving to her mother's house. No police involvement reported during the Review period. All CE's immunisations are up to date and he is registered with a GP*.
Luton were to liaise with Waltham Forest CSC and health visiting services with a view to transferring the case as AB was living in that area with her mother in a large and well maintained home.

Recorded Information - 26th August 2010. Luton CSC

5.115 A telephone call was recorded from AB's mother, by Luton CSC stating that AB was not contributing to the household and she had asked her to leave. She wished to inform them that AB has recently moved into a one bedroom flat in Enfield. She had also informed Enfield CSC that AB was back in their area

Breach of Non-Molestation Order - 30th August 2010. MPS

5.116 On 30th August, HB called police at the request of his aunt who had been on the telephone with AB who was apparently in dispute with DE.
AB alleged DE had visited her flat in Enfield, and having initially attended, left and then returned. She feared he would force entry if she refused, so she let him in. She stated that DE had demanded '*his*' money and hit her in the face. It is not described in any detail why they were arguing over money. AB was holding her baby, CE (*aged 10 months*) when he hit her again. During the incident DE and AB spoke to his mother on the telephone. DE is alleged to have threatened that if AB called police he would do some serious damage to her. It was at the scene of this call that police identified DE was in breach of a non-molestation order issued at Luton County Court relating to AB. He was **arrested** at the scene. During his arrest two officers were assaulted.

5.117 AB told officers DE had access to a gun and she was worried what he would do when released from custody. A risk assessment was completed and in view of his violence, alleged access to weapons, substance misuse and the history disclosed, the risk assessment was initially graded as high risk. This risk assessment was amended by the supervisor to standard risk on arrest as the threat had been removed. A crime report was completed for a Domestic Violence assault.

Comment: *As DE had been arrested and was in custody, the risk was therefore reduced and the reduction from high risk was appropriate. MPS guidance makes clear that the risk should be re assessed at any change of circumstances such as the release on bail of the alleged offender. No child referral was made.*
In view of the circumstances a child referral should have been completed for DE's presence and shared with the local authority Children's Services. There is no information recorded on the crime report as to what contact AB was having with support services or if the CSU spoke with the local social services on this matter. There is insufficient information to assess the impact this missing child referral may have had with any work the partner agencies were involved in with AB.
In fact CSC were made aware of the incident that same day by MPS and contacted AB.
There is no information on the crime report about what advice was given to AB regarding her future and current domestic violence situation

5.118 The incident was investigated by the CSU who supported the revised risk assessment it remained standard risk while he remained in custody. It was noted on the crime report that should DE get bail this would be revisited. DE gave a 'no comment' interview. The following day DE was charged with assaulting AB, assaulting two police officers, breach of the Luton County Court non-molestation order and offences for which he was arrested on 15th August. He remained in custody to appear at Haringey Magistrates Court on 1st September, when he was convicted and **sentenced to a total of 26 weeks imprisonment.**

Recorded Information – 30th November 2010. MPS

5.119 On 30th November, after serving half of the 26 week sentence, DE was released from HMP, to his mother's address in London, NW10. Police were notified in advance (*for information only*); he was not subject to any supervision on release and he fell below the threshold to become the subject of a MAPPA level 2. It would appear that by this date AB had moved but the review had not identified a specific address until the following incident.

***Comment**: There was arguably at the point of release an opportunity to consider the management of DE as a Category 3, MAPPA (2009) processes, given that by this point there had been a significant number of incidents of Domestic Abuse alleged, there were well recorded concerns about the risk to baby CE, AB was unlikely of her own volition to reduce the risks to both herself and CE and the convictions and intelligence that suggested his propensity to violence. These provisions are not used routinely but their potential does not appear to have been considered at any stage. The IMR writer for Enfield CSC also noted that it had been surprising that MAPPA had not been considered. There is no consideration to reviewing the risk assessment level to AB. This was reduced from high to standard based on the arrest and detention of DE. He had now been convicted and served a term of imprisonment for actions he would attribute to AB so the risk must now be considered high and a response appropriate to that risk put in place.*

Recorded Domestic Incident – 2nd January 2011. MPS and Enfield CSC

5.120 On 2nd January, AB called police to report that between, 31st December 2010 and 2nd January 2011, whilst staying with CE (*aged 14 months*) at room in a Travel Lodge, NW10, she alleged she had been assaulted over this period by DE and could not call police as he had taken her telephone.
DE was staying at the same address, but in a separate room. At some point an argument began and DE picked up a pair of scissors, grabbed AB by the hair and cut some off. During the attack her knee was cut by the scissors and at some stage he had demanded her car keys and bank card. When she refused he pushed her onto a bed in an attempt to go through her pockets. AB stated DE had choked her and threatened to break her jaw. He then left and she called police. CE was recorded as being present throughout all these events.

5.121 The risk was graded as standard risk. AB alleged DE only wanted to see CE to cause her trouble; the abuse was constant; he was jealous; he smoked cannabis and drank heavily every day.
This risk assessment was supported by the supervisor. A crime report was completed for domestic violence assault. In view of the circumstances the officers completed two reports; one for child welfare concerns as CE had been identified as being on a Luton CPP and the other for the Domestic Violence in the MPS.
These were subsequently shared (*2 - 4 January*) with the local authorities of Ealing, Brent and Enfield Children's Services and Bedfordshire Force Intelligence (*for their actions and to share with relevant partners*).
It is not clear in the reports why they were both staying at the hotel or if any support agency was assisting them but it would appear not. They provided police with respective Enfield and Brent addresses as home and contact addresses.

Within four hours, DE was arrested when he returned to the hotel. When interviewed he denied the allegations.
He was bailed to 17th January 2011, pending CPS advice, with conditions:

Not to contact AB, directly or indirectly;
To live and sleep at his mother's, in NW10
Not to attend the hotel where AB was residing.

5.122 The hotel reception staff were notified of the situation (they agreed to update other staff) and that DE should not attend the hotel. They were advised to contact police, via 999, should he return and breach his bail conditions.

5.123 On the 4th January Enfield CSC received a referral from the police Community Safety Unit with regard to the incident of domestic violence which had occurred at the hotel on 02/01/2011 between DE and AB. The referral noted that AB had booked DE into the hotel but this may well have been under duress from DE. AB was reported to have an Enfield address at this stage. Enfield CSC in turn carried out checks with Luton CSC and was informed CE had been on a CPP but AB had worked with the department and allegedly ceased contact with DE, therefore the CPP had ceased.

5.124 On 6th January, as DE was in dispute with his mother, these bail conditions were varied following a request to the investigating officers who made enquiries about the propriety of him moving back to the hotel. The room was paid for until April (*no details by whom*) and AB had by this time apparently moved back to her address in Enfield.

Comment: *There is no recorded information about the risk assessment being reviewed and updated at the change in circumstances. The risk assessment at this stage, with the known history is difficult to understand. It was graded as standard and this was agreed by a supervisor. This incident alone should have been assessed at high risk.*
It would have been appropriate to add a flag on the police system for AB's address. DE had previously shown that he did not respect authority having breached a court order, so there was a real likelihood he would contact her again, particularly as they continued to have a shared interest in CE. AB was updated as regards the change of bail conditions. The MPS IMR does not record what if any comment AB had in relation to the change of bail address. It is not clear what checks were carried out to establish if AB was still using the Travel Lodge, but it is clear from the information on the 28th January that they had resumed living at the premises by that date if not before.

Referral re Domestic Incidents – 13th January 2011. MPS

5.125 On 13th January, the MPS Child Abuse team received a written referral from Enfield (CSC) to discuss the recent domestic violence incidents in NW10 as AB and DE were back residing in Enfield. As a result of this discussion it was established that since August 2010, CE was no longer on a Luton CPP. There was no role for the CAIT and so no further action was required by them. The ongoing police investigation was being dealt with by the CSU at Southgate and Enfield (CSC) would deal with the matter within their guidelines.
Later this day, AB attended a Police Station where she provided an additional statement regarding the 2nd January report. AB and CE were also seen by CAIT

officers. They discussed that she was the subject of repeat domestic violence and established she intended to renew the non-molestation order previously granted at Luton County Court. Police protection was considered by the supervisor for Community Safety but due to insufficient grounds it was not actioned. This information was shared with Enfield (CSC) via a child referral.

Comment: *At this point it would appear AB was still cooperating with the prosecution*

Information on Prosecution Decision – 17th January 2011. MPS

5.126 On 17th January, a review of the evidence by the CPS took place relating to DE's offences between 31st December 2010 and 2nd January 2011. Due to, '*a lack of corroborating or independent evidence; her credibility was undermined by having withdrawn reports previously; admissions that parts of other incidents had never happened; inconsistencies in the recent account, the matter was not proceeded with'*. AB was updated and appraised of the reasons for the decision and appears to have accepted the result without comment. AB had told officers DE had been seeing CE, arranged through her and DE's mother.

Comment*: There may have been a breach of the bail conditions but AB told the officers that he had not breached them and the matter was not investigated further. AB was spoken to about obtaining an injunction and formalising access to CE and indicated that she was due to see her solicitor that week.*

Recorded information – 28th January 2011. Enfield CSC

5.127 Enfield CSC recorded information obtained from the police CSU. Confirmation was received from the Travel Lodge that both DE and AB were living at the hotel. The Hotel reported domestic incidents in the dining room. AB had allegedly responded aggressively when staff tried to intervene. No further action was taken against DE regarding recent allegations on 02/01/11 due to AB being inconsistent and serious concerns regarding her credibility. DE was reported to have said that he had tried to leave AB but she wouldn't let him go. Confirmation was received that CE was also residing at the Travelodge with AB.

Recorded information – 31st January 2011. Enfield CSC

5.128 An e-mail was received from the police CSU confirming details of allegation made by AB against DE of threat to kill made on 06/01/09. Subsequent allegation then made by AB of attempted sexual assault - DE denied this and AB refused to make a statement. Police took no further action..

Comment: *This would appear to be separate allegation to those made on 2nd January 2011 but no further action appears to have been taken.*

Recorded Information Contact with SD – 1st February 2011. Enfield CSC

5.129 An ICPC was held to discuss CE and AB which again clearly focused on the child. They were recorded as living in Enfield, and as a result of the meeting CE was placed on an Enfield CPP. As part of the decision to deal with the domestic violence within their relationship, there was planned to be discussion with both parents about outreach work and support, as well as an agreement for the social worker to refer the matter to the local MARAC. At this time it appears AB was living between the hotel in Brent and her home in Enfield. As a result police contacted the local police neighborhood team covering the hotel to make them aware of the potential for domestic violence incidents.
AB was informed, the next RCPC was planned for 15th April, and that CE had been placed on a CPP on the basis of AB and DE living together at the Travel Lodge address.
AB stated to CSC that she was not happy with that and would not engage with CSC.

Comment: *AB is recorded, when contacted to update her, as having confirmed that she was living with DE and CE at the hotel and that she will not work with CSC. The discussion in the CPC recorded a concern about the likelihood of AB refusing to cooperate with the CP process which was to be expected given previous experience, but this did not include any recommendation re: contingency procedures should this arise. Furthermore, although the conference recommended referral to domestic violence services, there was no suggestion of involving a domestic violence professional in future conferences or core groups which may have led to closer inter agency assessment and work.*
In the view of the Overview Report Writer it would have been appropriate at this point to have considered CE as potentially at immediate risk of significant harm and this could have been identified as a part of the contingency planning.

Recorded Domestic Incident – 3rd February 2011. MPS

5.130 On 3rd February, DE called police to the Travel Lodge Hotel. He stated his partner AB had assaulted him and taken his mobile phone but provided no reason for the assault. There is no recorded injury or any information to establish the extent of the assault. She was apparently in room 620. His room at the time is recorded as 710. It is unclear in which room the alleged assault took place. He was asked not to return to her room and to wait in reception and for police to arrive. Police attended the Travel Lodge but got no reply at DE's room. They were informed by staff he had left 10 minutes earlier.

5.131 Hotel staff stated AB had left and was expected back at the hotel later that evening. It was agreed with hotel staff they would call police when DE returned. Around 6pm, police were contacted and informed that DE had left a message with them to tell police he no longer wished to report the incident. In turn police left a message with hotel staff for DE to contact police if he changed his mind.

5.132 On 4th February, at about 12.45am officers attended the hotel to speak with DE. The staff knew of DE and stated that he had left and had not been seen for a few hours. He had by this time checked-out of room 710. The officers attended AB's room and DE was not present and the female occupier (believed to AB) did not wish to speak with police. The police report was closed with the comment that DE had refused to speak with officers and police had made reasonable enquiries to establish if he had or had not been assaulted. He had told the staff at the hotel that he no longer wished police to report the matter. A message was left with the hotel staff to contact police should he wish to report the matter.

***Comment**: The attending officers clearly tried to speak with both parties over the evening. Although the report notes the officers thought this matter did not reach the threshold for a domestic violence incident, as it appears that DE did not wish to report the assault; based on the information shown on the report that both parties were known for domestic abuse it should have resulted in a Domestic Incident crime report to record the facts.*

There was sufficient information on the report to create a report showing both parties names, the hotel details and to record the incident even though police may not have been able to progress the investigation at a later date.

It appears the MARAC referral was underway as the decision sheet noted the following: 'Social Worker is to follow up referral to MARAC and the specific need for a safety plan'. Additionally the record showed consideration should be given to re-housing AB and CE to an address unknown to DE. Part of the information being forwarded to support the MARAC referral was that AB had been involved in an incident at some time in late March where she disclosed to her social worker that DE had assaulted her in front of CE on the day she asked him to look after him while she took her other children out for the day. She also had reported (not to police) he was violent and paranoid when she came home late. She was advised by her social worker to report the matter to police. It does not appear that she did.

Recorded information – 14th February 2011. Enfield CSC

5.133 A request was made for a Legal Planning Meeting following the fact that CSC had not been able to contact AB and therefore see CE. This was then agreed to on the 16th February but later discontinued by April, *'on the basis of her cooperation'*.

***Comment**: It can be argued that the Legal Planning Meeting could have been considered sooner given the fact that on being told the outcome of the conference on 1st February, AB had stated categorically that she would not cooperate and that the discontinuance was premature as in reality there is little evidence of cooperation around the main safeguarding issue: her continued contact with DE, which she may not have been able to avoid or prevent.*
DE was later recorded by CSC as stating that he had been at the house throughout, hiding from CSC when necessary.

Recorded information – 28th February 2011. Enfield CSC

5.134 A Core Group Meeting was held. AB did not attend despite voice message and e mail from the social worker.

Recorded Domestic Incident – 22nd March 2011. Enfield CSC

5.135 AB informed CSC on a child protection visit that she had been assaulted in her own home by DE. She indicated damage to the front door and further damage to the flat. She alleged that DE had hit her head against the wall whilst CE was in the room. She confirmed to the social worker when asked that she had not reported the assault to the police as '*they did not respond with any sense of urgency'*. AB was advised to

call the police for the protection of herself and CE and to ensure that police keep a log of the incidents.
CSC recording stated that a referral to Women's Aid was made and that they made contact the next day but no refuge place was offered.
CSC is recorded as passing the information on to the police to ensure priority attendance.

Comment: *Both referrals are good practice*

Recorded Information Enfield GP Surgery – 22nd March 2011.

5.136 CE sustained an accidental fall from mother, who fell on a towpath; a laceration to the forehead of CE was recorded. No loss of consciousness, nausea or vomiting. CE was recorded as alert and active with a superficial laceration to right forehead.

Comment*: At this point the previous GP records had not been received in Enfield so the GP practice was unaware of the history of domestic abuse and child protection issues and the Primary Care was transferred to a Medical Centre on the 31st May. No referral to CSC was made.*

Recorded Information – 15th April 2011.

5.137 A Review Child Protection Conference was held and CE remained on a CPP.

Recorded Domestic Incident – 30th April 2011. MPS

5.138 On 30th April, AB called police alleging DE was trying to force entry to her home in Enfield.
Upon arrival of police both AB and DE were outside the flat. There was no sign of any damage to the door. DE claimed he was trying to collect his personal belongings and AB was being obstructive, so an argument ensued. AB was recorded as saying she only wished to have the events documented as she stated she was in the process of obtaining another injunction against DE. Later that day DE returned to the address and left with a TV. Police were called again to prevent a breach of the peace and no further action was taken. A domestic violence report was completed and the risk assessment graded as standard risk. AB declined to answer the officer's standard questions to assist the risk assessment. A Domestic Violence crime report was completed and a child referral was completed for CE's presence and shared with both Enfield (CSC) and Primary Care Trust by the PPD.

Comment*: The report was supervised by the weekend Detective Sergeant (DS) (responsible for all crimes). He was aware of the requirements of the research and review process and having done both, confirmed the risk assessment as standard risk. However, the research, reported as being conducted for the previous five years noted, 'there are no reports on the system that bear relevance to domestic violence issues'. There is no record as to what the research did identify or the criteria used which gave that result. As no offences were disclosed; AB reported the matter for it to be recorded and she was in the process of separation and renewing her injunction,*

the report was closed without either party being contacted further. Given the apparent failure to identify the previous recorded history of domestic Violence there was limited opportunity for the officers to consider arrest on either the first or second attendance.

The research should have identified the previous incidents and reports, including a term of imprisonment of DE for domestic abuse related offences against AB. Whilst in isolation this incident may have appeared a standard risk, consideration of the history would have almost certainly reflected a more realistic risk level of high. This was confirmed by the case being heard at MARAC three days later, MARAC being concerned with high risk cases.

MARAC Meeting Enfield – 4th May 2011.

5.139 On 4th May, Enfield held a MARAC where AB was discussed following a referral from CSC. It was listed for the meeting following an earlier referral from the social worker involved with the family and the decision to refer from the RCPC.
The following information was included as the reason the matter was referred to the MARAC: the family was previously known to Enfield, Brent and Luton (CSC) who referred them to Enfield CSU (*no date as to when exactly they were referred to the CSU*), AB had reported many incidents of domestic violence and at a recent home visit (22nd March), AB disclosed she had again been assaulted and DE had forced entry. CE was present, and when visited she was told to report all incidents to police and her social worker.

5.140 The minutes show that DE was considered by the referrer as 'v*ery controlling and subjects victim to serious domestic abuse*'. The meeting also noted that three of her children no longer lived with her and CE (*who did live with her*) had previously been the subject of a Luton CPP due to DV incidents. It would appear that the meeting was aware (*from the referral form*) of the Luton County Court Non Molestation order, but **there are no details of any domestic violence in Luton shared at the meeting.** At this time it appears AB was the subject of rent arrears and being threatened with eviction.
The agencies already working with AB appear to have been the result of the decisions of the RCPC. At the time of the MARAC, AB was already in contact with Solace Woman's Aid and the IDVA had planned to complete a risk assessment on 6th May.

Comment: There is no reason apparent for the non-inclusion of significant information from Luton with regard to previous incidents relating to AB and DE, *but given there was shared knowledge of the history of violence the meeting would have been aware of the risks to AB.*
The Enfield MARAC meets every three weeks and discusses between 20 – 25 subjects at each meeting. Once the decisions have been made, it is for the professionals engaged with the client to bring the matter back to MARAC if there are any issues requiring further discussion. ***In AB's case it did not come back to MARAC but a further referral appears to have been made on the 18th May. On 3rd August, the case was forwarded to Hertfordshire by a MARAC to MARAC referral by the MARAC coordinator, as AB had moved to Watford.***

Information from SOLACE – 6th May 2011. Enfield CSC

5.141 Solace Women's Aid/ IDVA confirmed the following day that AB was at high risk and that they were seeking to assist her with alternative accommodation and an injunction and by 17th May, a property in London was available and Solace assisted with other additional financial support.

Information – 17th May 2011. SOLACE

5.142 AB accepted the property arranged by Solace but was recorded as needing '*some support around asserting boundaries and not telling DE where she's living*'. AB had an appointment with the Citizen's Advice Bureau (CAB) for them to help her sort out her benefits

Information – 18th May 2011. SOLACE

5.143 A second MARAC referral was sent to Enfield MARAC by the IDVA.

Recorded Domestic Incident –19th/ 20th May 2011. MPS and Enfield CSC

5.144 On 19th/20th May, DE called police to AB's address in Enfield where he alleged she had hit him around the head and damaged his belongings.
Research by police control prior to police arrival noted the address was known for child protection and domestic violence, naming AB. On police arrival AB stated an argument had taken place over access to CE (*aged 19 months*) who was at the address at the time, and regarding DE's personal property. AB claimed he threw her clothes into the bath. It transpired AB was in the process of moving home that day (probably to the safe house) and DE had agreed to take over the tenancy of the flat in Enfield. DE stated they had a verbal argument over him having access to CE and he also wanted to recover his personal property. He would not substantiate the assault allegation. A Domestic Violence report was completed and the risk assessment was initially graded as medium risk in view of AB declining to answer the officer's questions to assist the risk assessment, previous known domestic violence incidents and the child protection matters.

5.145 Following supervision by a sergeant the risk assessment was reassessed as standard risk. The supervisor has not recorded any rationale as to why this was downgraded and cannot subsequently recall the reason why this decision was made.. A Domestic Violence crime report was completed as DE would not substantiate any allegation of being assaulted. A child referral was also completed for CE's presence and shared with both Enfield (CSC) and Primary Care Trust by the PPD.

5.146 The CSU supervisor considered the risk to AB and in the investigation plan recommended an IDVA referral. This was completed by the investigating officer who considered the risk and in agreement with the IDVA ensured a marker was shown to the address. The local CAIT were informed as CE was subject of an Enfield (CPP) for safeguarding matters. The officer sent an email to the PPD to make them aware

of this incident and to ensure that any child referral completed in the future was shared with CSC. The rationale for this was to ensure that relevant agencies were aware of the incidents and so all would be considering MARAC referrals should anything occur. At this time the officer recorded that AB was working with the IDVA. Later that day AB contacted CSC and provided a slightly different version of events - DE had attended her home - pushed his way in and stolen her keys and other items. AB stated that she not called the police because DE had called them, claiming that she had assaulted him. She confirmed that CE had been present. The social worker discussed concerns that DE had belongings in a property where he was reported not to have lived, AB stated that DE has never lived with her, stating that he is fabricating stories to get the police on side. AB also stated that DE was able to ascertain the address of her new "safe" address. AB informed social worker that she and CE could stay at DD's (ex partner).

Comment: *There appears to be some confusion in the recording around the dates. Solace encouraged her to report her version of the incident to the police herself as no arrest was made or report taken on AB's part when the police attended; and she had been subject of assault herself she alleged. She stated to them that she would do so but it appears she did not contact the police again. The risk assessment again would seem to reflect this as a single incident and not taking the history and ongoing MARAC case into consideration.*

MARAC Meeting – 25th May 2011. Enfield CSC

5.147 On 25th May there was a further MARAC meeting at which the case was discharged.

Comment: *There is no rationale for the discharge (although it seems likely there was an anticipation of a transfer to Watford on 3rd August), given the recording that there was continuing violence and neither CE nor AB were regarded as being safe, Solace continued to support AB and there was ongoing work to move AB to Watford. This action would appear to be totally inappropriate with the ongoing issues at the time.*

Core Group Meeting – 2nd June 2011. Enfield CSC

5.148 A Core Group Meeting was held at the family home. AB was supported to identify safe areas where she could move to safeguard herself and CE. AB was informed that should she choose to remain in the Enfield area, the Local Authority would instigate legal care proceedings and would consider removing CE from her care. She was given 24 hours to make a decision.
AB had not progressed with the injunction (as advised to a number of weeks prior) as she had been unable to prioritise this due to having to move quickly.

5.149 AB did agree to follow this up within 2 working days and the following day confirmed that she would move to Watford.

Information recorded re move to Watford – 8th June 2011. Solace / CSC

5.150 AB moved to Watford into Bed and Breakfast on the 8th June with the intention of finding longer term accommodation and was being supported by Solace and Enfield CSC in moving. AB was recorded there as coming back to Enfield for hospital

appointments and Solace and CSC staff expressed their concerns about the danger to her and CE in coming back to Enfield.

Comment: *This is evidence of good focused work to try and support AB in changing her address and to protect her.*

Recorded Domestic Incident – 19th June 2011. MPS

5.151 On 19th June, police were called by a third party (*declined details*) stating a domestic argument was ongoing at the address in Enfield, where young children were heard screaming and sounded very distressed; property was being thrown out of the window and sounds of 'smashing' inside the flat. They were recorded as having been arguing all day. The reporting system identified previous domestic violence at the address.

5.152 On police arrival there was no disturbance and both were calm. AB and DE were spoken to separately. AB said she was at the address to reclaim money from DE. DE stated he was given the money to buy groceries. CE (*aged 20 months*) was present and officers recorded he appeared fit and healthy and no concerns were raised for his welfare. There was no recorded damage at the premises. The informant did not wish to be spoken with. Police took no further action and did not complete the required Domestic Violence report or risk assessment.

5.153 The officers completed a child referral which reflects the above information for CE's presence. The child referral report shows the officers recorded the matter was a '*civil dispute'*; AB was now living in Watford, and DE at Enfield.
The child referral was assessed by the PPD and cross referenced to the crime report created when CE was placed on an Enfield CPP. The referral was subsequently shared with both Enfield (CSC) and Primary Care Trust by the PPD.

Comment*: This incident should have been recorded as a Domestic Violence incident and on the circumstances later given by the mother of AB possibly a crime which required further investigation.*
The mother of AB in speaking to CSC later asserted that AB was cut to her arms with a knife and that DE had threatened to stab her. AB herself later informed CSC that she had gone to Enfield to collect a letter regarding her benefits - she stated that DE was there and that she had called the police - DE had allegedly taken her bank card, £40.00 cash and her mobile phone. The police were able to retrieve the phone and bank card, but not the £40.00 cash. The police report in relation to the matter did not corroborate AB's version of events and CSC challenged AB about the differing versions of events - she claimed that police had taken "DE's side".

Recorded Information – 21st June 2011. NMUHT and Enfield NHS

5.154 AB missed an appointment for management of her Crohn's Disease due to an "*altercation",* with partner therefore was unable to attend hospital. The Hospital noted that CSC were already involved and had moved AB for her own safety. A letter was sent to her GP and advised of the domestic situation and CSC involvement. This was the first noted evidence of domestic violence indicated within NMUHT. A subsequent follow-up appointment was arranged.

Comment: *This information was forwarded to the Medical Centre, were AB was registered for primary care but was not followed up on the basis that by this stage AB was already resident elsewhere, although still registered with the Centre. The Centre had not received the previous medical records by this date following the transfer to them so were not aware of the full history of DA.*

Recorded Domestic Incident – 23rd June 2011. MPS and Enfield CSC

5.155 On 23rd June, Hertfordshire Police contacted the MPS following an abandoned call for police traced to the Enfield area. Although this was a pay-as-you-go mobile with no subscriber, Hertfordshire Police completed further research and identified an address, as connected to the telephone number. MPS were asked to complete a welfare check on the occupants of this address. This address did not exist and an alternative was checked later that day. It was not clear whether the confusion around the address originated with the MPS or Hertfordshire but it caused delay in attending.

5.156 Some hours later therefore officers spoke with AB there who said she was there as she did not have enough money to feed CE (*aged 20 months*). She and DE admitted they had argued over money. Following a discussion with officers, DE was fully cooperative and agreed to leave to defuse the situation. A Domestic Violence report was completed and the risk graded as standard, a child referral was made due to the presence of CE.

5.157 The incident was supervised by the CSU Detective Sergeant who revised the initial risk assessment, based on the report information and research information, to medium risk. The report had very detailed research and a précis of the known police information. The DS appears to have required more clarification about the answers in the report and directed the investigating officer to contact AB for clarification. In the investigative strategy he advised the matter should be referred to the IDVA and for MARAC consideration. The child referral was subsequently shared with both Enfield (CSC) and Primary Care Trust by the PPD.

5.158 The investigating officer noted on the crime report that AB was engaging with social services and cross-referenced the report created when CE was placed on an Enfield CPP. The officer spoke with AB who had apparently moved to a ‘safe house’. The officer also spoke with the IDVA who informed him that AB was engaging with them and she had been spoken with the day before. On reviewing the risk assessment, he concluded the risk had been reduced. She was living at a location believed to be unknown to DE, being supported and was engaging with local authority Domestic Violence services. The following day Enfield CSC, advised AB that she was not safeguarding CE by continually returning to Enfield and placing them both at risk. She was advised that it was a concern that she was not being open and honest and therefore was jeopardising CE’s wellbeing.

Comment*: This was good work in persevering in researching the call and following up but again, it is possible to argue that strict compliance with the positive action policy would have resulted in the arrest of DE given the previous history and the later recording shows supervising officers recognized the issue as DV and the potential risk to AB. It is accepted that in this case the argument for arrest is tenuous on the circumstances taken in isolation, but the attending officers did identify the incident as domestic and it appears to be confirmed that AB was the caller.*
CSC records show that Solace state that AB said that DE had again cut her arms and tried to stab her but AB had not pursued the allegations as DE made counter

allegations. CSC record that Solace continued to work with AB over the following days to try and assist and support her.
It is not clear if this was referred to MARAC separately as the process of transfer from Enfield to the Hertfordshire MARAC appeared to be in place at this point.

Recorded information – 27th July - 2011. Enfield CSC

5.159 A Core Group Meeting and Statutory Visit (Child Protection) in Watford Travel Lodge was recorded. AB was looking forward to moving to the new property. AB said she would be pursuing the injunction as she acknowledged that this needed to be in place for CE's safety.

MARAC Referral to Hertfordshire – 3rd August 2011.

5.160 On 3rd August, the CSU MARAC Coordinator completed an Enfield MARAC to Hertfordshire MARAC referral form, sent by email, showing the movement of AB and CE to a temporary address in Watford.

Comment: *there is no apparent reason for the gap in the discharge from the Enfield MARAC in May and the referral. It is assumed that it was based upon AB actually confirming the move to Watford but in reality agencies continued with contact with AB. This should have occurred in a far more timely fashion.*

Recorded Information – 18th August 2011.

5.161 A Statutory Visit (Child Protection) was carried out – CE was seen at home in Watford. AB confirmed that she would not make any further contact with DE or attempt to return to Enfield. The Injunction had still not been pursued as there was an issue with Legal Aid for AB.

MARAC Hertfordshire – 23rd August 2011.

5.162 AB was referred to the Western MARAC in Hertfordshire via the Enfield MARAC. The reason for the referral was due to AB's move into Hertfordshire and the history of DV committed by DE.

Risks Identified.

5.163 Threats to kill. Attempted strangulation. Use of weapons. Drug use. Access to firearms. Previous violent behaviour. Failure to comply with previous injunction. Child Protection. Previous self-harm by AB.
AB reported that she currently felt safe at her address.
The risk was not recorded as imminent as DE was in custody. Risk of harm was considered high upon his release.

Actions.
5.164 Actions already completed prior to MARAC. Marker placed on her address. AB referred to Watford Women's Centre.

Actions from MARAC.
IDVA to be invited to CP conference. To encourage AB to engage.
Children's Services Representative to seek to chair CP conference.
Police to make further enquires with the Met Police.

5.165 AB was referred to the Hertfordshire IDVA Service in August 2011 by the West Hertfordshire MARAC co-ordinator. At that time two IDVAs covered the Watford area. One was a recently recruited police employee, whilst the other was employed on a temporary basis. Neither was CAADA trained. Their line manager was a newly appointed Victim Support employee based at Hertfordshire Police HQ in Welwyn.

Comment: *The recording indicates that AB received good support from the IDVA service in Hertfordshire and that the fact that staff were newly in post did not have any impact on AB. Following contact with AB a full Domestic Abuse Stalking and Harassment (DASH) risk assessment was completed and safety advice was given. A marker was placed on the police intelligence system to indicate that AB was a vulnerable victim.*

The issue for the IDVAs was that AB was difficult to contact and would not reply to their messages. However, they continued to monitor the situation and made a welfare call after the incident on the 23rd September 2011, which led to a West Hertfordshire against Crime (WHAC) home security service referral.

The two IDVAs reported back to the Watford MARAC on the support they had provided to AB. However, the case was ultimately closed due to their other caseload and difficulties in contacting AB.

AB seemed to them as reluctant to engage, this could be for a number of legitimate reasons apparent to AB due to the level of threat and assault she has been subjected to and these reasons would have been worthy of exploration..

Recorded Domestic Incident – 27th August 2011. MPS

5.166 On 27th August, police were called by DE's mother stating his ex-girlfriend (*AB*) was trying to break into her flat in, NW10. Over a period of three minutes she described over the telephone DE fighting with AB who at some stage allegedly had a knife and was causing damage at the home. On police arrival there was no disturbance, no knife was found and no offences were alleged. Allegedly AB had attended the address as she wanted some money from DE. She was with CE and was advised by officers to leave which she did. She was also advised to seek '*civil remedy'* regarding maintenance payments from DE. Police took no further action but completed a domestic violence form and risk assessment grading the risk of the incident as standard, they completed a child referral. The child referral gave AB's address as High Street Watford, and DE is shown as living at his mother's address in London.

5.167 The incident was supervised by the CSU Detective Sergeant who advised the investigating officer to contact AB, complete necessary research regarding revising the risk assessment and refer the matter appropriately. It was identified that there was to be an Enfield RCPC and liaison took place between the PCLO and CSU supervisor as regards attending the conference and sharing information. The officer

was unable to contact either AB (*no contact number*) or DE (*his mobile was not working*) so sent both letters with a list of support agencies contact details and a message for them to contact the CSU. The risk assessment was confirmed as standard risk. The report was closed as there was no contact made by either party. The child referral was subsequently shared with the Hertfordshire Force Intelligence Bureau for dissemination within their area by the PPD.

5.168 On 3rd October, police attended the Enfield RCPC. The case was still awaiting transfer to Hertfordshire as AB and CE were now residing in their area. At this time the meeting noted that AB had a new male friend named A (*no other details*). A request was made to the social worker to follow up a referral to MARAC in Watford in order to ensure a safety plan was being completed. Police agreed to research 'A' when full details were established.

5.169 On 31st October, the child protection plan was transferred to Hertfordshire and CE was removed from the Enfield CPP and became the responsibility of Hertfordshire.

Comment: *AB provided a different account of the incident to Solace worker alleging that DE had cut her arms and attempted to stab her.*
The IDVA service continued to try to keep contact with AB after this date but ultimately as recorded above took no further action based on the difficulty in maintaining contact with AB.

Recorded information – 1st September 2011. Enfield CSC

5.170 A telephone contact from AB was made chasing the Transfer out Conference date. It had not yet been arranged. Contact was made with Hertfordshire and message left.

Recorded information – 21st September 2011. Enfield CSC

5.171 A Core Group meeting and Statutory Visit (Child Protection) were carried out by Enfield CSC, in Watford (no concerns with CE) - AB confirmed her benefits had been sorted out. She had not at this point applied for the injunction – AB stated that DE did not know they were in Watford. AB stated that CE last saw his father in July prior to the move to Watford; this was later then changed to August in Brent.

Comment: When considering the fact that an injunction had not been applied for the fact that AB had an issue with Legal Aid (5.162 above) funds and that she was concerned that DE may be able to locate her location at that time have to be taken into account.

Recorded Domestic Incident – 23rd September 2011. Hertfordshire Police

5.172 At 13:14 hours on Friday 23rd September 2011, Hertfordshire Constabulary received an emergency telephone call from a person calling herself AB. The incident log indicates that a female could be heard in the background screaming.

The Police were unable to verify a location from where the call was made and intelligence checks were conducted on the incoming mobile phone number without success. At 13:23 hours, Force Control Room Staff were able to speak to the caller again who stated that DE had cut her hair with scissors and threatened to kill her with a knife. She stated that she was at an address in Watford, and that there was a child in the house although DE had now left. His description was given.
At 13:25 hours, officers were deployed and due to the allegation that DE may still be in possession of a knife, the authority was given to deploy tasers. By this time the Force Control Room Intelligence Unit were able to access the National Intelligence Database which confirmed the address and provided details of the victim, perpetrator and child.

5.173 At 13:46 hours, officers arrived at the scene. AB explained how they had argued over a set of keys and how DE had held her down and cut bits off her hair, had then gone into the kitchen and threatened to stab her in the legs. There was no recording of evidence of any physical injuries and '*AB did not appear distressed, but was more interested in getting her expired injunction back*'. Officers confirmed that DE was not still on the premises. AB believed that DE would go to his mother's address in Wembley. Other officers, in the meantime, were in the process of conducting an area search for the suspect, including the railway station, without success.

5.174 The officer left the premises momentarily to return to his vehicle to obtain statement papers and when he returned there was no answer at the door. The officer tried AB's phone, again there was no reply. CCTV was viewed and there was no sign of a male fitting the description of DE leaving the flats at the time of the call. Police officers continued with their enquiries, speaking to neighbours and making further attempts to contact AB.

5.175 At 18:17 hours Hertfordshire Constabulary Control Room received a call from AB who stated that she was in London and wanted to be seen between 0900 and 12:00 on the 24th September. She stated that she had waited 30 minutes for the officer to return but had to go out.

5.176 At 11:17 hours on Saturday 24th September, officers attended AB's address in Watford as a result of her request the previous day. On arrival there was no reply, although initially the television could be heard. Enquiries were made with the neighbours who stated that they saw the female return home at about midnight and they had heard a baby cry approximately one hour ago. Bearing in mind the initial incident, the officers took the decision to force entry. There was nobody in and there had been a power cut inside the address.

5.177 At 13:00 hours an officer did manage to speak to AB as a result of her returning to the flat. It would appear that AB confirmed that an incident did take place but she was unwilling to provide any details. The officer recorded the incident as a crime (ABH) and assessed the risk to AB as 'High'.

5.178 At 15:03 hours DE was **arrested** at Hemel Hempstead Police Station by prior arrangement on suspicion of assault occasioning actual bodily harm. He was detained for a period of 11 hours 31 minutes. He was not charged, but released on bail until the 16th October 2011, as a consequence of AB being unwilling to support a prosecution.

5.179 On the 27th September 2011, 'Associated Persons' details were placed on the incident relating to DE, and a Domestic Violence marker was placed on the address. The case was also referred to CSC.

5.180 Attempts were made to obtain a witness statement from AB without success. Finally on the 4th October 2011 AB was spoken to by a Domestic Violence Officer (DVO) and she remained adamant that she would not provide a statement or support a prosecution. AB stated that she had got over the incident and that she was finding it increasingly difficult to cope with Social Services and how they were treating her like a bad parent and scrutinising her when she was the innocent victim. The DVO recorded that AB remained insistent that she would not make any statement and that nobody would convince her to do so. She could only cope with one thing at a time and it would all be too much. AB was given contact numbers for the Harm Reduction Unit, but she stated she would be unlikely to call and wanted to be left alone.
On the 6th October 2011, the Crown Prosecution Service advised the case officer that due to there being no victim statement, the case would not go to court. DE's bail was cancelled and no further action taken.

5.181 AB was referred to MARAC (Multi-Agency Risk Assessment Conference) and a meeting took place on the 25th October 2011(see below). The outcome of this meeting was that the IDVA would advise AB to move out of the area and also to support the Police '*in bringing DE to justice'.*

Comment: *AB's failure to engage with officers in this incident reflects her reluctance or inability to take positive action against DE on previous occasions. The events following each reported incident tend to follow the same pattern. The initial emergency telephone call had been made and the event superficially resolved. AB made it difficult for the officers to conduct their enquiries through her unwillingness to support a prosecution. This was the first incident where Hertfordshire Constabulary had been involved with AB and Officers showed patience and spent a great deal of time trying to bring the investigation to a successful conclusion. They carried out enquiries with neighbours, examined CCTV and returned to the address on more than one occasion in spite of AB apparently going out of her way to avoid them. They attempted to deal with the offender without the victim's support.*
Police referred the matter to the CPS initially, and CPS was recorded as deferring any decision until AB had been seen by a specialist DA officer which was good practice.
This reflected the perseverance of Hertfordshire Constabulary in trying to pursue a prosecution and extremely good practice by both police and CPS.
Note: This was the second MARAC to be held in Hertfordshire regarding AB. The first one was on the 23rd August 2011 as a result of a referral from Enfield. Once a case has been subject to MARAC, and there is a second incident of DV within twelve months, there is an automatic referral.

5.182 The incident was referred to Victim Support's Victim Care Unit (VCU) by Hertfordshire police on the 23rd September 2011. On this occasion contact was made with AB by a Victim Care Officer (VCO) and a referral made to the Independent Domestic Violence Advocate (IDVA) and she declined support. In accordance with the operating instructions in place at the time no further action was taken.

Comment: *Those interviewed from the IDVA service agreed that access to better information would have made the risk assessment process more effective. For example, the two relevant IDVAs did not have direct access to Victim Support's information systems. The culture appeared to be at that time that an IDVA should*

look at the situation from the client's perspective and there was a view that having greater access to information might change the IDVA/ client relationship. Thus prior to MARAC the police in Hertfordshire would only provide the IDVA service with basic referral information. There was a view that such an approach enabled the IDVA to be independent, in that they had no preconceptions.

Neither IDVA subscribed to the view set out above when interviewed for the respective IMR, but were of the opinion that access to information was essential to making informed decisions. Access to better information might also have helped the IDVAs to challenge AB's behaviour and reluctance to engage at an early stage.

The IDVA team leader recognised that there could be a conflict between representing the client's views and acting in their best interests. However, she was also of the opinion that access to relevant information was essential, not least to protect the safety of the IDVAs.

Recorded information – 30th September 2011. Enfield CSC

5.183 AB said that she had gone to Court previous day but had to write an affidavit before she could apply for the injunction. Contact was made by AB with the National Centre for Domestic Violence - statement given by her in support of her application for an injunction. She did not want to move area again but was willing to consider this given DE was aware of her location. AB reported that HB (older son) was returning to her care the following month

Recorded information – 3rd October 2011. Enfield CSC

5.184 A Review Child Protection Conference was held and a decision made that CE would remain subject to a CPP. A Police report stated a further incident between AB and DE on 27/08/11 that had not been reported to social worker by AB. Conference recommendations included urging AB to report all incidents to the police, apply for an injunction, risk assessment of DE for contact and police checks on AB's new boyfriend and babysitter. AB was to be discouraged from applying for residence order revocation on her other children.

Recorded information – 6th October 2011. Enfield CSC

5.185 Closure record completed. The level of ongoing risk was assessed to be high and there was a need for continuing involvement on a formal basis to protect CE.

Hertfordshire NHS GP Consultation – 13th October 2011.

5.186 AB disclosed for the first time to a GP in Hertfordshire her history of domestic abuse. The information is recorded but the focus of the consultation is the physical illness presented by AB. This did not prompt proactive contact with CSC.

Comment: *As is reflected from the IMR conclusions there is a need for greater clarity around the communications to and from GPs in relation to Domestic Abuse and Child Protection issues.*

Recorded information – 22nd October 2011. Enfield CSC

5.187 Children's Social Care: Form Completion - CP Transfer Out is recorded.

Transfer In Conference and repeat MARAC Hertfordshire – 25th October 2011. MARAC, Hertfordshire CSC and NHS Hertfordshire

5.188 CE was made subject of a CPP to Hertfordshire CSC which included that Enfield provide a full chronology by 28th October 2011, Hertfordshire to update the core assessment, and liaise with Multi Agency Risk Assessment Conference (MARAC) which was due to meet that day. Support services for CE and AB were identified. There was no requirement for AB to seek a Non Molestation Order. The conference reports provide comprehensive historic and current risk issues and confirmed that CE was subject to a protection plan on transfer from Enfield which was to continue and outlined the Protection Plan. The GP was not in attendance and no report from the GP appears in documents, although AB had by this time disclosed domestic abuse. It was not clear on the report if the GP was invited or apologies sent in accordance with CP procedures relevant at the time.

5.189 The following information was recorded from the MARAC meeting that took place that same day:

Risks Identified.
Repeat Victim. Threat with weapon. Child present. AB failure to support Police action. Address now known by DE. AB has not changed her phone contact number.

Actions
Actions already completed prior to MARAC. AB referred to local solicitor re: obtaining injunction. Safety check carried out at her home.
Police have attempted to obtain statement from AB.

Actions from MARAC:

IDVA to offer support for her to move out of area. Encourage her to engage with Police. Consult with housing provider.

Comment: *The fact that AB had not applied for another Non Molestation Order (the original one having expired) probably indicated that she anticipated contact with DE, and that risk should have been noted. Indeed the CPP states only that DE and AB were not to be together in CE's presence and DE was not to have contact with CE pending a risk assessment. The issue of how their relationship would be likely to be, if they did not disengage from contact was not therefore addressed. Hertfordshire CSC were to consider legal proceedings if plan was not complied with.*

It was not made clear to Hertfordshire CSC that Enfield CSC had reached the conclusion that unless AB lived somewhere where DE did not know the address, care proceedings would be commenced. The conference was informed DE did know

the new address in Watford, so effectively Enfield's threshold for considering care proceedings had been reached and conference should have been made clear about this.
In effect AB and DE obtained another opportunity for care proceedings not to be taken immediately in respect of CE. Hertfordshire CSC did not have sufficient information to immediately progress care proceedings. The chronology from Enfield was placed on CE's ICS file on November 4th 2011; there is no note of when received. Hertfordshire placed a comprehensive file from Luton and Enfield and Brent on February 8th 2012, on CE's Hertfordshire ICS file (no record of when requested, or received).

Request for assistance – 2nd December 2011. Hertfordshire Police

5.190 At 10:58 hours on Friday 2nd December 2011, Hertfordshire Constabulary Force Control received a telephone call from a Social Worker with Watford Child Protection Services requesting assistance at a Watford address. The social worker stated that a two year old child at the address, CE, was subject to a Protection Plan, the mother, AB, had refused entry and it was believed that the father, DE, was at the address. The caller also stated that there was a team outside the address ready to take the child into care as they believed the father was inside.

5.191 Hertfordshire Constabulary Control Room Intelligence Unit carried out various intelligence checks, including previous incidents at the address. An officer was sent to the scene at 11:08 hours, arriving at 11:17 hours. At 11:48 hours the incident log indicates that the child has been taken into 'Protective Custody' and that there were arrangements in place with the Emergency Duty Team from Social Services who would be making Foster Care arrangements.

Comment: *The actions above clearly reflect a joint, planned proactive response to information about the ongoing contact between AB and DE with the intention to protect CE in line with the CPP. This was presumably based on the fact that DE was present and in breach of the CPP agreement. Police Protection powers were utilised at this point and CE placed with foster carers.*
Application was made by Hertfordshire CSC for an Emergency Protection Order (EPO) but the Court could not accommodate a hearing within 72 hours, by which time CE was back with family members. The EPO was rejected by the Court.

Care Proceedings – 6th December 2011. CSC Hertfordshire and West and Central Family Proceedings Court

5.192 As above CSC made an application for an EPO but after a contested hearing the application was rejected and a written agreement accepted.
The court continued to oversee the written agreement up to the date of the death of AB with a number of ongoing assessments over that period.

Comment: *the involvement by courts in overseeing cases where no order has been made is increasingly common. In this case it is reasonable to reflect that a number of experts and CSC took a variety of views in relation to the parenting ability of both DE*

and AB. The court process and the provision of information to the court continued up to the death of AB and thereafter.

Recorded Information – 10th January 2012. Hertfordshire CSC and NHS

5.193 A CPP Review took place at which it was agreed that the social worker and health visitor to continue to conduct planned and unannounced visits to family home Social worker to request AB's medical reports from GP; AB to be referred back to family intervention team in relation to work around domestic violence. At this conference CE remained subject to a Child protection plan under the same category of Neglect. The report is comprehensive and within the Conference plan is an action for the GP that requests a medical report in relation to maternal current health needs and treatment. The report provides information regarding a police protection order being required when DE, AB and CE were seen together outside her property and subsequent refusals by AB to allow CSC access to the property.

***Comment**: The GP's attendance at Child protection conference would be an essential way of participating in risk assessment and ensuring an awareness of the multi-agency plan in relation to contact between DE and AB. However the GP was not in attendance at conference or a report sent. There is evidence of a post conference report having been sent following the request for GP medical report found in the GP records for this time.*

Recorded Information – 3rd February 2012. Hertfordshire NHS GP

5.194 Following referral from West Hertfordshire Hospital Trust early pregnancy unit (WHHT) to her GP, AB was recorded as undecided whether to continue with the pregnancy and there is no referral to CSC. A miscarriage is confirmed by the 23rd February.

***Comment**: It may be arguable that at this early stage to inform CSC would be premature. However there is no recorded discussion or risk assessment in relation to the current relationship that leads to the pregnancy and whether it was with the previous partner DE. This which would be a significant risk especially as research is clear that the incidence of domestic violence is increased during a pregnancy.*

Recorded Information – 8th February 2012. Hertfordshire NHS GP

5.195 On the 08.02.2012 the GP made a referral to a private Consultant Psychiatrist in Child & Adolescent Medicine at The Portland Hospital with a follow up phone call the day after. It requests an assessment of parental abusive relationship impact on CE.

***Comment**: The referral letter and records do not demonstrate any communication with CSC in relation to this request for assessment. Significant in the letter is that it includes the statement, "after the relationship ended because she was medically ill she did allow the father to have contact with CE and herself again, as she had no choice as she was diagnosed with severe Crohn's disease and significantly disabled" and also "that he continues to have intermittent contact but Social services are concerned that previous abusive relationship has affected CE and have instigated proceedings"…*

Communication with Social care services was not documented in relation to this referral which was acknowledged by the GP at interview but he did say they had been informed when interviewed for the IMR.

Care Proceedings – 9th February 2012. CSC Hertfordshire

5.196 CSC made an application for an Interim Supervision Order in relation to CE on 9th February. DE and AB signed a further parental agreement. The West and Central Family Proceedings Court ordered assessments of both parents by a psychologist and the Family Assessment Service Team (FAST). There was a change in the named psychologist mid proceedings and the Issues Resolution Hearing initially set for July 6th was then put back, first to August 22nd, and then November 21st 2012. On August 22nd the recommendation for a psychiatric assessment of AB was agreed.

***Comment**: Hertfordshire CSC did not delay in the decision making regarding instigation of care proceedings regarding CE, and for subsequently making an application with regard to HB. The application for CE might have been made a few weeks earlier, but that would not have impacted materially on the tragic outcome.*

Recorded Information – 20th February 2011. Hertfordshire NHS, GP

5.197 A referral was made on 20th February by the GP to the Enhanced Primary Care Mental Health Team following offer of counselling requesting work in relation to AB avoiding entering destructive relationships and provides a brief outline of domestic violence and childhood circumstances that have had an impact.

***Comment:** Although this is no doubt a useful resource and indicative of AB's determination to break away from the Domestic Violence cycle there is no evidence of communication with CSC in relation to this. This would have been best practice in view of the child protection process and related assessments underway.*

Recorded Information – 6th March 2012. Hertfordshire NHS, GP

5.198 On the 6th March 2012 a report from Enhanced Primary Care Mental Health Team psychologist was received that indicated scores from a depression and anxiety assessment. They noted: Depression score of 15 –severe depressive features; Anxiety Score 15 –moderate anxieties
It advised AB not to be concerned at the scores explaining that it was part of the assessment and would help to ascertain the best way to provide her with help. It noted that AB had a complicated personal life involving issues of care for 4 children and trouble with abusive ex-partners causing her to experience depression and anxiety. AB requested help in managing her thoughts, daily functioning and managing to balance her personal life. She was offered a further appointment, given out of hour's mental health contact details and advised to seek GP appointment if she had urgent needs.

***Comment**: There is no information indicating a need for mental health medication on the record or evidence of subsequent antidepressant or anti-anxiety medication being prescribed. The GP explained that he had assessed her mental health at consultations and did not view medication as being currently required*

Concern for Health - 30th March 2012. Hertfordshire NHS, GP

5.199 In a telephone consultation the GP recorded that AB could not walk 20 metres and had a weight that was below 7 stone and that she had been unwell now for 16 months. On the 12th April she was described as almost unable to walk by the GP.

Comment: *Although there is ongoing recording of the issue of Crohn's disease it is seldom referenced into her ability to protect herself or CE to this point. As is reflected from the conclusions there is a need for greater clarity around the communication of both Domestic Abuse and Child Protection issues to and from GPs and primary care services.*

Recorded information - 19th April 2012. Hertfordshire NHS. GP

5.200 On 19th April during a telephone contact AB reports to being stressed due to being "interrogated by social worker". AB asked the GP to provide a full medical report for her solicitors. This report is recorded as being sent on 10th May to her solicitor regarding Crohn's disease, effects of treatment, impact on ability to manage child care and travelling and a summary of other physically health related conditions and family health history. It includes description of impact on capacity to manage activities of daily living noting, poor concentration, exhaustion, memory loss and fluctuating exacerbations.

Recorded information - 26th April 2012. Hertfordshire NHS. GP

5.201 By the 26th April 2012 a report from Enhanced Primary Care Mental Health Team was received by the GP regarding AB's failure to attend 3 appointments and hence discharge from that service, unless contacted otherwise.

Recorded information - 22nd May 2012. Hertfordshire NHS. GP

5.202 On the 22nd May 2012 the GP received a letter which stated that AB had failed to attend a physiotherapy appointment and as such has been removed from the waiting list on the assumption that service is no longer required

Comment: *The two above entries evidence ongoing attempts to support AB which she was unable to access, greater consideration could have been given to her deteriorating physical condition and the impact that it has on her ability to access provision.*

Concern for safety – 28th June 2012. Hertfordshire CSC

5.203 CSC were informed by DE that he has been contacted on 6 occasions by AB on the telephone, stating that she will send people round to his mother's address and that his mother is worried. DE was advised to contact the police. DE informed CSC that he wanted to be considered as the primary carer for CE. DE informed CSC that although not in a relationship they had seen each other 3 days ago.

CSC then contacted AB who stated that she has been threatened by DE who had said that he was coming to get her. She was advised to contact the police but stated that there is no point as they will do nothing and that DE has told them, '*a load of lies'.*

Comment*: Despite the lack of reported incidents for a period of time it appears that there was continuing contact between AB and DE.*

Concern for safety – 14th July 2012. MPS and Hertfordshire Constabulary

5.204 At 11:06 hours on Saturday 14th July 2012, the Metropolitan Police contacted Hertfordshire Constabulary control room stating that they had just received an emergency telephone call from a person living in London. The caller had stated that she had received a phone call from her grandson who said he was going to kill his mother. The location was given as the home of AB in Watford. The potential victims name was AB and the grandson was HB, aged 14 years.

5.205 Almost at the same time, Hertfordshire Constabulary control room received a call from one of AB's neighbours stating that there was a domestic disturbance going on next door, with shouting and screaming and items being thrown, A female had knocked on the informants door asking them to call the Police. Hertfordshire Constabulary graded the response as 'High' and officers arrived at the location at 11:22 hours. At 11:36 hours the incident report records that there had been a verbal argument between the mother and her son who is only 14 years of age. He had left the scene. The incident was closed with no further action being taken.

5.206 At the time of this incident the definition of domestic abuse was:
Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults ***(aged 18 or over)*** *who or have been intimate partners or family members regardless of gender and sexuality.*

Comment: *The police Review Officer was of the view that in the absence of any offences being committed, the officers attending could not have taken any further action in relation to the domestic dispute. The Overview Report Writer agrees with that view. At the time of this incident the definition of domestic abuse did not include persons under the age of 18. In March 2013 the definition of domestic abuse changed to include those aged 16 years, and would now include incidents of this nature.*
However, bearing in mind the previous incident on the 2nd December 2011, with the presence of a two year old child at the location, consideration should have been given to referring this incident to CSC for their attention.

Recorded information - 1st August 2012. Hertfordshire NHS. GP

5.207 On the 1st August 2012 AB had a telephone consultation for Crohns review. Subsequently she was then seen on the 16th August by the GP for Crohns review where AB reports feeling stressed. The GP's assessment was that her problems were practical rather than psychological as she seemed perfectly normal and capable.

Information on the relationship – 8th August 2012. Hertfordshire CSC

5.208 As part of an assessment for the child care proceedings AB gave a detailed insight into the history of the abuse by DE. This included the statement that their relationship was amicable if they met on the street and she does not know why DE states that they are still in a relationship. AB also stated the relationship had not been sexual since the end of 2010 and that she had been subject to domestic violence between 30 and 40 times by DE. She stated it did not get worse but continued the same. AB stated that she had never attacked DE but had got him back by burning or bleaching his clothes, something she had learned from him as he had done that to her clothes.
She also is recorded as reflecting on the abuse she had witnessed as a child to her own mother.

***Comment:** This is arguably the nearest we are likely to get of recorded account of the relationship with DE provided by AB and her thoughts around it.*

Information on the relationship – 13th August 2012. Hertfordshire CSC

5.209 DE as part of a parenting assessment was recorded as stating of his relationship with AB that '*we are always going to see each other. "There are things I am holding back from you because of the situation, it will cause hurt and go against me".*

***Comment:** This caused concern at the time to CSC.*

Information on the relationship – 17th August 2012. Hertfordshire CSC

5.210 CSC carried out a statutory visit at which both HB and CE were resident and it was recorded that, throughout the visit, AB walked between rooms and responded with one word answers. CE was seen and observed to be well, although poor speech was noted. **AB said she saw DE all the time.**

Comment: Given the clear statement from AB it is doubtful that the contact with DE had ever stopped for any significant period of time.

Recorded Domestic Incident – 27th August 2012. Hertfordshire Constabulary and CSC

5.211 At 20:05 hours on Monday 27th August 2012, Hertfordshire Constabulary received an emergency telephone call from AB stating that her 14 year old son had just assaulted her and had left the property and she did not want him back. She was concerned as he was only 14 and she thought that he may be heading for Enfield. CSC out of hour's service had already been contacted a few minutes earlier by AB's mother who had stated that HB was left on his own by AB and that this was distressing him. Shortly after receiving that information they were in turn contacted by AB who informed them that she had contacted the police about HB. During the telephone conversation with the police AB provided more information regarding her

son, including the fact that her son's best friend lived in Enfield and that AB knew her phone number and was going to call her to see if he had arrived there.

5.212 Previous incidents at the address were viewed, and this included the incident on the 14th July 2012. Officers arrived at the Watford address at 21:04 hours. At 23:39 hours, HB was seen by officers from the Metropolitan Police. HB was in London, EN3. The log indicates that he was fit and happy as he was used to staying at the location. There was no immediate cause for concern, even though the occupant of the address was known to the Police.

5.213 There was a query on the incident log from a supervisor which states, "*What about the assault?"* This seems to have been disregarded and is not commented on. The incident was closed as '*Child at Risk'*.
An officer stated that en route to the incident he had been made aware of previous domestic incidents between AB and her partner, but had not been made aware of any previous issues involving her 14 year old son. The officer was informed of the '*Child at Risk'* report, but this had nothing to do with the 14 year old (HB). The officer stated that on arrival he found AB to have what he described as a "*very energetic personality*". There was no evidence of any injuries or assault taking place.

5.214 The officer contacted HB on his mobile phone, confirmed his whereabouts and arranged for officers from the MPS to check on his welfare. AB did not want HB back at the house, and as far as the police were aware, HB did not wish to return. During the following two weeks the officer tried to arrange meetings between CSC, HB and AB. It was the view of the officer that although HB and Social Services were eager to take part, AB would not engage.

Comment: *As with the incident which took place on the 14th July 2012, due to HB's age this incident did not fall within the definition of a 'Domestic Incident', therefore there was no requirement to record it as such. The actions taken by the officer were proportionate and appropriate. Bearing in mind the previous incident dated the 14th July 2012, the officer acted appropriately to bring this incident to the attention of CSC. The officer did not wish to 'criminalise' HB as any assault that had taken place had been extremely minor. The officer did not record the incident as a crime, as there was no evidence that anything other than a domestic argument, between mother and son, had taken place. Neither did the officer record the incident as a Non-Crime Domestic, due to HB's age.*

Recorded Information – 28th August 2012. Hertfordshire CSC

5.215 On August 28th 2012 the West and Central Family Proceedings Court agreed that DE would have CE every other weekend, and could transport CE alone, but should not have contact with AB.

Recorded Domestic Incident – 28th September 2012. Hertfordshire Constabulary

5.216 At 08:50 hours on Friday 28th September, AB made contact with Hertfordshire Constabulary via the emergency phone line and stated that she was having a domestic dispute and had locked herself in the bathroom, the male was still somewhere in the flat. The Police graded the response as 'Immediate' and viewed

previous incidents at the Watford address. Officers were sent to the location and arrived within twelve minutes of the call. A search on the address provided information on the previous domestic incident at the location between AB and DE on the 23rd September 2011. The officers attending this incident were made aware of this and the *warning markers on the address.*.

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***Comment:** Information was entered onto the Hertfordshire Constabulary Command and Control system by staff from the Harm Reduction Unit who carried out a daily check of crime reports related to domestic abuse. This helped provide up to date information to officers attending incidents of this nature and to Control Room staff when deciding on the type of response required. This also allowed for Control Room staff to carry out Intelligence checks on possible offenders even if the victim was reluctant or unable to provide information by the time the Police arrived. Therefore the officers attending would have been in full possession of all the relevant information on attendance.*

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5.217 On arrival, the officers found both parties still at the scene, and it was obvious there had been a heated argument. According to the Crime Report the argument had been over both parties holding on to each other's property. AB admitted that she had thrown DE's mobile phone out of the window. The damaged phone was recovered by the officer. Both parties agreed that there had been no physical assaults on this occasion but AB did mention previous assaults by DE. It is unclear from the Crime Report if DE wanted to make a formal complaint regarding damage to his phone, but the officer made arrangements for AB to attend Watford Police Station at 22:00 hours on Monday 1st October 2012 in order to be dealt with for the Criminal Damage.

5.218 The officer stated that on arrival at the scene, AB initially ignored the officers. It was not a good start but she soon settled down and it became obvious to the officers that although she was arguably responsible for committing the only recordable offence, (damage to DE's phone); the attending officers considered that in the greater scheme of things she was the true victim.

5.219 DE wanted AB arrested, but refused to give a victims statement and was refusing to attend court. He did sign the officers note book, giving a brief account of what had happened. The officer stated that he was reluctant to arrest AB and did not see the requirement or necessity to do so. It was agreed that AB would attend Watford Police Station on the following Monday (to fit with her child care and officers shift patterns), where she would be interviewed and almost certainly receive a 'Caution'.

5.220 The officer stated that he had sympathy for AB. "*She had a good work ethic, was working full time as a Personal Assistant, and in the past DE had burgled her boss's house after stealing the keys from her. DE would usually arrive at her home at the end of the month after she had been paid and pressurise her into giving him money. She was worried that DE would burgle her boss's house again, which it would appear he had done in the past".* The officers made DE leave the address and arranged with a voluntary organisation to change AB's door locks, which was done that day. The officer later checked with AB to ensure this had been done.

Comment:** This was the last interaction AB had with the Police. **The officer rightly identified AB as being the victim in this case, but the circumstances surrounding the incident meant that the officer had little option but to deal with her as a potential offender. The manner in which he did so was proportionate. He acted not only in the best interests of AB, but also fairly in respect of DE.

The officer went further than that. Having identified AB as being at risk from DE, the officer put in place the means of changing the door locks on AB's home to mitigate that risk and also made further contact with her to ensure this work had been carried out. This was good service.

The officer could have considered the arrest of AB straight away. This would not only have caused her undue hardship, but would have achieved little and almost certainly would not have prevented AB's death two days later.

Recorded Information Murder – MPS

5.221 AB was found stabbed in a car in north London. Forty minutes later she was pronounced dead at a London hospital.
The MPS police investigation established that at about 8pm, AB left her home in Watford where she was living with HB (then *aged 14*) and CE (then *aged nearly 3*). HB was left to provide the care for CE. AB travelled to central Watford, met DE and they drove to London, NW10, together.

5.222 At some point events occurred which culminated in AB being stabbed repeatedly by DE, who then left the scene. He surrendered himself at a police station the following day. He was later charged with the offence of murder and additional offences of attempted murder and rape relating to another woman.
DE was convicted of the murder of AB in 2013 after pleading not guilty together with offences of rape and causing grievous bodily harm with intent, relating to the second woman.

5.223 DE as part of his assessment for the Court following the murder provided information around his use of drugs and alcohol. *He first drank alcohol at the age of 9 years, regularly from the age of 14 years and heavily from his late teenage years. Alcohol helped him get through the day and takes his mind off things, for example thoughts that he did not want to think about. These included paranoid thoughts and feelings of wanting to hurt others. He said these thoughts started at the age of 18 or 19 years but got worse in his 20s. The thoughts of hurting people and of people wanting to hurt him just came into his head and he did not like the thoughts. Most of the time he could control his thoughts but he said that he has attacked other people in the past with weapons. He had hurt people before, but not killed anybody. At times he has felt quite dangerous. His largest intake of alcohol was in the months prior to the alleged offences where he said he was drinking two bottles of brandy a day. He denied any symptoms of alcohol dependence however, and said that he had not suffered withdrawal from alcohol at any stage.*

5.224 DE *smoked cannabis regularly from the age of 15 years. This included skunk, a strong form of cannabis. He found that cannabis relaxed him. He used crack cocaine on an occasional basis from the age of 16 years, which he described as the "devil's drug". He smoked in binges lasting a few weeks, it made him feel high and think more, but not violent. He could then go for years without smoking any crack cocaine. DE started to take Tramadol, a painkiller, after suffering an injury to his arm, some months prior to the alleged offences. He was prescribed the painkillers but he got hooked on them and was taking up to 20 to 25 a day. Sometimes he could see colours when taking Tramadol and he had feelings that he would pass out.*

5.225 Sentencing DE and reflecting on the level of violence involved in the three offences for which he was convicted, the trial Judge made the following remarks:

"These three crimes are all individually horrifying in the extent of the mere brutality with which they were committed.

"Taken together, they represent a level of violent behaviour carried out during a period of just a few hours that I have rarely encountered".

"You went out armed with at least one knife that day and by the time you murdered AB you had two knives"

"I am not of the slightest doubt that you intended to kill her.

Furthermore, whatever your mental state at present, there is no doubt in my mind that at the time of the offence your mind was not so afflicted as to lessen the culpability of what you did to any extent."

6. ANALYSIS OF KEY ISSUES

6.1 The summary of agency involvement and analysis has been written within the terms of reference and the analysis has addressed the issues outlined below within the Home Office DHR Guidance in addition to the specific TOR agreed at the outset.

The Home Office Guidance outlines the purpose of the Review which should "consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each homicide may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances".
Below are some of the relevant examples of the areas that should be considered as outlined in the guidance together with specific comment made by the Overview Report Writer relevant to the specific circumstances.
This is followed by the Key Lines of Enquiry, as agreed within the Terms of Reference for the review, with similar comment:

6.2 Did the agencies comply with domestic abuse protocols agreed with other agencies, including any information sharing protocols?

All the agencies over the relevant period are recorded as having appropriate information sharing protocols and for the most part there is ample evidence of information being shared reflected in the IMRs. It is interesting to note that in contrast with other recent similar incidents reported in the media there is a consistent pattern of police and other agencies clearly recognising that domestic violence is a child protection issue in itself and sharing the information in a timely manner.

Police response officers in the majority of cases in London, Bedfordshire and Hertfordshire recorded the incidents as domestic abuse and ensured that they were reported through internally and to CSC. On the occasions that did not happen it was unlikely to have had any significant impact. Officers and partner agencies appear clear about their role in protecting children and vulnerable adults through a joint approach. There is some evidence of health professionals, particularly GPs not being fully aware of their ability to share information appropriately but again for the most part information was shared and with a minimum of delay.
As reflected within the Overview Report there was arguably a delay in making available all of the information between the interested CSC parties at the point of the transfer of the CPP relating to CE from Enfield to Hertfordshire over the summer of 2011, culminating in the transfer in review on the 25th October 2011. Over that period Enfield CSC had reached a view that they would seek to use legal powers in relation to CE if AB did not comply with the CPP and cease contact with DE. Despite concerns around breaches of that agreement and the apparent crossing of what had been a trigger for legal proceedings by CSC in Enfield, the transfer to Hertfordshire was allowed to continue and it would appear to be the case that Hertfordshire were not fully aware of all the information at the point of the transfer in. Arguably this did allow further delay in legal proceedings as effectively CSC in Hertfordshire started that process afresh and it was still ongoing at the point that AB was murdered. The family view expressed to the Review Panel was that the credible threat of the removal of CE was the only potential opportunity to curtail the contact between DE and AB and therefore the delay caused by allowing the transfer to proceed without the timely exchange of full information was potentially a missed opportunity to protect CE, HB and AB herself. It remains probable given the history of contact between DE and AB, that it would have continued in some form into the future.

6.3 Did the agencies have policies and procedures for (DASH) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used?

All the agencies are consistently recorded within the IMRs as having knowledge of and using appropriate risk assessment tools. The level of risk applied to AB was often inconsistent, there were times when an incident was dealt with in isolation and the risk assessment reflected this with the level of standard being used. Where agencies were able to take into account of all of the circumstances that often were available to them, particularly on supervisory or secondary assessments it should have been obvious that the risk was consistently high over long periods. The fact that AB did not always appear to cooperate with agencies was a challenge for agencies but they perhaps should have reflected on the reasons that AB did not engage with them. It is not possible to speculate on the immense pressure that AB was subjected to both physically and emotionally by a violent and manipulative offender. In addition to this AB was suffering medically from a debilitating condition. It is difficult for front line practitioners to recognise and take all such factors into consideration but where occurrences take place over a protracted period one would hope that multi-agency review meetings would start to ask these questions.
In August 2010, the CAADA-DASH (Domestic Abuse, Stalking and Honour based Violence) 2009 risk assessment model was introduced updating the SPECSS+[5] risk assessment model. Since November 2011, police policy dictates that DASH completion is mandatory for all Domestic Violence incidents. All agencies are required to use this tool for DV as a referral method into MARAC.

6.4 Was the victim subject to MARAC?

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[5] See Appendix 6

AB was subject of MARAC meetings in both London (Enfield) and Hertfordshire. The rationale for the decisions to close the referrals after initial discussions were not clearly recorded but it is likely that as AB was not regarded as being cooperative with the process then engagement at that level had limited value. Whilst in London it appeared that referrals to MARAC were not timely with opportunities missed on 11th and 20th October 2008.

In Bedfordshire on two occasions the case notes were marked up as 'not for MARAC' in January and August 2009. On the last occasion this was on the basis that the victim was not cooperating. We should be asking why the victim will not engage, what are the barriers and what can be done to facilitate that cooperation. If it is firmly believed that the cooperation cannot be achieved then what can be achieved without the direct cooperation to put all measures in place to protect the victim as far as is possible in the circumstances.

Some of those at most risk will not always be entirely cooperative, (that includes significant numbers of the referrals made to MARAC), so the system needs to be reviewed or adapted to at least consider alternative means of engagement and an ability to build trust so it manages risk rather than levels of cooperation. (See Recommendation 14)

CAADA[6] (Coordinated Action against Domestic Abuse) is responsible for the MARAC process. CAADA has been funded by the Home Office from 2011 to 2015 to support MARACs as they develop and improve their practice. Individual police forces provide staff to chair local MARACs and the Home Office has provided some funding for MARAC coordinator posts. All other agency representatives attend MARACs as part of their normal, day to day work. MARACs are not a statutory provision, so there is no formal obligation for MARACs to exist in every area. New MARAC Development Officers are now working with MARACs in London to provide an accessible service which is tailored to the needs of the individual MARAC pan London.

They assist in one-to-one support, workshops, guidance with performance management as well as data reports analysing MARAC performance to help monitor outcomes.

Between October 2011and 30th September 2012, based on the population of the Enfield borough, CAADA estimated the borough would deal with 510 cases. The actual figure for this period was 311 cases (*CAADA data*). To support the MARAC on the Enfield Police area, the CSU MARAC Coordinator in conjunction with a local authority Domestic Violence coordinator, completed joint training of police and other agencies on approximately four or five occasions a year. This multi-agency training is to assist staff in understanding the MARAC process and the completion of risk assessments. At the relevant time there was reasonable consideration of MARAC by agencies in relation to AB, and local training and use since that time will have increased awareness of MARAC.

6.5 Were practitioners sensitive to the needs of the victim and perpetrator?

The recording and extended chronology does evidence for the most part that practitioners were sensitive to the needs of AB and DE. It is arguable that CSC across London and outside gave AB a number of opportunities to keep CE with her despite her repeated and sometimes openly stated lack of cooperation with every CPP that was instigated. DE was also involved in the considerations and planning around CE, as was her mother and other family members.

Conversely throughout the much recorded planning for CE and to an extent the other children little account seems to be made of the debilitating impact of Crohn's disease

[6] Coordinated Action against Domestic Abuse – existed at the time of the incident now called Safelives

as was reflected upon by health IMRs. It is reasonable to assume that AB was seriously ill before the diagnosis but this does not appear to be sufficiently reflected in the CPP meetings and planning nor in the response to the repeated domestic abuse. There is no satisfactory explanation in relation to this and the Health IMRs, in particular, recognise that more could have been done to address the issue of AB's significant illness and provide a greater level of support and linking that to her vulnerability and potentially her ability to protect herself and the children. It is fair to say that the full impact of her illness on her ability to protect herself and CE was probably about to be fully reflected in the considerations of the court process but unfortunately events overtook that process.

DE is recorded as frequently making counter allegations. It is reasonable to reflect that AB was a small frequently ill woman, DE a man with serious convictions for violence, a continuing propensity to use it and is described, at the time of his arrest in September 2012, as a fit and powerful male who is recorded in July 2012, as part of the court assessment process, as staying fit by attending the gym for two hours a day.

More consideration and attempts to understand the reasons why AB did not want to engage with some agencies should have been given. She was under extreme pressure from all around her; family, violent partner and agencies with whom she had contact. She realised that access to her children was under constant threat, this was the correct action to protect the children but how did this effect the relationship AB had with organisations who were trying to support her? AB stated on a number of occasions that the police were not able to respond to her quickly enough and that when they did DE lied and was able to manipulate events. Whilst front line practitioners often did their best and followed the correct procedures from AB's perspective it must of seemed that she had few options and limited support. There was a period when the onus for obtaining an injunction was put on AB and when this did not happen she was criticised. It has to be asked how mentally and physically able AB was to be able to achieve this.

6.6 Did actions and risk management plans fit with the assessment and decisions made?

The actions undertaken by a range of agencies taken in isolation do represent for the most part a reasonable, even sometimes high level of response.

CSC practitioners recognised the risk of DA to CE and repeatedly sought to manage it. It is reasonable to reflect that given the length of time the situation continued that CE and HB were left in a vulnerable position for an extended period of time. In terms of the child protection issues there was a level of drift and a rule of optimism that eventually AB would cooperate and was a capable mother. In reality, in the view of the Overview Report Writer, there is little evidence to support that contention whilst she remained subject to contact with DE.

As is also outlined below there is also an issue about the police response to the clear allegations of domestic abuse. Hertfordshire Constabulary, Bedfordshire Police and the Metropolitan Police Service all have common positive action policies for the attendance at such incidents. This often translates into a positive arrest policy on initial attendance to remove the alleged perpetrator from the scene prior to any form of consultation or negotiation with any party. On some occasions this was followed, on a number of occasions it was arguably not. It remains the case that even if DE had been arrested at nearly every attendance it is unlikely to have prevented contact between AB and DE and therefore the ultimate tragic outcome. Had arrest been part of a coordinated plan to manage DE as reflected in Recommendation 1 it may have had a greater impact.

All the agency involvement reflects a focus on AB and to varying extents the four children. The numerous contacts with police, children's services and a range of other agencies do reflect that she was frequently difficult to deal with and was often oppositional to work with her around domestic abuse, but also in relation to the children. There was no recording evident in any of the IMR's of a sustained and coordinated attempt to deal with the issues through a focus on DE as the perpetrator. Although he was not being managed by the Probation Service there is provision under the MAPPA arrangements to manage violent offenders under Category 3 of the MAPPA Guidance 2009, applicable at the time, and this does not appear to have been considered by any agency as a means of dealing with repeated and complex issues, which DE was at the centre of for a sustained period of time.
Indeed in the Core Assessment completed on the 10th October 2011 by Enfield CSC, the section on parents views records the view of AB, she feels "*that professionals have not done the necessary work with DE and he has not been made to accept his behaviour and the impact of this on CE*". She feels that, "*he should engage in services and groups re his parenting and anger and that if he does not do this, there will continue to be issues in the future".* That is a reasonable and insightful view.
AB flagged to professionals at that point that the issues need to be addressed through DE, at least in conjunction with any work with her. There is little evidence of this approach being progressed, beyond attempts to engage him in parenting classes.

6.7 Were appropriate services offered or provided?

Services were offered by a range of professionals including specialist domestic abuse staff. Women's Aid, IDVAs and specialist police officers all at some time offered and provided additional assistance which was ultimately either rejected or simply not engaged with. On occasions there are examples of very good practice and a determined effort was made to assist AB .
Conversely the debilitating impact of her combination of mental and physical health issues on her ability to protect herself was not fully addressed, or if it was it was not clearly recorded.
Earlier referrals to MARAC and strategies to work with victims who are unable to engage for any number reasons may have helped to understand what AB's needs really were.
There was a delay in accessing any medical opinion which ultimately came from a GP. He advised that AB would be debilitated by the disease and need support in caring for CE; she would also be debilitated by long meetings. That level of information would not have helped the case conference in establishing what level of support she would need to manage. More specific advice and information might have been obtained from AB's hospital consultant or support groups which may have triggered a more focussed response to her needs. Had AB's health been stabilised this would in all likelihood have had a positive impact on her overall ability to manage her life and she may then have been directed to resources that would enable her to develop the mental strength required to break her ties with DE. Following receipt of the GP information, the conference did not address it further, despite the earlier agreement on AB's part for a referral to adult services.
Child Protection Plans were consistently appropriate but took considerable time to recognise that AB was unable to comply with the plan and did not consistently identify resources to support AB as a victim and to change i.e. to be able to separate from DE and for AB to obtain a second Non Molestation Order.

Specifically as part of the TOR, the Panel wish to determine the following:

6.8 What disclosures AB made to agencies and the circumstances behind them coming into contact with her?

It is recorded across all the IMRs and chronologies consistently that AB made a range of disclosures. It is reasonable to assume that the information provided to the police and other agencies in the many emergency calls over the years was reasonably accurate when initially provided, in that she was subject to violent and repeated physical and sexual assaults. It is equally clear that there were occasions on which she did not provide full information, or fairly quickly withdrew any cooperation with agencies that could have been in a position to protect her. On the few occasions that there was extended contact with agencies, such as some of the specialist staff from the police, SOLACE and the IDVA services, she provided a clear insight into the danger that she was in and the frequency of the domestic abuse she was subject to.
Whilst there is a theme running through the recorded contacts of non-cooperation, and on some occasions stated defiance to agencies, it is clear that agencies did recognise the overall truth of the disclosures and recognised the risk to both AB and her youngest child CE.
Nearly all the contact that AB had with a range of agencies was generated through the concerns around domestic abuse and the risks to her and CE. Many attempts were made to protect CE from the domestic abuse he was frequently witnessing but ultimately they were unsuccessful.

6.9 If and how agencies assessed risks to AB and her children?

For the most part all the agencies involved used appropriate risk assessment processes for both the children and for AB. The police and MARAC processes have nationally adopted formats which are research based and evidenced as effective. Throughout the period under review the risk was generally recognised as being high both to the children, in particular CE, and to AB. Similarly children services in the various London Boroughs as well as those outside recognised and recorded the high risks presented by the continuing domestic abuse. The various child protection plans, court orders, expert witnesses, health assessments and MARAC minutes record the clear view of the range of professionals that there were throughout high risks to CE and AB.
It is the case that the recording and recognition of the risks to AB, CE and the other children were comprehensively and well recorded.
GP practices that had contact with AB and CE had Safeguarding children policies and generally a good understanding of the issues of risk to CE although their focus was almost exclusively the health of AB. The Review reflects that there was less certainty around the domestic abuse issues in relation to the protection of AB and their part in that process and the recommendations recognise the need for additional training with GPs in this area. (See Recommendations 6, 7 and 8)

6.10 Were the agencies' responses good practice and proportionate concerning their knowledge?

There are many examples of good practice outlined in the various IMRs which have been reflected in the Overview Report. The more problematic issue for all the agencies is whether given the totality of the ongoing issues and the non cooperation

of both AB and DE, for the most part of the period of review, is whether it was reasonable to carry on attempting to negotiate agreements with both parties. There were attempts to use court powers to exercise a greater degree of control over the behaviour of AB and DE and offer greater protection to all the children and in some cases this was successful, arguably in relation to CE less so.

Hertfordshire CSC in particular, once armed with all the information around the risks to CE and the ongoing contact between DE and AB, took a more assertive approach to managing the risks. Commendably when in possession of information about the ongoing contact they took proactive steps with the police to protect CE immediately. It is not the role of the Report to attempt to review the decisions of the court around 6th December 2011 onwards but it is unfortunate that there was not the opportunity to consider the EPO application by Hertfordshire CSC within the statutory timescales.

It has been reflected within the analysis of the various incidents that throughout the focus remained around managing the behaviour of AB. There is little evidence of any significant exploration of managing DE, other than the reference by Enfield CSC to MAPPA, and thereby reducing the risks to AB and CE.
As has already been reflected AB herself is recorded as holding the view that this was the key to assisting her.

It is arguable that the police response to the many emergency assistance calls fell short of existing current good practice on some occasions. Each of the individual police services who had contact with AB have policies that dictate positive action by attending officers and those supporting them. This is usually taken to include positive arrest policies in which the intention is to remove the alleged or suspected perpetrator from the scene by way of arrest whenever legally possible. Although on occasions arrest was used, there are others when it was not. Given the overall number of attendances, nature of the calls and additional information about the propensity of DE to violence and the vulnerability of AB arrest could have been used on more occasions. The Overview Report has identified three occasions (paragraphs 5.18, 5.76, 5.151) when the MPS or Bedfordshire were contacted with regard to alleged domestic incidents when the arrest of DE could have been further considered.

6.11 Whether relevant agencies discharged their duties properly?

All of the agencies involved with AB, her children and DE showed, over an extended period, commitment on a personal and professional level. The various CSC departments that were involved continued in the face of considerable opposition from AB herself, a willingness to try to support her as well as her children. It can be argued that in relation to CE in particular that there was an unfounded optimism that eventually AB would be in a position to provide appropriate care for CE although in truth there was seldom any substantial evidence that she would be able to maintain this whilst she had any contact with DE. All the agencies recognise that she would probably not be able to do that, but nevertheless continued to create plans and agreements predicated on her ability to protect herself and CE from DE. At the time of her death there were again active proceedings to make CE subject to shared care with Hertfordshire CSC.
Each individual agency subject to the review can for the most part make a compelling argument that they provided a service that was of an appropriate quality and reflected some real determination to protect AB and CE. That it ultimately did not protect AB can reasonably be argued to be partly the responsibility of AB herself. However in terms of measuring the joined up response of a range of agencies it can

be said that there were opportunities to combine knowledge which would have better reflected the high and immediate risk to AB and CE; and that possibly a joint focus on DE and managing his behaviour was not something that was pursued to the extent it could have been.

There were referrals to MARAC and joint approaches were taken, but ultimately agencies regarded the non cooperation of AB as a block on their ability to protect her. As has been reflected already substantial numbers of those referred to MARAC fall into a similar category and therefore alternative means of managing the protagonist needs to be explored more readily. There has been work carried out in North London that has looked at empowering professionals across agencies in dealing with offenders and victims who are not cooperative and this has been shown to be effective. (See Recommendation 4)

6.12 Could this homicide have been prevented?

Given that AB was provided with substantial support over years in relation to both herself and her children it is probable that no matter what support she was given that she would have maintained contact with DE and thereby remained at risk. The formal intervention through the court process eventually progressed by Hertfordshire CSC, and the threats of her losing contact with her child CE did not prevent that contact but it does appear to have led to some compliance by both AB and DE, at least on a superficial level.

Given the totality of the information available to all the agencies at the point of the murder of AB it is reasonable to assert that an outcome of her, or one of her children, receiving some level of extremely serious injury or harm from DE was predictable. That outcome had been judged as a potential high risk on a number of occasions over a number of years by a range of agencies.

It is true that AB herself presented the agencies trying to protect her and her children with real difficulties through her repeated, disguised and non cooperation, and failure to access some of the support offered. To quote the MPS IMR, '*her engagement with professionals appears to have been most effective while the children were subject of Child Protection Plans' (CPP*) and this reflects the view of her family; that this was the only thing that AB was likely to respond to positively.

The question for this Review in the view of the Overview Report Writer is whether given that frequent disguised or non cooperation: could agencies have found additional or alternative means of protecting AB and her children?
The analysis and conclusions attempt to answer that question in so far is possible on an objective basis avoiding the benefit of hindsight. The Conclusions have been based around four significant themes which have arisen through the Review process: 1. Disguised or non compliance, 2.Significant health issues, 3. Arrest policy, 4. Focus on the offender.

It is always a matter of judgment as to whether this or similar incidents could have ended less tragically but it is reasonable to conclude that there would have been a greater chance of avoiding significant harm to AB and her children if those issues had been addressed in parallel across agencies. The detail of the available information and the extensive work and support provided by agencies is outlined within the respective sections of the Report. It should also be noted that overall there

was a great deal of work that was carried out by the agencies to support and protect AB and her children and some of that work by CSC, police and specialist domestic abuse services was exemplary on occasions.

The family view expressed by the mother of AB and her sisters is that AB maintained some level of contact with DE not simply through fear but also because she continued until the end, to view him as somebody she wished to maintain a relationship with, and that she had some deep concerns about losing that relationship altogether. That is a view that is difficult to prove one way or another at this point, but the continued contact and apparent sharing of her new and secure addresses, even outside London, tends to reflect that may well have been the case.
As has been outlined in the Overview Report the family view was that only the credible threat and follow up action in terms of removing CE from her care might have acted as an effective deterrent to the ongoing contact AB had with DE. This is speculation but reflects the clear view of family members and to some degree relevant IMRs.

On balance therefore AB would probably never have been free of the risks that DE presented if she was expected to manage that contact. Arguably therefore the most effective means of managing the risk and creating the potential to avoid the ultimately tragic outcome was through managing DE, through MAPPA or other multi agency work.

In drawing that conclusion dialogue and advice was taken from the Association of Chief Police Officers (ACPO) lead on MAPPA currently working within the National Offender Management Service (NOMS).

6.13 Lessons to be learned for the future?

The recommendations at section 7 below are all significant and are intended to improve the quality of the services delivered to victims of domestic abuse but as has been highlighted within the report the single most striking issue in looking at the history of engagement with AB, her children and DE, was that nearly all the focus of the considerable work, support and planning related to AB and the children. It is only at one point over the extended nature of the contact that MAPPA relating to DE appears to have been considered as an alternative.
Therefore in the event of continued non cooperation with support agencies by the victim of domestic abuse agencies should regularly and formally review the joint opportunities to manage the alleged offender. This currently could take the form of MAPPA Guidance 2012 which retains much of the substance of MAPPA 2009, in terms of the Categories of offenders. In this particular case it could have taken the form of ensuring that on the basis of the history, the alleged offences and of DE himself, that a positive arrest policy was utilised unless there were no legal grounds for doing so as a minimum and that there was a multi agency plan aimed at monitoring DE for a substantial period of time.
It does appear to be the case that AB was asked about supporting prosecution or the nature of the allegations with DE present or proximate, which must have placed her in the invidious position of being identified as the person absolutely responsible for the pursuance of any prosecution.
Professionals could well have benefited from a greater understanding of the psychological issues that were probably at the heart of her behaviour and more specifically greater understanding of managing service users with a potential combination of personality disorder and very significant health issues.

6.14 Good practice identified within the Review.

There is evidence of substantial levels of good practice across agencies. The detail and consistency of the recording of the incidents is commendable.
Similarly as is reflected on below the information sharing was both professional and well done, with minor exceptions which were unlikely to have altered the tragic outcome.
The MPS, Hertfordshire and Bedfordshire Police have adopted best practice in terms of managing risk to domestic abuse victims and there is ample evidence that these systems were used appropriately.
The adoption of the MASH structure nationally and across the MPS will undoubtedly improve the responses to domestic abuse into the future through that capacity to share information and risk assessment.
There is evidence of close working relationships between GP Practice, Health Visitors, Mental Health services and Hospitals, which evidenced the joined up nature of the responses. Again on the relatively minor number of occasions that this did not happen, it was not of such a nature to have impacted on the tragic outcome. It is likely that this information exchange would be improved further through a structured communication process around domestic abuse and Child Protection cases that are being shared.
All the agencies continued to try to provide services and support to AB and CE despite her frequent non cooperation.

At no point is there evidence of agencies simply walking away because of the difficulties in maintaining support and involvement with AB. In the view of the Overview Report Writer this is a significant change to attitudes of some ten or fifteen years ago.
It was of note that in particular, Hertfordshire CSC once aware of all the information and risks to AB and CE took positive action, quickly, appropriately and sought to work within a legal framework at the earliest opportunity.

6.15 The effectiveness of inter-agency communication.

Generally information sharing between the main partners in contact with AB and her children was excellent. There were occasions in which information was not shared as promptly as would have been ideal, but certainly between CSC departments and the Police, both in and out of London, information in all the relevant detail was shared. There are some incidents when that was not the case, for example the Luton domestic abuse history not being available to the Hertfordshire MARAC and the IDVA service in Hertfordshire not having access to all relevant police information, but these were minor in the overall picture of detailed information sharing. Probably, most importantly as reflected within the Overview Report, there was a delay in making available all of the information to all the interested CSC parties at the point of the transfer of the CPP relating to CE from Enfield to Hertfordshire over the summer of 2011, culminating in the transfer in review on the 25th October 2011. Over that period Enfield CSC had reached a view that they would seek to use legal powers in relation to CE if AB did not comply with the CPP and cease contact with DE. Despite breaches of that agreement and the apparent crossing of what had been recorded as a potential trigger for legal proceedings by CSC in Enfield, the transfer to Hertfordshire was allowed to continue and it would appear to be the case that Hertfordshire were not fully aware of all the information at the point of the transfer in. Potentially this did allow further delay in legal proceedings, as effectively CSC in Hertfordshire started that process afresh and it was still ongoing at the point that AB was murdered.
Another minor exception is arguably with and between the various Probation services involved with AB but this did not impact significantly in terms of the information

available to agencies in the long term. Similarly there were some issues with information sharing to and from GPs.

It is likely that given the national impetus to introduce Multi Agency Safeguarding Hubs (MASH) the level and detail of information exchange is likely to be improved further.
The MPS, supported by the Mayor of London's Office, has introduced a policy that reflects national policy, that in order to improve safeguarding for vulnerable children and adults and build on the learning and good practice already identified through Public Protection Desks (PPD), Multi-Agency Safeguarding Hubs (MASH) are currently being rolled out across the MPS. They are being introduced with the support of partners. The model reflects the fundamental principle that agencies meeting, working and talking together earlier, increase the chances of saving lives and keeping vulnerable people, particularly children, safe. One of the consistent criticisms from Child Protection Serious Case Reviews and DHRs is that partners often fail to see the overall picture; that they only look at their own information and assess it accordingly in isolation. Although there was substantial information sharing in this case there is nevertheless some elements of that being an issue in this case; primarily around health services. A great deal of progress has been made nationally in information sharing and the MASH structure will further develop the process

6.16 Any difficulties agencies encountered when working with AB and her family that impact on the case.

There were a number of difficulties encountered in this particular case but which are reflected in other similar reviews consistently nationally.
Probably most significantly was the real or perceived non-cooperation of AB both in terms of her own protection but also in terms of her willingness to engage with CPP. This theme is examined in more detail at 6.19 below and within the Conclusions, but it is reasonable to reflect that it was never fully addressed. There was repeated recording of AB, and to a lesser extent DE, cooperating with CSC.
This was repeated in some of the statements made for the care proceedings. In reality there is very little evidence at any stage of anything other than 'disguised compliance', at best. This applies both to her willingness to recognise the risks to CE and to herself. Hertfordshire CSC can be said to have acted more quickly once the level of non-compliance was identified as evidenced in their joint work with police in obtaining the Police Protection Order (PPO) and the application for an Emergency Protection Order (EPO)
Various CSC departments made attempts to involve AB's family members in supporting AB and in particular the children. Whilst these arrangements offered some opportunity to help the children those arrangements failed to protect CE and HB and never appeared to offer a real long term solution to supporting AB. Indeed at the time of her death both HB and CE were living with AB, and at significant risk.
Viability assessments were carried out on family members at various times and for some periods family members did provide care to HB and CE but at the time of her death AB was once again caring for both HB and CE, who had considerable needs which were additional to her own needs.

6.17 The accuracy of records and information imparted.

For the most part the sharing of information and recording, particularly between the organisations having the most sustained contact with AB, CE and DE was good. Certainly nearly every contact with police service was recorded, risk assessed and shared with CSC in the various areas. Domestic abuse services were engaged at

various stages appropriately and the quality and timeliness of the information exchanged was good.
There are a number of exceptions which are noted elsewhere within the report but they are a minority and had no real impact in terms of potentially changing the tragic outcome. In particular the IDVA service in Hertfordshire is recorded as having a view that there are occasions when some significant information would not be shared between the police and their service but as their own IMR records neither the frontline staff nor the IMR Author understood the reasoning for that. The policy should be reviewed with the police. (See Recommendation 14)
On some occasions the transfer of information across geographic boundaries between CSC departments and between GP practices was slower than it could have been. Similarly the delay in transferring patient files between the GP practices was such that the passing of relevant information relating to domestic abuse was significant. It cannot now be known whether those delays were significant or not but given the nature of the relationship AB had with DE it is unlikely to have impacted the tragic outcome in the long term.
The family of AB specifically queried the level of knowledge that AB had of the offending history of DE and the level of violence. Given the frequent discussions AB had with professionals and her attendance at meetings at which this was specifically discussed it appears that she was aware on the nature of his offending and that it did not impact on her continued contact with him.

6.18 An understanding of the nature of the behaviours and triggers exhibited by AB.

The IMR and recommendations from Enfield CSC flag up the need for additional training for social workers in recognising the impact of psychological issues such as personality disorder and this is specifically addressed at 7.1 in the conclusions section.
Although both Probation and CSC record AB as having expressed some level of distrust in the police there seems little evidence of any slowness to respond by the police and there were repeated attempts to assist her despite her frequently withdrawing allegations at an early stage. The determination and seriousness with which the police generally treated the calls for assistance reflect a significant change in the culture of the service over the last few years.
There is no recording evident by any of the agencies that seek to minimise the risk to AB or make judgements about her behaviour and her refusal to work with them. There are occasions when the recording by agencies recognises AB as, on occasions manipulative, sometimes lying and at the very least capable of making physical threats. Family members confirmed that on occasions all of that could have been true but none of it changed the fact that the violence and threats offered by DE to AB and potentially the children was of a different scale.

6.19 Themes: Additional information arising from the Review process

There are a number of significant themes which became apparent through the Review. Some of the themes were recognised by some professionals during the period of their engagement with AB and are partially reflected in some of the key lines of enquiry above, set out at the start of the Review process.
Those themes are reflected upon within the conclusions section.

7. CONCLUSIONS

Theme 1: Disguised compliance or Non-Compliance/ Personality Disorder

7.1 The IMR and recommendations from Enfield CSC flag up the need for additional training for social workers in recognising the impact of psychological issues such as personality disorder (PD) and this is true for all agencies subject of this Review. There is no recorded formal clinical diagnosis of AB having suffered from a personality disorder, but the expert witness work for the Court in July 2012 is arguably moving in that direction. The behaviour of AB does reflect that this was potentially a significant issue in the way she presented to a range of professionals. The chronology records repeated patterns of behaviour which presented CSC and police with great difficulty in reducing the risks to AB, CE and HB. It may well have been the case that the ongoing legal proceedings at the time of her death could have resulted in some form of therapeutic support for AB that would have assisted both her and professionals in changing her behaviour. The expert witness (a psychologist), in the Care Proceedings in July 2012 refers to her '*personality problems'* that warrant psychiatric assessment.

7.2 The impact of personality disorder has been a theme in other case reviews relating to both child deaths and domestic homicides. There has been recent work in North London with BEHMHT in which clinical psychologists provide both training and discrete supervision for specific cases where there are concerns about the behaviour of a victim or potential perpetrator where PD (diagnosed or otherwise) is believed to be an issue. This has been shown to provide professionals with alternative methods of creating improved engagement with service users. This could be explored in terms of additional training for agencies across the partnership as overall given the continued non-compliance and contact with DE it is reasonable to reflect that there was a rule of optimism that eventually AB would be able to break free of DE when nearly all the available evidence, even at the time, was that this was extremely unlikely without the real threat of the removal of CE.

7.3 The specialist domestic violence services, including the IDVA services recognised that working with clients who do not want to cooperate is a significant challenge but one that is arguably necessary given those individuals such as in this particular case are most at risk of serious harm. The Review identified the fact that Family Nurse Practitioners have had specialist training in working with what may be a difficult client group and this pattern of work and expertise is worth additional study and development if established as being effective.

7.4 Victim Support policies on making contact with victims of domestic violence may be making it more difficult to engage with clients such as AB. Their Guidance (July 2012) states that two attempts (on different days) must be made to contact the victim within a 48 hour period. If contact cannot be made contact details must be verified and if found to be correct a third and final attempt will be made. If this attempt also results in failure to contact the victim the relevant police force is informed. Research in Essex cited in their IMR, has shown that in a sample of 312 domestic violence cases referred to Victim Support, 49% resulted in no further action. In many cases

this was because the victim could not be contacted, this therefore in all probability reflects a national problem with non-engagement. (See Recommendation 14)

7.5 In Brent CSC, it is now a routine contingency that a case will be presented for a legal planning meeting should there be a failure on the part of a parent to comply with a child protection plan or fail to engage in the child protection work. This is good practice in the view of the Overview Report Writer, as over the period of the Review overall there was an over reliance on AB eventually cooperating with any CPP, and it is clear, albeit with hindsight, that apart from possibly short periods of time she lied to both her family and professionals about the level of contact she had with DE. Professionals were aware that was the case at the time but were slow to act upon that information with the notable exception of Hertfordshire CSC.

Theme 2: Significant Illness

7.6 It is clear from recording that AB was able to access health care from her GP practice, particularly in Hertfordshire to meet her complex health needs utilising the service frequently (approximately thirty times). Referrals to appropriate health resources including hospitals and specialist departments to address the individual issues when they presented appears to have been within appropriate timescales and in consultation with AB's specified requirement and request. It is clear that AB's Crohn's disease had an immense impact on her life. The GP was expedient in addressing all the related needs that arise and referring to all resources and treatments to mitigate these.

7.7 Multi-agency communication is less evident both in relation to GPs proactive engagement with CSC around domestic abuse but also in alerting other agencies to the full impact of her significant physical and mental health issues. Communication must be undertaken and recorded when Domestic Violence and Safeguarding Children issues feature. National and local legislation and guidance require all health professionals to share information, and participate with CSC and multi-agency colleagues when Child Protection and risk issues arise (Sec 47 Children Act (1989 & 2004).

7.8 Although the Royal College of GPs (RCGP) produced a domestic violence Guidance for General Practices "responding to domestic abuse" in May 2012, sent direct to all registered General Practitioners, risk assessment awareness by GP's may not be sufficient to promote its standard use nationally, and it would be appropriate for LSCBs, SABs and CSPs to check within their own locality.

7.9 The Hertfordshire GP confirmed knowledge of CAADA risk assessment awareness and the practice GP's had utilised domestic abuse resource for patients. There was also awareness of the MARAC process. However it is evident through consultation as part of the IMR process that standard application of a formal risk assessment tool is not common practice amongst all GPs. Frequently a risk assessment will be based on GP professional knowledge and experience, which it could be argued is potentially less robust than use of a formal tool, and again this should be checked locally. (See Recommendations 5 and 6)

7.10 The HV service responded appropriately within the context of the work that they did to support the multi-agency process in protecting CE to a good level .They worked in close liaison with the social workers in an effort to support AB and monitor CE's development for any impact as a result of the destructive relationship his parents had with each other. The home visits achieved were both planned and

opportunistic and would have been more frequent had AB engaged. HVs reported the failed engagement attempts to the social worker and core groups

7.11 An effective assessment of AB's health as a part of the Safeguarding processes would perhaps have allowed a greater understanding of the impact of Crohn's disease on her physical and mental health. AB advised on several occasions (26th September 2011, 24th October 2012) that she felt unwell and unable to cope and the HVs observed her to be very thin and anxious looking. At other times she was well and holding down a job which would be in accordance with the presentation of the condition which may well have disguised her real levels of need.

7.12 There was a delay in accessing any medical opinion in relation to the domestic abuse and child protection issues which ultimately came from the GP in Hertfordshire. He advised that AB would be debilitated by the disease and need support in caring for CE she would also be debilitated by long meetings. That level of information would not have helped the child protection processes in establishing what level of support she would need to manage. More specific advice and information might have been obtained from AB's hospital consultant or support groups which may have triggered a more focussed response to her needs. Arguably had AB's health been stabilised this would have had a positive impact on her overall ability to manage and she may then have been directed to resources that would enable her to develop the self-efficacy required to break her ties with DE and avoid future violent relationships. Following receipt of the GP information, the child protection process did not address it further, despite the earlier agreement on AB's part for a referral to adult services.

7.13 AB's previous history of mental ill health was not raised as an issue when she lived in Watford although addressed later when AB reported depression to the GP. The severity of the impact of Crohn's disease on AB's ability to protect herself and the children is not as well documented as it could be, however it is highly likely to have had an impact on her mental wellbeing, her physical health and in turn her ability to cope with a small child. Crohn's disease is a chronic inflammatory bowel condition which is relapsing, remitting and for which there is no cure (National Association of Crohn's and Colitis). Most patients can be maintained in remission for most of the time but will require lifestyle changes and lifelong medical follow up including medication. HVs would not have had the specialist knowledge on Crohn's disease required to establish the severity and impact of it in relation to AB's case but because of their nursing background would have been well placed to observe AB's physical and emotional health and to support AB in accessing the right kind of medical input to manage her Crohn's disease, and make informed judgements around her ability to protect herself and the children. There is some reflection by health professionals that communications between GP surgeries and Health visitors is less structured that it has been in the past and speculation that this is related to a reduction in numbers of staff. This is a matter again for the respective LSCBs to examine locally. (See Recommendation 5)

7.14 The increasing frequency of failure for AB to attend health condition related appointments once resident in Watford should have initiated increased domestic violence risk assessment and communication with CSC in recognition of the potential for contact between AB and DE in view of AB's previously volunteered information that she has allowed contact in the past when her physical health deteriorated and she needed support with CE's care.

7.15 AB had a recorded mental health history including overdose and attempted suicide during adolescence and depression in 2008 on record when she first

registered at the practice in Hertfordshire. However although it is evident she was suffering anxiety in relation to her health and circumstances, the GP did not consider her to be clinically depressed and she was not under any treatment or medication for this. It is evident however that at times AB's circumstances give rise to heightened anxiety as she approaches the GP requesting a temporary anxiety medication.

7.16 There is no evident communication with CSC in relation to AB's mental health specifically when resident in Watford and therefore a missed opportunity to review how circumstances and stress affected her ability to remain in good physical and mental health and be able to appropriately parent CE and later HB.

7.17 When the specialist Mental Health Services informed the GP practice that after failure to attend appointments offered AB was being discharged from the service on 26th April 2012 there was no record of consideration of need to specifically review her current counselling needs; even though two subsequent GP consultations issues are recorded that relate to mental wellbeing and the impact on her physical health.

Theme 3: Police Response/ Positive Arrest Policy

7.18 The initial response to calls for assistance by MPS, Bedfordshire Police and Hertfordshire Constabulary were good. The Police responded with urgency and on arrival made an attempt to deal with the incident and bring it to a successful conclusion despite sometimes being hindered by AB who they recognised they were there to help. It is fair to say that there are examples within this review where the Police went out of their way to support AB and protect her from the person who finally took her life. When analysing the various incidents it is clear that AB used the Police to deal with the immediate event, but withdrew her co-operation and on occasions went out of her way to avoid engagement with the authorities or even frustrate the investigation. AB used the emergency telephone line to contact the Police when she has perceived a threat, but when officers arrived she was reluctant to pursue any allegations from the recorded information. It is notable that all of the allegations made against DE by AB, with the exception of one, subsequently had no further action taken and this was as a direct result of AB failing to pursue the complaint.

7.19 In this case, the Overview Report Writer, with the exception of the observations already made, has only minor criticism of the way the individual incidents were dealt with, either by the response officers or the specialist officers who provided support and shared information with other agencies.

7.20 However it is the view of the Overview Report Writer that given the number of incidents at which police attended and all the available information and intelligence that there were occasions when arrests would have been appropriate and where not carried out, these have been identified at Section 5 above. The MPS, Bedfordshire Police and Hertfordshire Constabulary have systems in place to ensure proper procedures are carried out by individual officers and that the decision making process regarding referrals is re-evaluated by dedicated specialist departments. The MPS, Bedfordshire and Hertfordshire have policies relating to domestic abuse which stresses the importance of positive action when attending at incidents of alleged domestic abuse; and that was the case at the relevant time. That is in part frequently interpreted as being the arrest of the person suspected of being the abuser. A theme throughout is that AB in particular, following the reporting of crime or domestic violence incident, would not support police action or would change her account of events. Although there are occasions when AB was aggressive with DE it is also clear that DE was recorded as the perpetrator with the risk being recognised to AB

and her children. Therefore it is arguable that on more occasions positive action, in the way of arresting DE at the scene with immediate follow up with AB as a victim, may have increased her willingness to cooperate with a prosecution. There is research evidence that supports the removal of the potential perpetrator, from the scene and the proximity of the potential victim, as a means of increasing the potential to work with apparently reluctant victims. It is contended that the phrase '*positive action'* is intended to create a mindset for police officers and other agencies that takes account of the full context of the potential offences with a consequence of the proactive use of police powers in that wider context. In November 2012, to coincide with the national White Ribbon campaign, the MPS ran Operation Athena which led to the arrest of 320 alleged offenders for domestic abuse offences of rape, assault and harassment. That Operation was predicated on the basis of focusing on the alleged offender with arrest being a suitable and effective tactic in reducing the number of offences and the risk to victims.

7.21 The Overview Report has identified three occasions (paragraphs 5.18, 5.77, 5.152) when the MPS or Bedfordshire were contacted with regard to alleged domestic incidents when the arrest of DE could have been further considered. Within the report those three incidents are examined in some detail and the view of the Overview Report Writer, as reflected within the comments, was that on some or all of the occasions the arrest of DE would have been possible and legal, particularly given all the available information around DE and the history of the domestic incidents. It is accepted that arrest as outlined within Code G, (as attached Appendix 3), clearly identifies the responsibility of arrest to be one for an individual officer making an assessment of all the available information and that not all of that information is now available. There was considerable discussion between the Overview Report Writer, police IMR writers and police supervisors around the potential to arrest on additional occasions: it is fair to reflect there was a range of opinions with some disagreement with the views of the Overview Report Writer.

7.22 The crime recording of domestic violence issues have in almost all cases been dealt with according to the guidelines and procedures with risk assessments having been completed. The small number of cases when it was not is reflected within the Report

Theme 4: Focus on the offender

7.23 All the agency involvement reflects a focus on AB and to varying extents the four children. The numerous contacts with police, children's services and a range of other agencies record that she was frequently difficult to deal with and was often oppositional to work with her around domestic abuse and also in relation to the children. This prompted a variety of responses over the period of the Review by agencies attempting to support her. There was an element of simply repeating the process of completing and reviewing a CPP at various stages and then assuming that AB would eventually work with agencies; when it was reasonably clear that she either would not or could not do so. This is clearly reflected within both the chronologies and Section 5 of the Report. The one exception to that rule of optimism was Hertfordshire CSC who acted proactively when they had evidence of her non cooperation.

7.24 There was no recording evident in any of the IMR's of a sustained attempt to deal with the issues through a focus on DE the perpetrator. Although he was not being managed by the Probation Service there was provision under the MAPPA 2009 to manage DE under Category 3, given his conviction for violence and the threat he

offered to AB and to others and this does not appear to have been considered by any agency as a means of dealing with repeated and complex issues which DE was at the centre of for a sustained period of time. The issue was raised once as part of the CPP process in Enfield but it does not appear it was followed up. MAPPA 2012 continues to provide similar scope to that offered by MAPPA 2009. Operation Dauntless is a new MPS domestic violence Continuous Improvement Plan, a new strategy being implemented MPS wide, in order to identify and disrupt offenders deemed most likely to imminently re-offend, particularly around domestic violence, and MAPPA could be utilised to supplement this work as outlined.
(See Recommendation 1)

7.25 As was noted above AB herself reflected to CSC in Enfield that she saw the management of DE as key to protecting CE (and thereby herself).

General Conclusions

7.26 Overall professionals demonstrated a good understanding of the impact of domestic violence on children and followed procedures appropriately. The risk assessments were carried out by police and social workers within the various assessment and the safeguarding processes. Agencies also made referrals to domestic violence services in an attempt to support AB and liaised with those services, however in line with the recommendations, more direct involvement might have been beneficial , eg IDVAs attendance at child protection case conferences and core groups. Similarly GP attendance at CPC would have been beneficial.

7.27 Persistence was demonstrated in conducting child protection visits despite the difficult circumstances and an appropriate balance was struck between the use of authority to protect the children and the need to secure a safe environment for AB. This showed a proportionate use of authority and challenge in relation to the safeguarding process, unfortunately despite that challenge the non-cooperation of AB did not prompt a sustained focus on contingency planning by CSC until the interventions in Hertfordshire in 2012.

7.28 The review found that policies in place for child safeguarding within the GP practices were reasonably robust, up-to-date and generally informative. The policies provided practices with a resource which could be referred to, and as a result advances appear to have been made in child safeguarding in relation to understanding and practice. However, there still appeared to be issues with implementation and embedding the principles of the policy into practice and this was particularly true in relation to the sharing of information and detailed recording of contact with CSC.

7.29 GP practice around adult safeguarding policies and procedures was more mixed and contrasted significantly with child safeguarding. It was apparent that some practices lacked a full understanding of the issues of adult safeguarding. As such they were unaware of their obligations in highlighting concerns, confused about any obligations they had with regard to vulnerable adults who were not in families with children, and so when the practices had developed their own adult safeguarding policies and procedures these were sometimes inadequate and should be reviewed.
(See Recommendation 6)

7.30 The delivery of significant training with GP practices appears to have been effective in increasing staff understanding of safeguarding. There is evidence that

this has impacted upon practice, with significant improvement in the awareness of the impact of domestic abuse on families. Where there appeared to be room for development was on the active implementation of this knowledge, specifically the need to share and exchange information with other services. Additionally if there had been GP attendance at the relevant child protection conferences that occurred they would have been able to participate in multiagency discussion and planning. There was awareness of the Royal College of General Practitioners (RCGP) and CAADA 'Responding to Domestic Abuse' guidance for general practices. This instruction was issued to all general Practitioners by their Royal College in May 2012 and includes a link to the DASH Risk Identification Checklist for agencies. The RCGP guidance was issued to all GP's it has the status of guidance only, and is not used as standard practice within all General Practices.

7.31 Had the medical records of AB and CE been transferred more efficiently between GP practices, information on domestic violence and child protection would have been available earlier to each practice. It is likely that clinicians would have addressed these issues within the consultation setting. In this case, practices did not proactively seek AB's engagement when domestic violence was identified and records were obtained (e.g. appointments to review domestic abuse issues were not made routinely). It is unlikely that the delay had any significant impact overall in terms of the tragic outcome. (See Recommendation 7)

7.32 There appears to be general agreement that health visiting services along with midwifery were an important resource and key in the safeguarding process as they carried out initial checks and had links into the community. Resource issues were identified as a potential problem. However aside from resource issues, it appears there was an inconsistent level of engagement with different GP practices and this is reflected in the recommendations. (See Recommendation 5)

7.33 There were two occasions when AB reported pregnancies to her GP in Hertfordshire and there was no detailed documentation in relation to risk assessment at this time in relation to domestic violence history and who the relationship was with. AB was ambiguous as to the desire to continue the pregnancy and in event they spontaneously failed to progress, but this was an omission. It is an excepted feature of domestic violence research that pregnancy is a period for likelihood of exacerbation of domestic violence incidence .As such communication with CSC and the Health Visitor would be essential. Informing the agencies working in partnership with AB would have enabled pre-birth risk assessment which should include the male partner. However it is appropriate to acknowledge that the pregnancies were both of short duration.

7.34 There is no evidence of discussion or receipt of Police notification to the respective GPs in relation to episodes that occurred during the period of review. There was a protocol established in October 2012 in Hertfordshire that requires the notification to be shared with the GP within 5 days of Health Visitors receipt in high risk cases.

7.35 Current guidance on the procedures to be followed in domestic abuse cases is available in Victim Support's: Supporting Victims of Domestic Violence: Service Delivery Operating Instructions (July 2012), which was preceded by earlier but similar policy documentation. There is also the CAADA material. However, a succinct document that sets out the local business process is required. This could include:

- the information that should be received from a MARAC

- the checks that should subsequently be undertaken by an IDVA
- the options for subsequent action (and associated timescales)
- the recording of a safety plan
- what constitutes an appropriate exit strategy (although frequent attempts were made by the IDVAs to contact AB they felt there was no criteria that they could refer to - to justify either closing her case or continuing in their attempts to make contact). (See Recommendation 14).

7.36 There appears to be significant overlap between the IDVA role and that of the police Domestic Violence Officer (DVO), with both signposting to other agencies and conducting safety planning. (See Recommendation 14)

7.37 The creation of a single Victim Care Unit to cover the East of England has significantly improved the quality of supervision. Record keeping is now of a higher standard and there is little risk that actions taken by a Victim Care Officer would not be properly supervised or documented.

7.38 Research in Essex has shown that in a sample of 312 domestic violence cases referred to Victim Support, 49% resulted in no further action. In many cases this was because the victim could not be contacted. It is likely therefore that this is a national issue. (See Recommendation 14)

General Family Concerns

7.39 The family raised the following specific issues that they wanted the Review to seek to examine and will be addressed specifically within the Conclusions of the Report at Section 7 below;

7.40 The level and quality of the liaison and information sharing between agencies and in particular children's social care, the police and probation

The issue of information sharing has been addressed within Section 6 above as it was one of the specific issues contained within the TOR, specifically at 6.15

7.41 The focus that was placed on protecting the children of AB and in particular in relation to CE and HB

The issue of the focus on safeguarding the children of AB has been reflected on throughout the Report and within Sections 6 and 7. In summary there was evidence of drift in managing those risks to the children with the notable exception of Hertfordshire CSC.

7.42 To what extent the information relating to DE and his history of crime and violence was shared across agencies and used to manage the risks he presented to AB and the children?

Again the issue of information sharing has been reflected upon within the Report and specifically within Section 6 and Section 7. Recommendation 1 at Section 8 is intended to address the issue of the lack of specific focus on DE throughout the Review period.

7.43 Whether AB would have been fully aware of all the information relating to DE and his offending behaviour that was available to agencies and therefore in a position to judge the level of risk to herself and the children?

There was significant evidence of detailed information around DE being shared across agencies and with AB at an early stage in their relationship. This even extended to information about DE having links to Operation Trident and therefore alleged access to firearms, being shared at a CPC. Additionally the circumstances in which AB met DE as part of the work around his rehabilitation would mean she was likely to be fully aware of his offending and propensity to violence.
Family members who may have been able to offer some additional protection to AB and CE were not however fully aware of all the information. Currently the guidance around disclosure is being amended. A pilot scheme run by the Home Office and four police forces in England and Wales concluded in November 2013. The pilot, (referred to as Clare's law across the media, formally titled the Domestic Violence Disclosure Scheme) allowed greater disclosure of relevant information to those at risk of domestic violence (or other legitimately concerned persons). The Government announced on 25th November 2013 that these arrangements would be extended to all of England and Wales from March 2014. The pilot scheme reflected significant levels of disclosure in each of the pilot areas and positive feedback from professionals and potential victims around the protective impact of the disclosures.

8. KEY RECOMMENDATIONS

The majority of the IMRs make recommendations and where these are applicable as more general recommendations they have been adopted as appropriate into the Overview Report Recommendations. It is anticipated that the more specific organisational recommendations will be subject of review by the appropriate Children and Adult Safeguarding Boards or Community Safety Partnerships

Recommendation 1:

That in complex high risk repeat cases where victims of domestic abuse are unwilling or unable to cooperate fully with agencies in protecting themselves and/ or their children, formal consideration is made within any CPC, MARAC or other multi agency professionals meeting of utilising MAPPA provision in order to produce a clear, multi agency plan aimed at managing or reducing the risks presented by the alleged perpetrator and reference to the plan recorded on Police National Computer systems to ensure that the information is shared across the Police Service. Consideration should be given in such cases to an application for a Domestic Violence Prevention Order.

Recommendation 2:

In complex high risk repeat cases of domestic abuse an arrest policy should be considered in order to assist and guide officers attending any incident that will allow them to consider the full nature of the relationship and extent of the threat of violence offered by any alleged perpetrator. Where appropriate this should be reflected as a

part of the MAPPA considerations and accessible to operational staff, at all times (including if possible recording on PNC), and arrest positively considered and recorded on all occasions when there are legal grounds.

Recommendation 3:

Local Authority CSC should not, without a full and joint recorded consideration of risk, transfer a case to another Local Authority when it has actively considered instigating care proceedings. The receiving local authority should specifically ask the question of the 'transferring out local authority' as to whether there has been consideration of any care proceedings, before accepting the transfer. The respective Local Authorities should ensure that all relevant information is available for full consideration at the time of the request to transfer. Hertfordshire CC and the London Borough of Enfield should consider the creation of a specific transfer protocol.

Recommendation 4:

Parental non compliance should be routinely recognised as a high risk indicator by all agencies involved in the delivery of Children and Adults services and should be challenged at the earliest opportunity. All agencies should train staff to enhance skills in recognising and addressing non-compliance.
Where appropriate, clear time limits should be established for legal planning meetings and subsequent child care proceedings where non compliance continues.

Recommendation 5:

LSCBs should review and develop guidance which should outline the respective responsibilities for health visitors and GPs and the requirement to maintain structured communication in cases involving children subject to a CPP and domestic abuse to ensure all available relevant information is shared with CSC and to consider the nomination of named linked Health Visitors to each practice.

Recommendation 6:

That SABs and LSCBs review and develop, if necessary, policies advising GP practices in relation to the handling of adult safeguarding concerns linked to allegations of DA. The policies should contain specific guidance on responsibilities

and examples for situations in which there may be no perceived risk to children with specific emphasis on information sharing and issues of consent.
All GPs should receive annual Level 3 Safeguarding training.

Recommendation 7:

That Clinical Commissioning Groups consider an audit of cases which have been transferred between GP practices to establish if there is significant delay in the transfer of files and if this is established to be the case to take measures to improve the timeliness of that process and to set time guidelines.

Recommendation 8:

Operational health staff including GPs should be considered routinely by CSC for attendance at CPC and Core Groups when they have **significant involvement** and that GPs should endeavour to attend, or at least provide comprehensive information on all occasions.
All contact should be recorded by GPs and where appropriate pro active action taken to contact CSC with relevant safeguarding information.

Recommendation 9:

Specialist Agencies providing domestic abuse and child protection services should ensure that they obtain specialist health advice at the earliest opportunity when they are dealing with individuals who may have complex health needs which could have a significant impact on their ability to safeguard themselves or their children

Recommendation 10:

Consideration should be given by LSCBs and CSC to recommending training to specialist Child Care lawyers and local child care courts in relation to thresholds for applications for a range of child care orders with particular reference to the impact of domestic abuse and parental non compliance.

Recommendation 11:

Consideration should be given by the appropriate LSCBs and CSC services to recommend the inclusion of specialist domestic abuse services (for example IDVAs) as essential at a range of professional meetings such as CPC and Core Groups, where domestic abuse is recognised as an issue.

Recommendation 12:

Minutes of Multi Agency Risk Assessment Conference (MARAC) should be placed on relevant child's ICS file with appropriate safeguards in place to ensure that sensitive confidential information remains accessible but secure.

Recommendation 13:

Routine checks should be carried out with A and E for all hospital admissions prior to MARAC meetings in relation to both the potential adult victim of domestic abuse and any relevant child or young person.
Similarly potential victims being treated by hospital out patient services should be flagged by the appropriate services to the consultant for future consideration.

Recommendation 14:

Victim Support should provide local service delivery operating instructions for the IDVA service which complements Victim Support and CAADA training and review policy in relation to non contact or apparent non cooperation by victims and around the provision of information by the police to domestic violence specialist services.

Recommendation 15:

That the London Ambulance Service review at a senior level the funding for Children and Adult Safeguarding within the organisation and specifically it's ability to support MARAC processes into the future.

Recommendation 16:

The respective SABs and LSCBs ensure that the individual recommendations contained in the IMRs and the recommendations with the Overview Report are shared within the appropriate agencies and any training issues identified addressed as a part of the work plans for those bodies and individual agencies.

APPENDIX 1

Chronology

03.03.08 – AB and family recorded as moving from Brent to Enfield. HB on CPP
04.03.08 – Brent CSC single agency visit to address, DE at premises alone with children
07.03.08 – HB discloses physical abuse to Brent CSC, living partially with MGM
24.04.08 - An invitation to attend a transfer in conference on the 30th April 2008 was received in Brent from Enfield in relation to HB
30.04.08 – Enfield decline transfer of HB as not resident with them
02.05.08 – MGM disclosed concerns around AB and DE and Brent CSC refer to Enfield CSC
02.06.08 – Enfield recorded as declining Transfer in as work not completed by Brent
05.06.08 – AB recorded as attending Barnet Enfield and Haringey Mental Health Trust for assistance with mental health issues
20.06.08 – AB recorded by Probation Service and CSC Enfield as having stabbed DE, police recorded by them as being present but not in police records. Probation record later conversation with police to confirm incident(s)
24.06.08 – MPS first record, attend at home address of AB. DE alleges attacked by AB with a knife
30.06.08 – Brent Probation record bruising on AB's legs
07.07.08 – MGM informs CSC that she has returned HB to his mother due to lack of support
14.07.08 – Information relating to an incident in the street in Enfield involving AB and DE
15.07.08 – AB attended North Middlesex Hospital with abdominal pains after a fall. Noted as pregnant
29.07.08 – Child Protection Conference at Enfield at which all three children placed on a child protection plan
08.08.08 – AB discussed domestic abuse with Enfield CSC
11.08.08 – Mother of AB attends Enfield CSC and reports significant concerns and knives at home of AB
12.08.08 – Brent Probation meet with AB and record detailed discussion around violence between AB and DE with children present.
19.08.08 – Interim Care Order obtained placing all three children away from AB. No contact with DE and supervised contact between AB and HB
23.08.08 – Domestic incident recorded by MPS relating to AB and DD relating to access to children
03.09.08 – Brent Probation record AB at a meeting with a swollen lip which she states is from a fall but OM records scepticism
22.09.08 – AB was taken to BEHMHT after fires seen at the house. Recorded as taken by police under S136 MHA but not detained. Disclosed domestic abuse including knives to SW but not recorded on MPS chronology
02.10.08 – First meeting with Enfield probation
03.10.08 – Enfield CSC record a meeting with AB at which she denies knowledge of the Brent concerns.
11.10.08 – MPS record a domestic assault by DE on AB. DE **arrested** on 13.10.08 when he handed himself in. AB attends at same time to withdraw complaint. NFA
13.10.08 – Enfield and Brent CSC record the exchange of information on child protection and domestic abuse issues.
16.10.08 – MPS record an abandoned call on AB's mobile. Attend address. No allegations made. NFA
18.10.08 – MPS record a domestic incident at the home of DD relating to access to the children
20.10.08 – MPS attend an allegation by AB of assault by DE. DE **arrested**. AB given full range of support but withdraws allegation. NFA, **MARAC** and MAPPA considered but not pursued
25.10.08 – MPS record a domestic incident relating to AB and access to the children
11.11.08 – Enfield CSC record a CPC Chair as requesting domestic abuse services for AB.

19.12.08 – First recorded involvement of Bedfordshire police called by DE to an address in Luton at two separate times, alleging AB trying to break in. No allegations made.
06.01.09 – Bedfordshire police attend Luton address where AB alleged an attack by DE with a knife. DE **arrested**. Full disclosure by AB of domestic abuse and sexual offences but no statement taken, DE bailed, AB then not contactable after she was arrested the following day for obstruction. **MARAC** considered but not pursued
31.01.09 – MPS attend home address of mother of DE after AB phones to allege offences by DE but later withdraws allegations. AB cautioned for wasting police time
05.02.09 – Transfer of AB to probation in Luton
02.03.09 – AB attended Luton and Dunstable Hospital reporting abdominal pain and bleeding after a fall onto some clothing
09.03.08 – Enfield CSC recorded as removing children from CPP
10.03.09 – OM probation in Luton refers to probation in Enfield and CSC concerns following meeting with AB on 3rd March
15.03.09 – Abandoned phone call to Bedfordshire police from the mobile of AB, screaming heard but not linked to Luton address, therefore no attendance
16.03.09 – AB informed OM Luton probation that she had moved out to Brent for safety reasons. AB confirmed that she had been attacked and had tried to phone police. Case transferred to Enfield probation
15.04.09 – Enfield probation contact Bedfordshire probation who in turn raises concerns for welfare of AB and unborn child in Luton with police and CSC
05.06.09 – Bedfordshire police attend address after AB alleges assault overnight after running to telephone kiosk. NFA as police mediate between DE and AB.
23.08.09 – Bedfordshire police contacted by AB alleging assault and some confusion over names and address causes delay in attendance. DE not at scene and subsequently circulated as wanted for common assault. **MARAC** considered but not referred
26.08.09 – AB obtained a Non Molestation Order against DE
04.09.09 – AB attended a planning meeting with Luton CSC at which she agreed a ten point plan
23.09.09 – Both AB and DE are recorded as attending an Initial Child Protection Conference (re unborn CE), together with professionals whilst DE wanted for assault.
29.09.09 – Police put in place safety measures at home address of AB
07.10.09 – CE born at Luton Hospital
13.10.09 – Enfield CSC record concerns around AB, HB and CE resident with MGM around DE and safety measures were put in place
15.10.09 – Enfield CSC record NFA in relation to the children of AB as they are resident with MGM
15.12.09 – AB took up an offer of a Refuge place following a planning meeting with Enfield CSC at which AB and MGM express their concerns around DE
17.12.09 – Luton Women's Refuge report a breach of a Non Molestation Order to police but have no contact with DE at that time and no contact is made with AB
09.03.10 – AB attended North Middlesex University Hospital for diarrhoea and vomiting and left before seeing a doctor
12.03.10 – AB attended the NMUH above and was admitted as an inpatient till the 19th March. **Diagnosed with Chrohns disease** for which she received treatment from this point on through Hospital and GP services
28.05.10 – CE removed from CPP by Luton CSC as resident with MGM with AB
26.08.10 – MGM reports AB and CE as resident back in Enfield to CSC
30.08.10 – MPS were contacted by family members to report a domestic incident and assault on AB by DE. DE arrested for breach of non molestation order and assault on two police officers. Charged and sentenced to 26 weeks imprisonment
30.11.10 – DE released from prison
02.01.11 – MPS attend incident at Travel Lodge and AB alleges assaults. DE arrested and bailed to 17.01.11 to live at his mother's address
06.01.11 – Bail address changed to Travel Lodge

17.01.11 – AB informed of CPS decision to NFA and informs police that DE has had contact with CE arranged by AB and mother of DE
28.01.11 – Enfield CSC record additional information re DA from MPS CSU
30.01.11 – Enfield CSC record further information from MPS CSU
01.02.11 – ICPC in Enfield re CE recorded AB and DE as living at the Travel Lodge, at least part time. Police give advice re safety. AB states openly she will not cooperate with CPP
03.02.11 – DE contacted MPS and states that he has been assaulted by AB and phone stolen. AB and DE were living at the Travel Lodge. Neither at premises on arrival and DE did not want to pursue.
14.02.11 – Enfield CSC record a request for a legal planning meeting as a result on the non cooperation of AB re the CPP
28.02.11 – Enfield CSC held a Core Group meeting
22.03.11 – AB informed Enfield CSC that DE had assaulted her but she had not reported to police. CSC advised reporting and tried to arrange refuge place unsuccessfully
22.03.11 – Enfield GP recorded attendance of AB with CE who had sustained a laceration to his forehead after '*falling on the towpath*'
15.04.11 – A Review Child Protection Conference was held re CE and he remained on a CPP on the basis of domestic abuse concerns
30.04.11 – AB contacted MPS and alleges DE trying to force entry to Enfield address. No allegations recorded and NFA
04.05.11 – MARAC meeting Enfield, range of agencies already working with AB
06.05.11 – SOLACE IDVA recorded as working with AB
17.05.11 – AB agreed safe house offered through IDVA
20.05.11 – MPS attended at the Enfield address at which DE was now living. DE alleged assault by AB. AB provides a different account to CSC.
25.05.11 – MARAC meeting took place in Enfield and discharged on basis of intended transfer to Hertfordshire
02.06.11 – Core Group meeting with Enfield CSC at which AB was informed that if she did not move away consideration would be given to removing CE from her care
08.06.11 – AB recorded by SOLACE as having moved to B and B in Watford
19.06.11 – MPS contacted by an anonymous informant alleging that there was an ongoing disturbance at the Enfield address with damage and children screaming. All quiet on police arrival and NFA
21.06.11 – NMUH record AB as missing an appointment due to '*an altercation*'
23.06.11- MPS were contacted by Hertfordshire police following an abandoned call which was traced to a mobile with AB and requested to check the Enfield address. Both AB and DE seen and no allegations made to police. NFA
27.07.11 – Core Group meeting with AB carried out in Watford by Enfield CSC
03.08.11 – MARAC formally transferred to Hertfordshire from Enfield
18.08.11 – Enfield CSC carried out a CP visit in Watford re CE
23.08.11 – Initial MARAC Meeting in Hertfordshire, IDVA support provided
27.08.11 – MPS attend a report by mother of DE of a domestic incident at the Enfield address now occupied by DE, NFA
21.09.11 – Enfield CSC carried out a child protection and Core Group meeting in Watford
23.09.11 – Hertfordshire police attend a domestic incident in Watford at which a woman is heard screaming and allegedly attacked with a knife by DE. AB and DE not at premises. **DE arrested** the following day and bailed. AB refuses to cooperate when contacted
03.10.11 – Review CPC carried out by Enfield and CE remained on CPP
06.10.11 – Enfield CSC record intended closure of the case
06.10.11 – CPS NFA as AB refuses to provide a statement despite additional attempts by police DVO
13.10.11 – AB discloses domestic abuse to GP in Hertfordshire

22.10.11 – Enfield CSC record Transfer out of CE CPP to Hertfordshire
25.10.11 – MARAC meeting in Hertfordshire, risks recorded and support provided and Transfer in of CE on CPP by CSC
02.12.11 – Hertfordshire CSC attend the Watford address with police and use police powers to remove CE to a place of safety as both AB and DE at the premises in contradiction of CPP
06.12.11 – CSC application for an Emergency Protection Order rejected by the Court as out of time limits and unable to list prior to that day, CE returned to his mother, court oversees written agreement
10.01.12 – Hertfordshire CSC carried out a review on CE and he remained on a CPP
03.02.12 – Hertfordshire GP recorded pregnancy of AB
08.02.12 – GP refers AB for private psychiatric assessment
09.02.12 – CSC applied for an Interim Supervision Order for CE
20.02.12 – GP refers AB for counselling support for domestic abuse issues
06.03.12 – Mental Health Services report to GP their assessment that AB had issues with depression and anxiety
30.03.12 – GP records health concerns that AB "*cannot walk 20 metres"*
19.04.12 – AB requested a statement from GP for court proceedings re the impact of her health on her parenting ability
26.04.12 – Mental Health Team report to GP AB had failed to keep 3 appointments and therefore they would cancel contact
22.05.12 – GP contacted by physiotherapy services as AB had failed to keep her appointment and therefore cancelled services
28.06.12 – Both AB and DE report allegations against each other to CSC in Hertfordshire, AB reluctant to report to the police
14.07.12 – Mother and neighbour of AB report domestic incident to Hertfordshire police and CSC involving AB and HB with CE present
01.08.12 – GP recorded telephone consultation with AB re Crohns disease
08.08.12 – AB seen as part of the court assessment process by CSC and outlined the history of domestic abuse with DE
13.08.12 – DE seen by CSC as part of the court assessment process and states that '*they will always see each other'*
17.08.12 – AB seen by CSC and states that she still sees DE '*all the time'*
27.08.12 – AB reports to Hertfordshire police an alleged assault by her son HB
28.08.12 – West and Central Family Proceedings Court agreed DE contact with CE every other weekend that he can travel alone with CE and that DE has no contact with AB
28.09.12 – AB reports a '*domestic dispute*' to Hertfordshire police at the Watford address, on attendance DE alleges damage to his mobile phone. Appointment made for AB to be interviewed re the allegation of damage on 1st October by police
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APPENDIX 2 – Glossary

PNC	POLICE NATIONAL COMPUTER
SPECCS	RISK ASSESSMENT DOCUMENT. (**S**eparation, **P**regnancy, **E**scalation, **C**ommunity, **C**hildren, **S**exual/**S**talking)
RA	RISK ASSESSMENT
FIR	(Police) FORCE INFORMATION ROOM
DVLO	DIVISIONAL VICTIM LIAISON OFFICER
IP	INJURED PARTY
MARAC	MULTI AGENCY RISK ASSESSMENT CONFERENCE (specifically for issues of domestic abuse).
DVIU	DOMESTIC VIOLENCE INVESTIGATION UNIT

Sig	STREET INDEX GAZETEER
DASH	**D**omestic **A**buse, **S**talking, **H**arassment & honour based violence.
IDVA	Independent Domestic Violence Advisor.
CATS	**C**ase **A**utomated **T**racking **S**ystem
PPST	Public Protection Support Team
CAD	Computer aided Dispatch
CSC	Children Social Care
CPP	Child Protection Plan
IPCC	Initial Child Protection Conference
RCPC	Review Child Protection Conference
MPS	Metropolitan Police Service
MERLIN	Referral form to CSC used by MPS
CRIS	Crime Recording Information System
MGM	Maternal Grandmother
IMR	Independent Management Review
DHR	Domestic Homicide Review
CAADA	Home Office Initiative, **C**oordinated **A**ction **A**gainst **D**omestic **A**buse
OM	Offender Manager , Probation
(S)SW	(Senior) Social Worker
PPD	Public Protection Desk, Police
CSU	Community Safety Unit, Police
GP	General Practitioner
NMUHT	North Middlesex University Hospital Trust
BEHMHT	Barnet Enfield and Haringey Mental Health Trust
CRT	Crisis Resolution Team
ACPO	Association of Chief Police Officers
NOMS	National Offender Management Service (combination of Prison and Probation Services)
RCGP	Royal College of General Practitioners
SOLACE	London based Charity providing services related to domestic abuse
Form 124D	MPS Form for recording domestic violence incidents which contains guidance
MAPPA	Multi Agency Public Protection Arrangements (national scheme for managing violent and sex offenders)
PND	Police National Database (currently being developed to support PNC)

Appendix 3

Extract

POLICE AND CRIMINAL EVIDENCE ACT 1984
CODE G
CODE OF PRACTICE FOR THE STATUTORY POWER OF ARREST

BY POLICE OFFICERS
Commencement
This Code applies to any arrest made by a police officer after midnight on
31 December 2005

1. Introduction

1.1 This Code of Practice deals with statutory power of police to arrest persons suspected of involvement in a criminal offence.

1.2 The right to liberty is a key principle of the Human Rights Act 1998. The exercise of the power of arrest represents an obvious and significant interference with that right.
1.3 The use of the power must be fully justified and officers exercising the power should consider if the necessary objectives can be met by other, less intrusive means. Arrest must never be used simply because it can be used. Absence of justification for exercising the powers of arrest may lead to challenges should the case proceed to court. **When the power of arrest is exercised it is essential that it is exercised in a nondiscriminatory and proportionate manner.**
1.4 Section 24 of the Police and Criminal Evidence Act 1984 (as substituted by section 110 of the Serious Organised Crime and Police Act 2005) provides the statutory power of arrest. If the provisions of the Act and this Code are not observed, both the arrest and the conduct of any subsequent investigation may be open to question.
1.5 This code of practice must be readily available at all police stations for consultation by police officers and police staff, detained persons and members of the public.
1.6 The notes for guidance are not provisions of this code.

2 Elements of Arrest under section 24 PACE

2.1 A lawful arrest requires two elements:
A person's involvement or suspected involvement or attempted involvement in the commission of a criminal offence;
AND
Reasonable grounds for believing that the person's arrest is necessary.
2.2 Arresting officers are required to inform the person arrested that they have been arrested, even if this fact is obvious, and of the relevant circumstances of the arrest in relation to both elements and to inform the custody officer of these on arrival at the police station. See Code C paragraph 3.4.
Involvement in the commission of an offence
2.3 A constable may arrest without warrant in relation to any offence, except for the single exception listed in Note for Guidance 1.
A constable may arrest anyone:

- **who is about to commit an offence or is in the act of committing an offence**
- **whom the officer has reasonable grounds for suspecting is about to commit an offence or to be committing an offence**
- **whom the officer has reasonable grounds to suspect of being guilty of an offence which he or she has reasonable grounds for suspecting has been committed**
- **anyone who is guilty of an offence which has been committed or anyone whom the officer has reasonable grounds for suspecting to be guilty of that offence.**

Necessity criteria

2.4 The power of arrest is only exercisable if the constable has reasonable grounds for believing that it is necessary to arrest the person. The criteria for what may constitute necessity are set out in paragraph 2.9. **It remains an operational decision at the discretion of the arresting officer as to:**

- what action he or she may take at the point of contact with the individual;
- the necessity criterion or criteria (if any) which applies to the individual; and

• whether to arrest, report for summons, grant street bail, issue a fixed penalty notice or take any other action that is open to the officer.
2.5 In applying the criteria, the arresting officer has to be satisfied that at least one of the reasons supporting the need for arrest is satisfied.
2.6 Extending the power of arrest to all offences provides a constable with the ability to use that power to deal with any situation. However applying the necessity criteria requires the constable to examine and justify the reason or reasons why a person needs to be taken to a police station for the custody officer to decide whether the person should be placed in police detention.
2.7 The criteria below are set out in section 24 of PACE as substituted by section 110 of the Serious Organised Crime and Police Act 2005. The criteria are exhaustive. However, the circumstances that may satisfy those criteria remain a matter for the operational discretion of individual officers. Some examples are given below of what those circumstances may be.
2.8 **In considering the individual circumstances, the constable must take into account the situation of the victim, the nature of the offence, the circumstances of the suspect and the needs of the investigative process.**

Codes of practice – Code G Statutory power of arrest by police officers
2.9 The criteria are that the arrest is necessary:
(a) to enable the name of the person in question to be ascertained (in the case where the constable does not know, and cannot readily ascertain, the person's name, or has reasonable grounds for doubting whether a name given by the person as his name is his real name)
(b) correspondingly as regards the person's address an address is a satisfactory address for service of summons if the person will be at it for a sufficiently long period for it to be possible to serve him or her with a summons; or, that some other person at that address specified by the person will accept service of the summons on their behalf.
(c) to prevent the person in question –
(i) causing physical injury to himself or any other person;
(ii) suffering physical injury ;
(iii) causing loss or damage to property;
(iv) committing an offence against public decency (only applies where members of the public going about their normal business cannot reasonably be expected to avoid the person in question); or
(v) causing an unlawful obstruction of the highway;
(d) to protect a child or other vulnerable person from the person in question
(e) to allow the prompt and effective investigation of the offence or of the conduct of the person in question.
This may include cases such as:
(i) Where there are reasonable grounds to believe that the person:
• has made false statements;
• has made statements which cannot be readily verified;
• has presented false evidence;
• may steal or destroy evidence;
• may make contact with co-suspects or conspirators;
• **may intimidate or threaten or make contact with witnesses**;

Codes of practice – Code G Statutory power of arrest by police officers
• where it is necessary to obtain evidence by questioning;

Appendix 4

Extract MAPPA Guidance 2009

Category 3 Offenders: Other Dangerous Offenders
This category is comprised of offenders, not in either Category 1 or 2 but who are considered by the Responsible Authority (RA) **to pose a risk of serious harm to the public which requires active inter-agency management.** It could also include those offenders on a community order who are, therefore, under the supervision of the Probation Service.

To register a Category 3 offender, the RA must:
1. Establish that the person has committed an offence which indicates that they are capable of causing serious harm to the public; and
2. Reasonably consider that the offender may cause serious harm to the public which requires a multi-agency approach at level 2 or 3 to manage the risks.
The person must have been convicted of an offence, or have received a formal caution or reprimand/warning (young offenders). The offence may have been

committed in any geographical location, which means that offenders convicted abroad could qualify.
Establishing that a previous offence demonstrates a capacity for serious harm should usually be straightforward. In most cases, the offence itself will be of a clearly sexual or violent nature, although there is no requirement for it to be listed in schedule 15 to the Criminal Justice Act (2003). There may, though, be some cases where it is only an examination of the circumstances surrounding the offence which will indicate that the offender has a capacity for serious harm. This may show, for example, a pattern of offending behaviour indicating serious harm that was not reflected in the charge on which the offender was ultimately convicted.
Whilst any agency may refer a case for consideration as a Category 3 offender, it is for the RA to determine whether the offender meets the criteria.
In order to ensure that the MAPPA agencies remain focused upon those Category 3 cases where they can have greater impact, it has been agreed that only those offenders who require management via level 2 or 3 MAPP meetings should be registered in Category 3. The RA must maintain close oversight of this category, to ensure that they continue to require active multiagency management via the MAPP meetings.
Any agency can identify an offender who **may** qualify for Category 3. Once identified, they should follow the referral process

The Victim

The primary focus of MAPPA is how to manage the risk and behaviour of the offender but specific and general victim issues are also central to the effective operation of MAPPA. Victim safety, preventing re-victimisation and avoiding the creation of new victims is fundamental to the MAPPA agencies' public protection role. It is vital that the MAPPA agencies ensure their decision making is informed by an effective engagement with current victims and, where practicable and appropriate, with potential victims. Only by doing this can the Responsible Authority (RA) be satisfied that the risk assessment and
Risk Management Plans properly reflect victim concerns and provide appropriate measures to protect them.

In those areas where a Multi-Agency Risk Assessment Conference (MARAC) has been established, the Independent Domestic Violence Adviser (IDVA) team will have made contact with the victim(s) of serious domestic abuse.

Appendix 5

Biography – Tim Beach BA (Honours), MSc

Work Experience

Suffolk Constabulary November 1979 – November 2009, police officer in various roles, including Area Commander, Ipswich (Chief Superintendent) and Det Supt with responsibility for all areas of Public Protection which included Safeguarding Children, Vulnerable Adults, Hate Crime and Domestic Abuse Services.
Nationally accredited Senior Investigating Officer for major crime and undertook a number of investigations relating to domestic homicide.

Independent Chair of Safeguarding Children Board, Barnet, London (Sept 2009 to October 2013)

Chair Domestic Homicide Review (DHR) Cambridgeshire County Council/ Constabulary 2009/10

Overview Report Writer, DHR Hertfordshire (2012)

Member of London Safeguarding Children Board, (representing Chairs 2010 to October 2013)

Chair of London Independent Safeguarding Chairs Group, (2010 to October2013)

Independent Serious Case Review Report Writer for East of England for Multi Agency Public Protection Arrangements (MAPPA)

Local Government Association Peer Review - Cornwall Children Services – November 2011, Cambridgeshire 2013

Review of MAPPA arrangements - State of Jersey – 2011/12

Independent Investigations with regard to complaints under Children Act 1989/2004 (Suffolk County Council - 2010 to present)

Vice chair of a Fostering Panel - 2011 to present

Vice Chair Ipswich Umbrella Trust (Homelessness Charity) – 2007 to present

Appendix 6

Explanation of MARAC and DASH

A MARAC is a multi-agency meeting which has the safety of high-risk victims of domestic abuse as its focus. The identification of high-risk victims has been made possible by the use of a risk identification tool, agreed between a Home Office funded charity named CAADA (Co-coordinated Action against Domestic Abuse) and the Association of Chief Police Officers (ACPO), for use across a wide range of agencies. This has enabled practitioners, both within the criminal justice system and outside, to identify 'high-risk' victims of domestic abuse.

The MARAC is a high volume process reflecting the prevalence of domestic violence. It involves the participation of all the key statutory and voluntary agencies, and critically, specialist domestic violence services, most frequently in the form of an Independent Domestic Violence Adviser (IDVA). Referral to MARAC is usually by completion of the CAADA-DASH risk identification checklist for IDVA's and other

non-police agencies. MARAC referrals are discussed at the meeting and all agencies have an opportunity to contribute to the outcome decisions/actions.
MARAC is not yet on a statutory footing; however it is still one of the proposals in the National Government Strategy for Violence against Women and Girls. There is currently no corporate guidance for MARAC as it is a Home Office initiative led by CAADA which provides MARAC accreditation, implementation guidance and ongoing support.

In October 2011, The Domestic Abuse, Stalking, Harassment and Honour Based Violence Risk Identification, Assessment and Management Model (DASH 2009) was introduced and implemented across all police forces. A DASH Risk assessment is now contained within the Domestic DASH booklets. The risk assessment consists of 27 questions which must be asked by the attending officers in all Domestic related incidents and is used as a referral mechanism for MARAC.

The SPECCS booklet, a predecessor form, was replaced in October 2011. Officers attending domestic abuse incidents are now required to complete the national DASH (2009 version).