OVERVIEW REPORT (Executive Summary)

PREPARED FOR THE DOMESTIC HOMICIDE REVIEW PANEL REGARDING THE DEATH OF

AB

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1. INTRODUCTION

1.1 In 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 and later sentenced to serve a minimum period of 33 years.

1.3 The relationship between AB and DE is recorded back as far 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. Both DE and AB had a number of criminal convictions with a significant number of DE's involving violence. Over the review period both 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 Borough Council and Hertfordshire. There was some limited contact with other local authorities, as reflected within the extensive merged chronology, but this was not significant in terms of the delivery of services to the children of AB or to AB herself. Similarly AB and DE had contact with a range of health and support services and these are listed in section 2 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 a young girl. She lived in the Midlands area and London when she was growing up.
Her first child HB was born as a result of that relationship.
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 (DA), they however 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. He was made subject of a Child Protection Plan (CPP) in Brent.
In 2007 AB met DE and by early 2008 they lived together.
A while later formal arrangements were made with the Courts for HB to live with his maternal grandmother (MGM) 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 but information from health sources reflects significant health issues.

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

Name	Relationship	Recorded Ethnicity	Address at time of SD'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 (MGM) and had Residence Order re: HD	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: NH and TH	Not noted on ICS	LONDON,
(BB)	Maternal aunt	Not noted on ICS	ENFIELD, Middlesex,
(HE)	Paternal Grandmother to CS	Not noted on ICS	LONDON,

1.6 The MPS murder investigation and contact with the family identified the following information that was 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; but the contact is recorded within the chronology. 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 (DA) issues. The individual IMRs, particularly from the Local Authority Children's Social Care (CSC) Departments, contain an analysis of the child protection issues and should be scrutinised by the respective Local Safeguarding Children Boards (LSCB).

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 other of her children, BD and ED. There are also a small number of incidents that relate to her son HB. At the time 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 of the issues two chronologies have been provided within the main Overview Report. A brief chronology is contained within the Introduction to the Report with a merged chronology; Appendix 2 covers all of the relevant contacts with services within the period of the Terms of Reference (TOR) including the substantial recordings and meetings that relate primarily to the concerns around the children of AB.

1.14 The Appendix is intended to provide a focused chronology that more specifically reflects contact with services related to the DA issues or where there is specific recording of the issue and an attempt to manage it either as part of the Child Protection process or from the provision of DA services.

1.15 DE had a recorded criminal history which started in 1994 when he was 13 years of age. Many of the convictions from 1999 onwards involved acts or the threat of violence. In 2001, he was arrested and subsequently convicted of robbery, and at the time of the robbery DE stabbed the victim 5 times, causing serious injury and the loss of movement in the victim's left hand. He was sentenced to 6 years imprisonment
The MPS recorded intelligence that suggested DE had links to Operation Trident (MPS operation relating to gun crime) with markers for access to firearms and violence. DE had not at any point within the Review period been subject of direct work by Operation Trident staff.

Was the death of AB avoidable?

1.16 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 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.

1.17 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.

1.18. 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 DA services was exemplary on occasions.

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

1.19 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.

1.20 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 (TOR) AND THE REVIEW PROCESS

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 death.**

Purpose of the review is to:

- 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 Coroner and Court 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) risk assessment and risk management for domestic abuse victims or perpetrators and were those assessments correctly used?

Was the victim subject to MARAC?

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?

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 concerning 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.

Agencies Involved:

The following agencies provided an IMR

MET 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 police 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 and raised a number of issues which are specifically addressed within the Conclusions within the Report. 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.

2.7 Methodology

The DHR Panel set up following the death of AB in 2012 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 date of AB's death. 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 and 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, and if there was significant contact Individual Management Reports (IMRs) were requested.

Those agencies which provided an IMR have been identified above 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.

The various IMRs also record the analysis undertaken by the individual authors, much of which is directly reflected within the full Overview Report.

The Overview Report Writer followed up direct with a number of agencies as agreed with the Panel Chair. It was felt essential to pursue as many returns as possible due to the frequent and complex contacts across organisations and geographic boundaries sometimes simultaneously which created some level of difficulty in compiling the report and indeed created issues for agencies over the period of review which is reflected upon both within the report as well as in the recommendations.

The following agencies confirmed direct 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

Sources of material are reflected at the relevant point within the full Overview Report. 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.

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 at which DE was convicted of murder. 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.

2.8 Panel members of the 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

3. SUMMARY OF EVENTS AND KEY ISSUES

Brief Chronology – (significant events directly linked to Domestic Abuse (DA) falling within the Review period)

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, MS 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 BE 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 DA with Enfield CSC
11.08.08 – Mother of AB and HB attend Enfield CSC and report 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 DA 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 CP and DA issues.
11.11.08 – Enfield CSC record a CPC Chair as requesting DA services for AB.
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
19.12.08 – First recorded involvement of Bedfordshire police called by DE to and 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 DA 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 beach 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 Chron's 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 DA 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 CP 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 Domestic Violence Officer (DVO)
13.10.11 – AB discloses DA 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 CS 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 retuned 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 DA 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 DA 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

4. ANALYSIS OF KEY ISSUES

4.1 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 HO 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:

4.2 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 DA 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 DA 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 full Overview Report there was a significant 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 clear breaches of that agreement and the apparent crossing of what had been a clear threshold 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.
As evidenced by the fact that HB was left in sole care of CE on the day of the murder this left both children at considerable risk of both emotional and physical harm. 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 the case that given the history of contact between DE and AB that it would have continued in some form into the future.

4.3 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 referrals recognise that, for the most part, AB was at high risk and often a whole range of services attempted to assist AB in reducing the risks to both herself and her children, in particular CE. It is equally clear that AB consistently made it difficult for them to assist. This was most evident in her repeated calls for assistance from the police and then subsequent withdrawal from assisting any prosecution of DE. It is possible to speculate that there may well have been a range of reasons for that including fear and a level of influence being exerted by what was an evidenced violent offender.
In August 2010, the CAADA-DASH (Domestic Abuse, Stalking and Honour based Violence) 2009 risk assessment model was introduced updating the SPECSS+ risk assessment model. Since November 2011, police policy dictates that DASH completion is mandatory for all DV incidents. All agencies are required to use this tool for DV as a referral method into MARAC.
The risk assessments tools were applied consistently and frequently as outlined in the report with AB invariably being recognized at High Risk by all appropriate agencies which would evidence embedded understanding of the processes.

4.4 Was the victim subject to MARAC?

AB was subject of MARAC meetings both in 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. There is a reasonable argument that precious time and resource needs to be devoted to those who will work with the process.
The contrary argument that as some of those at most risk will not always be entirely cooperative, (that includes significant numbers of the referrals made to MARAC), that 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 (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-today 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.
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.

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

The recording IMRs and chronology does evidence for the most part 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.
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 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 DA.
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 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.

4.6 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 HD 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 DA. 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 one 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 DA, but also in relation to the children. 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 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.

4.7 Were appropriate services offered or provided?

Services were offered by a range of professionals including specialist DA 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 almost despite herself.
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.
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 and avoid future violent relationships. 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 would not 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 a Non Molestation Order.

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

4.8 What disclosures SD 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 DA 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 DA and the risks to her and CE. Many attempts were made to protect CE from the DA he was frequently witnessing but ultimately they were unsuccessful.

4.9 If and how agencies assessed risks to SD 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 DA. 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 DA 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)

4.10 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 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, (14/07/08, 05/06/09 and19/06/11), when the MPS or Hertfordshire/ Bedfordshire were contacted with regard to alleged domestic incidents when the arrest of DE could have been further considered.

4.11 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's 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, linked with personality disorders, and this has been shown to be effective. (See Recommendation 4)

4.12 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; if 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.

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 full 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 DA 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 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).

4.13 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 DA 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 DA, 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.

4.14 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 DA 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 DA 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 DA 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 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.

4.15 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 DA 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 significant 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 clear breaches of that agreement and the apparent crossing of what had been a clear threshold 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.
Another minor exception is arguably 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.

4.16 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 4.19 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 PPO and the application for an 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.

4.17 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. This is particularly true of the work at the point of the transfer in around October 2011 from Enfield CSC to Hertfordshire when not all relevant information was passed in a timely manner and this arguably did lead to some delay in the Core Assessment work carried out by Hertfordshire and therefore potentially care proceedings in either Enfield or Hertfordshire. Similarly the delay in transferring patient files between the GP practices was such that the passing of relevant information relating to DA 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.

4.18 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 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 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.

4.19 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.

5. CONCLUSIONS

Theme 1: Disguised or Non Compliance/ Personality Disorder

5.1 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 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 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 refers to her '*personality problems'* that warrant psychiatric assessment.

5.2 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.

5.3 The specialist DV 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 the 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.

5.4 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)

5.5 In Brent CSC, it is now a routine contingency that a case will be presented for a legal planning meeting should their 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

5.6 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.

5.7 Multi-agency communication is less evident both in relation to GPs proactive engagement with CSC around DA 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).

5.8 Although the Royal College of GPs (RCGP) produced a DV 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.

5.9 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)

5.10 The Health Visitor 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

5.11 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 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.

5.12 There was a delay in accessing any medical opinion in relation to the DA and CP 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 CP process did not address it further, despite the earlier agreement on AB's part for a referral to adult services.

5.13 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 well being, 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 SD'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 HVs 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)

5.14 The increasing frequency of failure for AB to attend health condition related appointments once resident in Watford should have initiated increased DV 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.

5.15 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.

5.16 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.

5.17 When the specialist Mental Health Services informed the GP practice that after failure to attend appointments offered AB was being discharged from the service, 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

5.18 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.

5.19 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.

5.20 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 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 DA which stresses the importance of positive action when attending at incidents of alleged DA; 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 DV 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 DA 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.

5.21 The Overview Report has identified three occasions when the MPS or Hertfordshire/ Bedfordshire were contacted with regard to alleged domestic incidents when the arrest of DE could have been further considered. Within the full 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 4 to the Overview Report), 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.

5.22 The crime recording of DV 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

5.23 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 DA 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 the chronology. The one exception to that rule of optimism was Hertfordshire CSC who acted proactively when they had evidence of her non cooperation.

5.24 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 DV 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 DV and MAPPA could be utilised to supplement this work as outlined.
(See Recommendation 1).

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

General Conclusions

5.26 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 , e.g. IDVAs attendance at child protection case conferences and core groups. Similarly GP attendance at CPC would have been beneficial.

5.27 Persistence was demonstrated in conducting CP 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.

5.28 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.

5.29 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)

5.30 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.

5.31 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)

5.32 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)

5.33 There were two occasions when AB reported pregnancies to her GP in Hertfordshire and there was no detailed documentation in relation to risk assessment in relation to DV history and who the relationship was with. AB was ambiguous as to the desire to continue the pregnancy and in the event they spontaneously failed to progress, but this was an omission. It is an excepted feature of DV research that pregnancy is a period for likelihood of exacerbation of DV 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.

5.34 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.

5.35 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 SD 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).

5.36 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)

5.37 The creation of a single VCU 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 VCO would not be properly supervised or documented.

5.38 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

5.39 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;

5.40 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 above as it was one of the specific issues contained within the TOR.

5.41 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. In summary there was evidence of drift in managing those risks to the children with the notable exception of Hertfordshire CSC.

5.42 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. Recommendation 1 is intended to address the issue of the lack of specific focus on DE throughout the Review period.

5.43 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 DV (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.

6. KEY RECOMMENDATIONS FOR ACTION

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 DA 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.

Recommendation 2:

In complex high risk repeat cases of DA 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 full joint recorded consideration of risk, transfer a case to another Local Authority when it has established that the thresholds for care proceedings have been met if the family remained within their local authority. The receiving local authority should specifically ask this question of the 'transferring out local authority', 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

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 and a review of the good practice of Family Nurse Practitioners is carried out to assist all other agencies.
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 DA 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:

Agencies providing DA 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 DA and parental non compliance.

Recommendation 11:

Consideration should be given by the appropriate LSCBs and CSC services to recommending the inclusion of specialist domestic abuse services (for example IDVAs) at a range of professional meetings such as CPC and Core Groups, where DA 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 DA 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 the IDVA service.

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

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 DA).
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 DA
Form 124D	MPS Form for recording DV 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)
PD	Personality Disorder