

Overview Report

Domestic Homicide Review

Christopher/2011

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Overview Report

1 Introduction

- 1.1 On Friday 14th October 2011 a man was stabbed to death by his ex-wife in her flat in Kent. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004 the Kent Community Safety Partnership have commissioned a Domestic Homicide Review (DHR) into this case. Greg Barry was appointed as the Independent Chair and Author of the overview report. Greg Barry is a retired Detective Chief Superintendent from Kent Police, he specialised in the investigation of abuse of vulnerable people, multi-agency working and reviewing of investigations. He was the Kent Police representative on the various strategic groups in Kent and Medway dealing with safeguarding and domestic abuse. He holds a Diploma in Child Protection. On his retirement in 2009 he worked for the Kent Safeguarding Children Board (KSCB) for two years as the Development Officer with lead responsibility for Child Death Review. Greg has not had any involvement with this family whilst working for Kent Police or KSCB.
- 1.2 The full terms of reference of the review can be found at Appendix A. The main purpose of a Domestic Homicide Review is to establish lessons to be learnt. The review was undertaken in accordance with the Home Office Guidance 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' published in April 2011 and the Kent and Medway Domestic Homicide Review Protocol published in September 2011.

2. Review Process

- 2.1 The review was carried out by a multi-agency panel that was independently chaired. The panel considered reports from Individual Management Reviews (IMRs) and information supplied by some of the numerous agencies who had been involved in providing services to the family. These agencies were identified by making requests from the core agencies to establish if the family had contact with them in Kent, Medway, Greenwich and Essex as the family had resided in these areas. As information was gathered further organisations were identified and they too were asked to participate in the review, especially if they had had recent dealings with the family. Some other support organisations were identified that may have had contact with the family between 2003 and 2007. A decision was made by the panel not to contact them as it was unlikely that they would have any additional information as the core agencies had been responsible for referring them to those organisations. The completion of the IMRs and provision of information by the agencies was achieved by a combination of an examination of relevant records and in some cases interviews with members of staff who had been involved with the family. The reports contained factual information and an analysis of the service provided by comparing what happened and what was expected in accordance with existing policy and good practice within that agency and on a cross agency

basis. Once the reports/IMRs were submitted they were circulated to the panel members and then discussed in a two day meeting. The Independent Chair then compiled an overview report and this was circulated for comment to all agencies that had contributed to the DHR. The final report contains factual background information; a chronology of contact between services and the family as well as an overview and analysis of that contact. The panel then met to discuss the draft final report and as a consequence further information was requested. In most cases this was obtained and an amended report was completed. As there are gaps in the information supplied some of the entries in the chronology are not date specific but have been included as they assist with the context. A list of the contributing agencies, authors of the reports and panel members is detailed at Appendix B unless the naming of the individual could lead to the identification of the family, an individual worker or make a location or organisation vulnerable.

- 2.2 The review was delayed as additional information had to be obtained from a number of the agencies and some agencies initially declined to participate in the review. Further delay was experienced as a result of agencies submitting reports which were not in the requested format or they did not address the terms of reference. This was in the main some of the health organisations that this family had contact with in Essex and Greenwich. In addition responses within the requested timescale were not adhered to. As a consequence numerous requests for additional information were made, and responses to these requests were not forthcoming from some of the agencies despite repeated approaches to the agency. The Independent Chair, after consultation with the Kent Community Safety Partnership made a decision not to pursue those requests but highlight the issue within the report in order for the matter to be addressed by the Home Office and NHS England. It is known that this family had contact with a number of other health organisations such as hospital accident and emergency departments during the nine years that this review has examined. Despite numerous attempts health professionals in Kent have been unable to even confirm the contact let alone make a request for an IMR. When approached, one response from a liaison point in the health economy in Greenwich was to the effect that as they had some thirty providers; it was not realistic to contact them all to see if the family were known. As a consequence there are gaps of information in this report and the chronology as regards to the services provided by the mental health services in Greenwich and Essex. In addition the information regarding contact with GPs in London for both the offender and victim is incomplete. The GP records for the victim prior to 2009 cannot be located although it is understood that the Kent Police may have these files in the archived murder investigation papers and so could be accessed at a cost and would require independent analysis. The IMR regarding contact by the victim with the GP in Greenwich post 2009 has limited information as it does not make clear the sources of information and contains possible inaccuracies. The offender's GP records for Greenwich are understood to be in the prison where she is serving her sentence; however accessing them has not been possible. Attempts to do so have

been drawn out with questions regarding consent and legitimacy of this review being raised by health professionals in Kent. It is unfortunate that the full health record of the offender has not been available for review as the significant time of pregnancies and domestic abuse has not been subject to detailed consideration. Other agencies such as Greenwich and Essex Children's Social Care (CSC), the three police forces as well as the various abuse support services in Essex and Kent; Her Majesty's Prison Service and the Kent Probation Trust have all cooperated fully with this review and responded positively to requests for additional information.

- 2.4 In May 2012 a representative from the Metropolitan Police Service (MPS) requested to restrict the scope of their IMR because they had been involved with the family for the duration of the timescale of this review and the large number of incidents that they had dealt with. In addition the MPS response to domestic abuse had changed considerably over these years. They stated that their IMR would include details of all the incidents recorded by them but the detailed analysis of those incidents would only be applied from 1st January 2008. This was agreed by the Independent Chair.
- 2.5 The decision to hold a review was made on 7th November 2011 and the panel subsequently met four times in total; initially to agree the terms of reference and then three times to consider the IMRs and agree the final report which was written by the Independent Chair. All of the agencies/organisations that supplied information to the panel were given the opportunity to comment on the final report before it was submitted to the Home Office.
- 2.6 The Crown Prosecution Service (CPS) were consulted about the timing of the review and requested that the review should not commence until after the criminal trial had been completed. As there was a criminal trial leading to a conviction there was no requirement for the Coroner to hold a full inquest.
- 2.7 This review examined the services provided to the woman, her husband and their two children. It focussed on the services that were relevant to the identification, investigation and prevention of domestic abuse and the impact on the children. The time period examined by this review was 1st January 2002 until 14th October 2011.
- 2.8 This review is not a serious case review examining the children's safeguarding response by agencies however child protection incidents and investigations have been included because of the acknowledged links between child abuse and domestic abuse. Comment has been made regarding some of the decisions regarding the children as domestic abuse was prevalent in the family at the time. This was known to the agencies involved and therefore relevant to this review that considered the impact of domestic abuse not only to the victims but also to the children of the victim

and the offender. This report will be shared with the Safeguarding Children's Boards in Kent, Medway, Greenwich and Essex.

- 2.9 This report has been anonymised therefore the core family members are referred to as:

Offender: Elizabeth
Victim: Christopher
Son: Peter
Daughter: Elaine

- 2.10 Agencies and organisations that have had contact with members of this family have been named unless they are a small service and the identification of them could lead to an individual worker or the family being identified.

3. Background

3.1 The victim

Christopher was thirty years old when he was murdered and had known Elizabeth since he was twenty years old. They were married in October 2001. Peter was born in 2002 and Elaine was born in 2004. They were divorced in 2009. Neither of the parents had full custody of either of the children at the time of the homicide but they did have contact. Christopher first came to the attention of the police when he was fourteen years old when he received a caution for attempted robbery and after that he came to the notice of the police on a regular basis for a variety of offences including dishonesty, threatening and abusive behaviour (including threatening a neighbour with a knife) as well as driving and alcohol related offences. He was convicted twice for assault, one of the victims was Elizabeth and the other was not domestic related. Christopher lived in Greenwich for most of his life. He did move to Essex with Elizabeth between September and November 2009. In addition he also lived in Birmingham around June 2009. Christopher had never been employed for any significant length of time. Christopher was White British with no recorded disabilities although he had suffered from mental ill health since 1999. In November 2009 he informed his new GP that he had been diagnosed with bi-polar disorder however this cannot be confirmed. His family also state he suffered from bi-polar. Christopher also had issues with alcohol and substance misuse from when he was a teenager; he was known to use cannabis and cocaine. On at least one occasion he took an overdose of prescription drugs and alcohol.

3.2 The offender

Elizabeth was twenty eight years old at the time of the murder. As a teenager her family was known to children's social services in Kent and then when they moved to Greenwich. She was known to have behavioural

difficulties. She met Christopher in 2001 through a friend when she was eighteen years old when they were both living in Greenwich. They were married soon after meeting and she gave birth to Peter in 2002 and Elaine in 2004 whilst living in Greenwich. They were divorced in 2009. In addition to the domestic abuse incidents Elizabeth came to notice of the police at least eleven times for offences including criminal damage, public order and assault. Prior to the murder Elizabeth was convicted/cautioned for six offences; one of which was assault. In 2009 she moved with Elaine to Kent for a short while and then to Essex. Sometime in 2010/2011 she commenced a new relationship and subsequently moved with this man back to Kent in April 2011. At the time of the homicide she was attempting to gain custody of Elaine. Elizabeth had never been employed for any significant length of time. She was White British with no recorded disabilities although she had suffered with mental ill health from 2002. She also had significant problems with alcohol misuse from when she was a teenager.

3.3 The children

Peter was nine years old at the time of the murder. He was living with his paternal grandmother and her husband. He is subject to a Special Guardianship Order which was made by the court in February 2009. He had been living full time with his grandmother since 2007 and prior to that had spent a great deal of time with her. Soon after his birth his paternal grandmother would look after him for the weekend.

Elaine was seven years old when the murder occurred. In August 2010 Elaine had been taken into Police Protection and then accommodated under Section 20 of the Children Act 1989 by Essex Children's Social Care. Elaine was placed with foster carers in Essex where she was living at the time of the murder. The weekend before the homicide, Elaine had spent her first unsupervised overnight weekend contact visit with Elizabeth as Essex Children's Social Care had decided to commence a programme of re-unification. As Elizabeth had not returned Elaine to the foster carer on time a decision was made not to allow the planned visit for the weekend of the murder.

3.4 Accommodation

At the time of the murder Elizabeth was living in privately rented accommodation in Town B in Kent. She had been living there since April 2011. Christopher, prior to going to prison was living in privately rented accommodation in Greenwich and he retained the tenancy whilst in prison. Christopher's family have stated that he was living with Elizabeth prior to him going to prison in August 2011.

3.5 Relationships

The relationship between Christopher and Elizabeth had always been affected by alcohol and violence. Elizabeth has stated that the first time Christopher was violent was two weeks after the relationship had started. She became pregnant a month after they met. During the ten years they knew each other there was no significant length of time when there were not problems because of alcohol, drugs, violence, dishonesty, child care, mental health, money, housing or imprisonment. It has been impossible to track exactly when they were living together, and although they were divorced in 2009 they still maintained an on off relationship with each other even though they also had other relationships. Between August 2010 and August 2011 there were no incidents involving both of them that came to the attention of any agency which was the longest known time that they had been separated. Christopher never reported any assaults upon himself by Elizabeth however his family have said that she did assault him on a regular basis. The assaults and incidents were invariably alcohol related. Christopher would often move back to live with his mother and her husband when he split up from Elizabeth. The deceased's family commented that Christopher and Elizabeth could not usually last more than three weeks before there was some problem. The relationship could be described as one of chronic co-dependency (the 'cannot live together but cannot live apart' relationship).

4 The Homicide

In August 2011 Christopher was sentenced to one hundred and eighty days imprisonment for stealing his stepfather's car and associated motoring offences. On 14th October 2011 he was released on Home Detention Curfew (HDC) to Elizabeth's address in Town B in Kent. As part of the HDC he was required to wear an electronic tag and the monitoring station was installed at 18:40 hours that day at Elizabeth's home with her consent. During the afternoon and early evening of the same day both of them drank alcohol and about 20:30 hours that day an argument ensued resulting in Elizabeth fatally stabbing Christopher numerous times with a kitchen knife. She was arrested soon afterwards and was later charged with murder. In April 2012 after a trial at the crown court, Elizabeth was convicted of murder and was sentenced to life imprisonment with a recommendation that she serve at least twelve years before being eligible for parole.

5 Family Involvement in the DHR

- 5.1 After the crown court trial the Independent Chair met the mother of the deceased to explain the DHR process and obtain information from her about the family. The mother was supported by a homicide worker from Victim Support although there has since been a change of staff. At the end of the review the Independent Chair met with the mother so she could read the

report and share her views. This information and comment from the deceased's mother is detailed at Section 9.

- 5.2 The family of the offender have declined to participate in the review.

6 Chronology

- 6.1 A chronology has been compiled from the IMRs and other information supplied by the agencies and organisations that have participated in this review. Additional information has been provided by Christopher's family. The chronology can be found at Appendix E.
- 6.2 Some of the agencies historic records have been unavailable as they have been destroyed in line with their retention policies such as the London Probation Trust and Greenwich Housing Department. KCA UK has archived the paper records and as they are not systematically filed they cannot be easily retrieved. In addition the medical records for Christopher and Elizabeth between 2002 and 2009 could not be located and therefore there are some gaps in the chronology when it is believed that they had contact with GPs and attended various hospitals in London.
- 6.3 A number of agencies have supplied IMRs or information regarding their contact with the members of this family which have no bearing on this case as they are in the main purely medical matters. As a result only some of those contacts have been included in the chronology to assist with the context however they have not been included in the analysis as they are not relevant to the terms of reference.

7. Overview and analysis of services

- 7.1 The following analysis is focussed on the relevant incidents that relate to domestic abuse and how the agencies dealt with them. Incidents of domestic abuse involving Elizabeth and Christopher with other partners have been included in the analysis but have not been subjected to close examination. They have been included to assist the reader to understand the full history of this case.
- 7.2 The chronology at Appendix E details all the matters that have a bearing on this case such as incidents involving misuse of alcohol and drugs and to put information into context, however they have not all been subject to detailed scrutiny. Some of the information provided by agencies contained inaccuracies and or contradictions, where possible these have been resolved however not in all cases and therefore some of the entries in this report could not be reconciled as will be apparent.
- 7.3 The review has examined events and the response by services over a nine year period during which agencies have developed and often improved their response to domestic abuse and the impact it has on children. This review,

wherever possible, has made comment in line with the policy and guidance in existence at the time of the incident. The review acknowledges that policy and guidance has changed over the period of time examined by this report. One example is that the Children Act 1989 was amended by the implementation of Section 120 of the Adoption and Children Act 2002 which came into force on 31st January 2005. This change in legislation amended the definition of significant harm for children to include “impairment suffered from seeing or hearing the impairment of another” this definition would include witnessing domestic abuse.

- 7.4 The development of the Multi-Agency Risk Assessment Conference (MARAC) across the country and subsequent improvements were also a significant change during this time. Also there were change in the type of risk assessment process used by the police and some other agencies from the SPECSS+ model and the SWP model to the DASH-RIC. An explanation of MARACs and the risk assessment tools can be found at Appendix D.
- 7.5 The first report to an agency of domestic abuse was in January 2002 within the first year of their relationship. Although the Metropolitan Police Service (MPS) had attended an incident in August 2001 when Christopher had damaged a trolley in a hospital in Greenwich as he was annoyed about the length of time it was taking for his pregnant partner to be seen, details of the partner were not recorded by the police but it is believed this was Elizabeth.
- 7.6 On 2nd January 2002 Christopher pushed Elizabeth after an argument in the street in Greenwich. Police attended and she did not wish to pursue a prosecution. The police correctly sent her an information pack regarding domestic abuse. Bearing in mind this assault was eleven days before the birth of Peter this incident could have been referred to Greenwich Children’s Social Services (CSS). This would have enabled CSS to consider a child protection investigation regarding the risks posed to the unborn child. Peter was born on 13th January 2002. This incident occurred before the implementation of the MPS policy of informing children’s social services of domestic abuse incidents where children maybe at risk, this policy did not come into use until 2004.
- 7.7 On 19th July 2002 CSS in Greenwich received the first referral concerning this new family unit. Elizabeth’s GP had concerns as Elizabeth had disclosed that she was suffering post natal depression and expressing feelings of harming Peter. CSS dealt with this matter appropriately by a regime of visits and contact with health professionals. It was established that Elizabeth was also a victim of domestic abuse.
- 7.8 On 23rd July 2002 the MPS Child Abuse Investigation Team (CAIT) in Greenwich identified concerns about the numbers of incidents of domestic abuse involving this family and the risks posed to Peter. After discussions with CSS a decision was made to commence a single agency investigation

- 7.9 On 23rd July 2002 there was a further assault by Christopher on Elizabeth and Elizabeth did not want any action taken when she reported it to the police in Greenwich on 12th August 2002. The matter was appropriately recorded by the police and a domestic abuse unit information pack was sent to her.
- 7.10 On 7th August 2002 CSS in Greenwich received a referral from Greenwich Mental Health Services regarding Elizabeth as she had a black eye and her telephone had been smashed by Christopher. CSS met with Elizabeth and discussed options with her and decided to hold a professionals meeting. The meeting never took place and this was an opportunity missed as it appeared that Christopher had left Elizabeth and she was willing to engage with services.
- 7.11 There were further incidents on 15th and 16th September 2002 in Greenwich with Christopher making threats and assaulting Elizabeth. On the second occasion as Peter was present the police correctly informed Greenwich CSS. Prior to 2004 it had been the policy of the MPS to inform CSS of domestic abuse incidents only where a child was present at a domestic abuse incident. In 2004 this changed to when a child was resident in the same household as those involved in the domestic abuse. The police gave her appropriate advice regarding civil action and safety planning. CSS on receipt of this additional information drafted a written agreement stating that Elizabeth would not have further contact with Christopher; however she refused to sign it saying that if she did it would put her at further risk. The assessment of risk during this period was superficial and the social worker did not appear to understand that separation can sometimes heighten the risk in domestic abuse cases, though it is likely that this approach reflected the practice at the time where the focus was on the child. In addition the assessment did not include Christopher even though the social worker knew they had reunited. The outcome was no further action by CSS. This lack of positive action in regard to Peter's safety was poor practice.
- 7.12 On 1st December 2002 Christopher assaulted Elizabeth and when Elizabeth reported this to the MPS she also alleged that in the past he had held a gun to her head. Christopher was charged with the assault and was convicted of this offence at a later date. The police appropriately informed CSS of this incident as Peter had been present. The police responded in a positive manner to this incident by arresting and charging Christopher with assault. The records of any action taken by CSS in response to this incident are unclear and they may have felt that as Christopher was in prison then Peter was not at risk. However, Christopher was released on the 7th January 2003 having been remanded in custody in connection with motoring offences on 17th December 2002. Peter remained in Elizabeth's care. This was a further missed opportunity to protect Peter immediately.

- 7.13 On 7th January 2003 both Elizabeth and Christopher appeared at Greenwich Magistrates Court. Elizabeth received a Community Rehabilitation Order for two years for a number of offences including being drunk and disorderly. Christopher received a Community Rehabilitation Order for eighteen months for the assault on Elizabeth that had occurred on 1st December 2002 and motoring offences. Both of these orders were supervised by the London Probation Service. Unfortunately the records of the Probation Service have been destroyed in line with their retention policy. It is understood from the IMR submitted by the mental health service in Greenwich that Christopher was required to attend a domestic violence course and an anger management programme as part of his order.
- 7.14 On 21st January 2003 Christopher met up with Elizabeth to celebrate her birthday and this culminated in Christopher taking Peter away as he alleged that she was not a fit mother. This incident was appropriately investigated by the CSS in Greenwich who liaised with the MPS, the London Probation Service and health professionals. This resulted in Peter being placed voluntarily into foster care.
- 7.15 On 4th February 2003 Elizabeth contacted Greenwich Housing Department stating she was homeless because of domestic abuse. No details of this incident are available other than the case was closed because she was not homeless. It has not been possible to establish if she was homeless because she did not pursue a housing application or that the assessment by the housing service concluded she was not homeless.
- 7.16 On 11th February 2003 Peter's name was appropriately placed on the Child Protection Register in Greenwich under the category of emotional and physical abuse. The Child Protection Plan was not robustly implemented with a number of changes of social worker and transfer of the case to the Long Term Social Work Team. This resulted in difficulties of engaging with the family, leading to few opportunities to fully understand the dynamics of this family, the risks to Peter and the unborn child, as well as Elizabeth. Although some practical support was offered such as bed and breakfast accommodation as well as two refuge places; Elizabeth made it clear that she wanted to continue the relationship with Christopher. In addition Elizabeth stated she was not willing to call the police as she was fearful of repercussions from Christopher; it is not clear from the case records whether this was ever challenged. There was no evidence of CSS taking any positive action to protect her, such as liaison with the police despite the very evident risks that existed. This was poor practice by Greenwich CSS.
- 7.17 On the 2nd April 2003 following an argument, Christopher took Peter to his mother's house. Police attended and returned Peter to Elizabeth. A notification form to CSS was completed however CSS have no record of receiving it.

- 7.18 Christopher was in prison from 7th April 2003 until 9th April 2003. It has not been possible to establish the reason why he was in prison despite enquiries by Her Majesty's Prison Service.
- 7.19 On 10th April 2003 police attended a domestic abuse incident between Elizabeth and Christopher and the police were rightly concerned as Peter was not at the premises, after making enquiries they traced him to his paternal grandmother's home. Police appropriately informed CSS. Christopher's mother has provided further information about this incident. Christopher and Elizabeth were at a friend of the mother's home and became drunk and Elizabeth 'tried it on' with the friend's son. This resulted in an argument between Elizabeth and Christopher. The friend contacted the mother who attended. When she arrived Elizabeth was attacking Christopher who was sitting in a chair and Peter was stuck between him and the arm of the chair. The mother pulled Elizabeth off and took Peter back to her home. When the MPS came to the mother's home to check on Peter the police officer told her that Christopher and Elizabeth's home was in a terrible state with dirty nappies and it was not fit for a baby to live in. The police officer checked that the house and the mother were suitable for the baby and informed the mother that social services would be told. CSS in Greenwich returned Peter to Elizabeth and Christopher's care a few days later despite the mother raising concerns.
- 7.20 On the 9th May 2003 Elizabeth again informed the housing department in Greenwich that she was homeless because of domestic abuse involving her partner. No details are available regarding this incident other than the case was closed on 1st July 2003 because Elizabeth had not contacted the department again.
- 7.21 On 22nd May 2003 Kent Police attended a call involving Elizabeth and her sister who had been arguing and fighting in a street of Town B. Both of them were drunk. The matter was correctly dealt with as a domestic abuse incident and as part of the risk assessment it was noted that Elizabeth suffered from depression, anxiety, paranoia, possibly schizophrenia and having a personality disorder. Peter was present but was only sixteen months old. The police made no enquiries with either Kent CSS or CSS in Greenwich. If they had, then they would have established that Peter's name was on the Child Protection Register and subject to a Child Protection Plan. This was an opportunity missed to have alerted CSS about a significant issue. The police officers were not happy to leave Peter with Elizabeth, however as Elizabeth's sister's partner was sober they were content to leave Peter in his care and they took no further action. This failure to make enquiries about Peter with CSS was poor practice by Kent Police.
- 7.22 On 28th May 2003 Christopher was sent to prison for five months for motoring offences, criminal damage and failing to surrender to bail and was released on 4th July 2003.

- 7.23 On 23rd July 2003 Christopher's prison licence was revoked as he had breached the terms of his licence and the MPS were informed that he should be arrested.
- 7.24 On 17th September 2003 Elizabeth contacted Greenwich CSS because Christopher had come to her home in a drunken state. Bed and breakfast accommodation for herself and Peter was arranged by CSS. Elizabeth stated she was scared because of the physical abuse she was suffering.
- 7.25 On 20th September 2003 Christopher was arrested and returned to prison on 21st September where he remained until he was released on 10th October 2003.
- 7.26 On 26th September 2003 Elizabeth was interviewed by a housing officer in Greenwich and she stated that she was a victim of domestic abuse. No information is available regarding that interview.
- 7.27 According to the report from Greenwich Mental Health Services sometime in 2004 Christopher commenced a new relationship.
- 7.28 On 12th January 2004 a Review Child Protection Case Conference for Peter and an Initial Pre-birth Conference on Elaine took place. Key persons from the child protection network were not present and the Chair decided that Peter could be de-registered and there was no need to place the un-born child on the Child Protection Register. It was agreed that the children in need service from CSS would continue to work with the family. This was poor judgement by the Chair of the conference as there were ongoing concerns regarding domestic abuse, potential issues around alcohol misuse, as well as the pending birth and the risks and stresses associated with a new born baby. There also appeared to be no recognition that the incidences of domestic abuse may have reduced because Christopher had been in prison for two months. As a result of this poor decision by the Chair and other performance issues it was decided that the 'sessional' Chair would not be used in the future.
- 7.29 On 28th January 2004 Elizabeth informed Greenwich CSS of an incident where Christopher threatened to assault her. Greenwich CSS were aware of the incident and the duty social worker had a telephone conversation with the previous social worker who shared background information. The duty social worker concluded that urgent action was required; however there is no record of any action taken. This was a failure to act especially as Elizabeth was nearly full term in her pregnancy and the risk to her would have been heightened.
- 7.30 On 30th January 2004 Elizabeth gave birth to Elaine.

- 7.31 On 21st February 2004 police attended Elizabeth's house as Christopher was trying to gain access. The police gave suitable advice regarding seeking a civil law remedy. As Elaine was present the police correctly shared the information with CSS; however there is no record of CSS receiving that information.
- 7.32 On 4th March 2004 Elizabeth's condition was reviewed by an Associate Specialist at Greenwich Mental Health Services having been referred by Greenwich CSS. During the appointment she disclosed a history of domestic abuse, alcohol misuse and that she and Christopher had caused criminal damage whilst drunk. Elizabeth also stated that she wanted to maintain the relationship with Christopher. She stated she was attending a local project for alcohol misuse. The review concluded that she was not suffering from any mental illness and was discharged back to her GP.
- 7.33 On the 8th and 9th June 2004 the MPS attended arguments between Christopher and Elizabeth; as no offences had been committed suitable advice was given.
- 7.34 On 17th June 2004 CSS in Greenwich held an Initial Child Protection Case Conference for both children as both Christopher and Elizabeth had not engaged with the children in need service. The decision was made to place both children's names on the Child Protection Register under the category of neglect. Following the outcome of the conference a Child Protection Plan was formulated, however the family did not keep appointments with the allocated social worker. The social worker was clear with the family that if they did not engage; then CSS would need to consider taking legal action. Elizabeth then began to engage; and attended appointments.
- 7.35 At a review conference on 31st August 2004 the Chair made a decision that Peter and Elaine's names could be removed from the Child Protection Register as Christopher and Elizabeth had separated and Elizabeth had engaged with services. This was despite the recommendation from the social worker that their names should remain on the register. The conference Chair did not appear to consider the impact on the children of the possible resumption of their parent's relationship, nor did they recognise the history of this case with the pattern of domestic abuse, alcohol misuse and the on/off relationship between Elizabeth and Christopher. This decision appears to have been inappropriate; however with the exception of Greenwich CSS none of the partner agencies involved with this family challenged that decision.
- 7.36 On 2nd October 2004 Elizabeth alleged to the MPS that Christopher had assaulted her and he was arrested and charged with common assault. It has not been possible to establish the result of this criminal prosecution. This was positive action by the police and in accordance with local and national good practice. However there is no information recorded about the children and there was no notification to CSS regarding this incident of

- domestic abuse. This was a missed opportunity by the police to take action to assess the risk to the children and share information.
- 7.37 On 24th March 2005 Christopher was sent to prison for six months for motoring offences.
- 7.38 On 5th May 2005 Elizabeth's mental state was reviewed by Greenwich Mental Health Services and the consultant psychiatrist concluded that the likely diagnosis was that of a severe personality disorder; the differential diagnoses included paranoid schizophrenia and substance misuse but was not confirmed. Elizabeth disclosed that she had a long history of alcohol misuse (eight cans of cider daily) from 1996 until 2003. She was prescribed a course of medication for her paranoid ideations.
- 7.39 On 25th May 2005 the London Probation Service in Greenwich rightly contacted Greenwich CSS to inform them of Christopher's impending release; however the CSS manager decided no action was required until a definite date of release was provided despite the social worker recommending an initial assessment. There was no follow up communication and no action was taken to carry out any safety planning for Elizabeth and the children. There appeared to be no attempt to ascertain why he had been in prison. This was poor practice and an opportunity missed to engage with the family. Christopher was released from prison on 27th May 2005.
- 7.40 On 27th June 2005 Christopher was sent to prison for five months for motoring offences and remained there until 9th September 2005. Whilst in prison he did engage with KCA a substance misuse service which continued for one appointment after his release. Unfortunately due to records being unobtainable no detailed information is available including details of where the service referred him onto.
- 7.41 During this time no agency had a true picture of the exact detail of Christopher and Elizabeth's relationship mainly because both of them were not completely honest when in contact with agencies. In addition there were times when both of them gave differing accounts to agencies of their alcohol and drug misuse history which made it difficult for professionals to establish the truth. At times Christopher would taunt Elizabeth about his other relationship.
- 7.42 The first time that an agency became aware that Christopher had commenced a new relationship was on 30th September 2005 when the MPS were called to a domestic abuse incident where Christopher had assaulted his girlfriend. She did not want any action taken against Christopher. It is believed that this relationship may have started as early as 2003.

- 7.43 On 22nd November 2005 Christopher and Elizabeth had been drinking and then an argument developed resulting in the MPS attending. Both of the children were in the flat. No action was taken by the police as no offences had been disclosed. The police correctly passed the information to CSS as the children had been present. The police also made a request that 'due to the extensive reports of these two children, please could further attention be paid to them and their welfare'. Greenwich CSS made a decision to take no further action which, bearing in mind all of the previous history, was an opportunity missed to examine the considerable risks posed to these young children which had been highlighted by the police.
- 7.44 The report from Greenwich Mental Health Services stated that in 2006 Christopher filed for divorce but withdrew the application as he and Elizabeth had reconciled their differences.
- 7.45 On 26th October 2006 CSS in Greenwich received a referral from the local mental health services as they had concerns regarding Elizabeth's ability to cope with the care of the children. This was the first time for nearly a year that any of the statutory agencies had any concerns about the family. An initial assessment was carried out and a decision was made for the case to be dealt with by the child in need team. As Christopher had taken on the day to day care of Peter and was living with his mother the focus was on supporting him in his parenting role. During this time Christopher engaged with the child in need social worker and did attempt to address his alcohol issues. The social worker also worked with the network to access appropriate services for Peter. There was also evidence of engagement and liaison with community agencies.
- 7.46 On 31st December 2006 Christopher was seriously injured when his girlfriend (not Elizabeth) stabbed him. This was the same woman that Christopher had allegedly assaulted in September 2005. Peter witnessed the assault. Christopher was heavily under the influence of alcohol at the time and did not want any action taken. However, because of the seriousness of the assault the girlfriend was arrested and charged with causing grievous bodily harm. Although a notification form was completed and faxed to CSS it has not been possible to establish which CSS office it was sent to by the MPS. This was poor practice both in terms of failure to get help for Peter who had witnessed a traumatic incident involving a knife and to consider the continued exposure to domestic abuse that he had endured between his father and mother and now in this other relationship. This assault occurred in the Borough of Bexley.
- 7.47 In June 2007 a GP in Greenwich referred Christopher to the local community mental health team because he was fearful of leaving the house and that he was not taking his five year old son to school. When the Assessment and Shared Care Team saw him he stated that he was drinking two litres of vodka a day with simultaneous cannabis use. He was referred

- to a specialist service for drug and alcohol users with complex needs and to an advice and guidance centre for alcohol users.
- 7.48 On 18th June 2007 Elizabeth attended an outpatient clinic appointment with the Greenwich Mental Health Services, Elaine was with her. Elizabeth stated that she continued to have thoughts of people watching her and talking about her, as well as having the idea that she was being watched by CCTV and that her telephone was bugged. She was diagnosed as suffering from phobic anxiety and having overvalued paranoid ideas; she was placed on a regime of medication.
- 7.49 On 16th July 2007 Elizabeth self presented to Greenwich Mental Health Services and requested medication to help with her anxiety symptoms which she felt were caused by Christopher as he had threatened to kill her. It was noted that she was due to commence group therapy in September 2007.
- 7.50 In July 2007 the alcohol treatment service in Greenwich informed CSS that Christopher had been consuming a litre of vodka a day for the last month and required detoxification. The social worker contacted the specialist alcohol service project, and was advised to ask Christopher to make contact with the service by attending the drop in service; where his needs could be assessed.
- 7.51 Elizabeth did not attend her appointment with Greenwich Mental Health Services on 17th September 2007.
- 7.52 In September 2007 it was reported that Peter was attending the Child and Adolescent Mental Health Services (CAMHS) in Greenwich as he was suffering from Post Traumatic Stress Disorder having witnessed his father being stabbed in December 2006. The child in need social worker was in regular contact with the network of professionals who were working with Peter and Christopher and assessing the impact of the interventions on the welfare of Peter.
- 7.53 On 8th October 2007 Elizabeth self presented to the Greenwich Mental Health Services Rapid Response Team. She was accompanied by her sister. Elizabeth was very irritable and abusive in her manner. She stated that she had stopped taking the anti-depressant medication as it was 'messing her head up'. Elizabeth was reluctant to engage with psychotherapy. The examination notes recorded that she was very irritable and un-cooperative.
- 7.54 On 9th October 2007 Elizabeth approached the housing department in Greenwich stating she was homeless, she was being harassed by Christopher and wanted to move from the area. The housing officer appropriately made contact with the children in need social worker and the mental health services. Elizabeth was offered a refuge place and additional

security measures to her home; both of which she declined. The following day she withdrew her homelessness application.

- 7.55 The mental health services in Greenwich on 9th October 2007 made a new referral to CSS as Elizabeth had alleged that she had been detained by Christopher for two weeks at his home. There were also concerns about the impact on Elaine. Although the CSS Child in Need Service were already dealing with Christopher and Peter the assessment of this new referral was dealt with by a social worker based in the central duty and assessment service.
- 7.56 On 22nd October 2007 Elizabeth attended an outpatient appointment with Greenwich Mental Health Services where she stated that she was unable to go out of the house due to fear of Christopher. She reiterated her paranoid beliefs. The notes stated that Elizabeth had been taking anti-psychotic medication in the past but she had discontinued this and had also been taking anti-depressants but had also stopped taking them. Elizabeth agreed to start taking a new anti-psychotic drug. The diagnosis was recorded as unspecified phobic anxiety disorder with paranoid overvalued ideas.
- 7.57 On 10th November 2007 one of Peter's teachers noticed a bruise on his face and when asked; Peter said it had been caused by Christopher. A joint MPS and Greenwich CSS child protection investigation was carried out. The outcome was that it was identified that the injury had been caused when Peter had fallen off a bed. Because Elizabeth avoided contact with CSS she was not seen until 22nd November 2007 when she confirmed that she was back with Christopher and that he had not hit her for three years. As part of the investigation Christopher signed an agreement not to physically chastise Peter.
- 7.58 Elizabeth did not attend her outpatient appointments with Greenwich Mental Health Services on 19th November and 3rd December 2007.
- 7.59 On 3rd December 2007 an Initial Child Protection Case Conference was held following the outcome of the Section 47 (child protection) investigation of the bruise on Peter. The focus of the meeting was on Peter, however the Chair of the conference realised that the couple had reunited and therefore the needs of Elaine should also be considered although the health visitor was not invited. The conference identified the impact of domestic abuse, attachment, parental relationship and mental health issues in the parents in relation to Peter. A decision was made that Peter should be made subject to a Child Protection Plan under the category of emotional harm. (The Child Protection Register was no longer used due to changes in national guidance). The same issues were not identified for Elaine probably as the relevant information was not available and there were more visible signs of trauma with Peter. As a consequence Elaine was not made subject of a Child Protection Plan. However, as part of the Child Protection Plan for Peter, a decision was made that when the case transferred to the Long

- Term Social Work Team that the social worker should assess Elaine's needs. Christopher's mother recalls this conference as she attended along with her mother. It is her view that the focus of the conference was too much on the parents and not enough on the children. Peter and Elaine remained in the care of Elizabeth until January 2008 when a decision was made to initiate care proceedings in respect of Peter. He was then placed with his paternal grandmother where he remained.
- 7.60 On 18th December 2007 Christopher was sentenced to twelve weeks imprisonment for drink driving. As it was a short sentence there was no statutory input by London Probation Service either during or after his time in prison.
- 7.61 Elizabeth attended her outpatient appointment with Greenwich Mental Health Services on 21st January 2008.
- 7.62 Christopher was released from prison on 3rd March 2008. According to the Greenwich Mental Health Services report he was collected by Elizabeth. On the day of his release the MPS were called to an incident where Christopher had assaulted Elizabeth. He was drunk at the time and was arrested. Elizabeth declined to make a statement. She had no visible injuries. The police carried out a risk assessment using the SPECSS+ Risk Assessment model (SPECSS+ is explained at Appendix D). Elizabeth gave misleading information such as having no alcohol and drugs problems. She did say that Christopher was jealous, controlling and had previously threatened to kill her. The risk assessment classified Elizabeth as being at medium risk of further abuse. Elizabeth was contacted by specialist officers the following morning whilst Christopher was still in custody; she maintained that she would not make a statement and declined a referral to victim support. Elizabeth was informed that Christopher would be released without charge and she made arrangements for him to be collected from the police station. It appears that this incident was dealt with in isolation and without the officers carrying out any research. If they had carried out the research they would have discovered a more detailed picture of this family however this may not have changed the risk assessment classification. This incident was prior to the advent of multi-agency meetings to discuss domestic abuse cases (MARACs). An explanation of MARACs can be found at Appendix D.
- 7.63 Details of the children were recorded by the MPS; noting that Peter lived with his paternal grandmother and as Elaine was present during the incident a notification to CSS was made. This incident was dealt with appropriately by the police with positive action at the scene and then the use of specialist officers dealing with Elizabeth. However, without the support of the victim and little corroborative evidence there was nothing more the police could have done other than provide her with information regarding support organisations. The police acted correctly when they notified CSS about the incident.

- 7.64 On 4th March 2008 the family proceedings court granted an Interim Care Order in respect of Peter; as a consequence he was no longer subject of a Child Protection Plan. He was living permanently with his paternal grandmother and her partner in Greenwich.
- 7.65 On 14th April 2008 the MPS were called to Elizabeth's home as Christopher was banging on the door; when they attended police saw Christopher was drunk and he left the area when requested. Elaine was asleep at the time and the police appropriately informed CSS of the incident. They also noted that Peter was not there and that he was subject to an Interim Care Order. The matter was correctly recorded as a domestic abuse incident. When the incident was risk assessed using SPECSS+; three heightened risks factors were recorded; escalation of incidents, pending divorce and Christopher's jealousy. The initial risk assessment was standard risk. When the incident was reviewed by specialist officers they carried out research on the police databases and identified six previous domestic abuse incidents. There had in fact been a total of thirteen incidents and it cannot be established why these incidents were not identified. Despite this additional information the risk assessment remained unchanged and there is no record of it being reviewed. The incident was closed and Elizabeth was sent a Domestic Violence Unit Information (DVUI) pack and a referral to Victim Support was made.
- 7.66 On receipt of this notification the team manager in Greenwich CSS interviewed Elizabeth regarding the incident. The team manager identified concerns about the impact of the incident on Elaine and advised Elizabeth that if further incidents occurred then the department would have to consider legal action. Liaison with Peter's Guardian ad Litem also occurred.
- 7.67 Elizabeth did not attend her outpatient appointments with Greenwich Mental Health Services on 21st April, 19th May, 17th June, 22nd July and 19th August 2008.
- 7.68 Christopher was discharged from the specialist service for drug and alcohol users with complex needs on 20th May 2008.
- 7.69 In the early hours of 31st May 2008 the MPS were called to Elizabeth's home as Christopher was outside, he was drunk and banging on the door. He left the area at request of the police and the matter was recorded as a domestic abuse incident. The SPECSS+ Risk Assessment graded the risk as standard. Three hours later Christopher returned to the home demanding his mobile phone which was recovered and handed to him. The matter was correctly recorded as a domestic abuse incident. There was no mention made of Elaine in the report and so no notification to CSS occurred. It is the policy for the MPS when attending domestic abuse incidents to identify if there are any children in the household and inform CSS. This was an opportunity missed to inform CSS of the continuing issues in this household. The incident was reviewed by specialist officers and they agreed with the standard risk assessment; they did identify seven previous

incidents (see previous comments). The specialist officers made contact with Elizabeth who declined referral to Victim Support and did not want to support any police interventions. They did not send a DVUI pack as one had been sent in April 2008.

- 7.70 In June 2008 a Forensic Parenting Assessment was conducted by the specialist mental health services at the request of Greenwich CSS in relation to the court process for Peter. This assessment identified the interdependency of Elizabeth and Christopher which compromised their ability to maintain their separation. It was acknowledged that at times there was good interaction between Elizabeth and Elaine and that there were no visible effects displayed by Elaine. However, sufficient consideration was not given to the long history with the patterns of behaviour and the chaotic lifestyle. The assessment concluded that Christopher lacked emotional depth or maturity, he was unruly and oppositional; that he lacked commitment to Elizabeth and that he did not meet the criteria for severe personality pathology. The assessment also stated that Christopher was drinking regularly to the point of collapse and was taking cannabis and cocaine. The report also concluded that he had poor insight into his alcohol abuse. The assessment concluded that Christopher's potential for future physical abuse of his children was low to moderate and that the future risk of violence to Elizabeth was moderate. The assessment of Elizabeth stated that she was naïve about her problems, minimising the past abuse by Christopher who often humiliated her and that she was emotionally dependent on him. The report went on to say that she had been aggressive and destructive in her teens and that she 'bottled up' the impact of the verbal, emotional and physical abuse she had suffered by Christopher. The report also stated that the domestic abuse was mostly fuelled by alcohol.
- 7.71 On 7th August 2008 police were called to Elizabeth's home in Greenwich as Christopher had telephoned her twelve times during the night, he was apparently drunk and then turned up and banged on the door. Christopher had left prior to the arrival of the police. The matter was recorded as a domestic abuse incident and the investigating officer contacted Christopher by telephone and warned him that if his behaviour continued he would be arrested for harassment. The officer followed this up by sending him a harassment warning letter. As Elaine was in the flat at the time CSS were notified of the incident although CSS have no record of receiving this notification. When the matter was risk assessed using SPECSS+ noting a heightened risk factor of separation it was classified as standard risk. This matter was dealt with effectively by the attending officer taking positive action and sharing information. However, when the specialist officers reviewed details of the incident they did not research the databases and so did not discover the extensive history and consider any further action. The specialist officers did make contact with Elizabeth to inform her of the harassment letter and she stated that Christopher had not been in contact.

- 7.72 On 3rd October 2008 a worker from the Greenwich Mental Health Services Assessment and Shared Care Team contacted Elizabeth's GP and no concerns were noted; they also made a check with Greenwich CSS and were informed that the case remained open. A decision was then made to discharge Elizabeth's care back to the GP.
- 7.73 On 30th October 2008 Elizabeth's GP in Greenwich contacted the Assessment and Shared Care Team from Greenwich Mental Health Services as Elizabeth had stopped taking her medication and they were worried about her mental state. On 10th November 2008 Elizabeth did not attend an outpatient appointment with the Greenwich Mental Health Services.
- 7.74 On 13th November 2008 police from Greenwich were called to the library where a couple who were identified as Christopher and Elizabeth had been arguing. They had left the scene prior to police arrival and after enquiries the couple were seen by police the following day. The argument was regarding child access and Christopher had become argumentative and Elizabeth was frightened. She requested that he leave the flat which he did. Elizabeth did not want to take any action against Christopher. Elizabeth did tell the officers that Christopher had made a comment to the effect that if he couldn't have her no one else would. She also said they were in the process of divorcing. As Elaine had been present during the argument a notification to CSS was correctly made although CSS in Greenwich have no record of receiving it. The notification report stated that Elaine was currently at her aunts and Peter was with his paternal grandmother. The matter was recorded as a domestic abuse incident and when risk assessed using SPECSS+ the risk was classified as medium. When the reports were reviewed by specialist officers they confirmed the risk assessment and when they carried out research they identified only nine previous incidents (see earlier comment regarding this issue in 7.65).
- 7.75 On 8th December 2008 Elizabeth's treatment was reviewed when she attended an appointment with Greenwich Mental Health Services. She was on a daily regime of anti-psychotic medication and she complained of frequent mood swings and asked to be started on anti-depressants. She was prescribed a daily dose of anti-depressants.
- 7.76 On 30th December 2008 both Christopher and Elizabeth called the MPS as Elizabeth had invited Christopher to the flat to see Elaine and then they had a few drinks leading to an argument. Elizabeth then armed herself with a kitchen knife and left the premises. She stated that she did this in self defence. Christopher had left the flat prior to police arrival. The matter was recorded as a domestic abuse incident and after a SPECSS+ Risk Assessment the risk was classified as standard. The incident was reviewed by specialist officers who after research identified only ten of the sixteen previous incidents; despite this and the escalation of violence and the previous incidents they confirmed the risk classification as standard. This

was an opportunity missed as a medium classification would have been more appropriate in view of the long history of domestic abuse, the potential for further incidents and the escalation from Christopher. The result of increasing the risk classification could have resulted in the police referring Elizabeth to other specialist agencies. A DVUI pack was sent to Elizabeth by the police.

- 7.77 As Elaine was present the police officer appropriately notified CSS of the incident. After a strategy discussion between CSS and the police a decision was made that CSS would conduct a single agency investigation. A child protection investigation under Section 47 of the Children Act 1989 was commenced.
- 7.78 On 27th January 2009 an Initial Child Protection Case Conference was held in regard to Elaine as a result of the incident on the 30th December 2008. The police did not attend but sent a report which detailed the four incidents of domestic abuse that they had attended between March and August 2008. The police stated that these previous incidents had already been shared with CSS. Greenwich CSS have no record of receiving these notifications and it has not been possible to reconcile this matter. The conference decided that there were no grounds for a Child Protection Plan and that Elaine would be the subject of a Child in Need Plan. Part of the plan included action to reduce the domestic abuse conflict in the relationship between Christopher and Elizabeth. The lack of police attendance at such a case conference when the matters under discussion surround domestic abuse with the police having significant information was poor practice. The decision not to make Elaine subject of a Child Protection Plan was also surprising considering the long history of violence, alcohol and drug misuse, mental ill health as well as evidence of poor parenting and lack of engagement by the parents. The Forensic Parenting Assessment which had been carried out in June 2008 had also highlighted many of these issues and was available to be considered as part of the decision making. There were clear risks to Elaine however it is probable that the 'rule of optimism' appears to have been applied even though all three elements of what is known as the 'toxic trio' were present – domestic abuse, mental health issues and alcohol misuse. It was particularly concerning that the elements of poor mental health and alcohol misuse were present in both parents.
- 7.79 On 24th February 2009 Peter was made subject of a Special Guardianship Order by the courts and was now being formally cared for by Christopher's mother and her partner.
- 7.80 On 27th February 2009 the MPS attended Christopher's home where they found Elizabeth hiding. She alleged that they had been drinking, an argument developed and Christopher's mood changed; he started speaking about when he had been stabbed by his ex-girlfriend in December 2006. Christopher then picked up a kitchen knife and forced Elizabeth to hold the

knife. This resulted in Christopher then attacking her and causing her injuries requiring hospital treatment. Elizabeth made a statement; however the two independent witnesses to the disturbance but not the assault declined to make statements. Christopher had left the scene prior to police arrival. The matter was recorded as a domestic abuse incident and after a SPECSS+ Risk Assessment it was classified as medium risk. Christopher surrendered himself to the police station a few hours later when he was arrested; he was under the influence of alcohol. The incident was investigated by specialist officers the following day and when interviewed Christopher denied assaulting Elizabeth, he alleged that during an argument she had threatened to stab him and so he gave her a kitchen knife and offered himself to be stabbed. He said that she then slashed towards him a few times and he then disarmed her. Christopher was then bailed from the police station to allow further investigations and for the police to obtain advice from the Crown Prosecution Service. The police imposed bail conditions on Christopher not to go to Elizabeth's home or approach any of the witnesses including Elizabeth. Elizabeth was offered additional security measures for her home but she declined stating that Christopher did not have the keys to her flat. There was nothing recorded by the police to indicate if any other risk reduction measures were offered or put into place.

- 7.81 There was no record of whether Elaine was present at this time, however her whereabouts should have been ascertained and this incident should have been notified to CSS which would have enabled them to consider again the risks posed to her. This was poor practice by the police not to share information with a view to protecting Elaine.
- 7.82 Elizabeth did not attend her appointment with Greenwich Mental Health Services on 9th March 2009; however she did attend on 23rd March 2009. Elizabeth reported feeling better since taking additional medication and her paranoia had decreased. She then missed appointments on 22nd June, 17th August, 8th September and 6th October 2009.
- 7.83 Sometime in the early part of 2009 Christopher was referred to Greenwich Mental Health Services by his GP for an assessment. A member of the Assessment and Shared Care Team made contact with the children's social worker from Greenwich CSS and established that Christopher continued to binge drink, and that he had supervised access to Peter who was living with his paternal grandmother. They established that Elaine lived with Elizabeth who he was divorcing and that he had weekly unsupervised access with Elaine. The worker also discovered that Christopher had been discharged from the local specialist service for alcohol and drug users with complex needs in May 2008. The worker liaised with Christopher's GP who agreed to prescribe anti-depressants for Christopher.
- 7.84 Following advice from the Crown Prosecution Service (CPS) Christopher was charged with the common assault on Elizabeth that had occurred on 15th April 2009 and he was bailed with the same conditions.

- 7.85 CSS in Greenwich had carried out work with Elizabeth and Elaine as part of the Child in Need Plan and this plan was reviewed by the network; and on 25th April 2009 the Child in Need Plan was ended.
- 7.86 On 28th April 2009 Elizabeth made a statement to the MPS stating that she no longer wished to support a prosecution regarding the assault on 15th April 2009 as the court process would be stressful. She confirmed that the assault had taken place and that no one was putting her under pressure to withdraw her support. After a review by the CPS the case was withdrawn at court on 20th May 2009.
- 7.87 In early May 2009 the police in Greenwich decided to forward the case to the Multi-Agency Risk Assessment Conference (MARAC) (see Appendix D for an explanation of a MARAC) even though the case did not meet the automatic referral criteria of cases that have been classified as high risk when risk assessed using SPECSS+. This case had been classified as medium risk by the police, however referrals to MARAC could be made if the professional using their professional judgement was of the opinion that the case was worthy of discussion. Any case referred to a MARAC would automatically be re-classified as high risk. MARACs had only been introduced in Greenwich earlier in 2009 and there had not been any formal training in their use.
- 7.88 The decision making by both the MPS and the CSS in Greenwich at this time appeared to be at odds with CSS closing the case regarding Elaine as matters seemed to have improved, however the police were sufficiently concerned to refer the case to the MARAC.
- 7.89 In May 2009 Christopher did not attend his outpatient appointment with the mental health service in Greenwich.
- 7.90 On the 11th May 2009 Elizabeth informed the social worker in Greenwich that she was moving to Kent and she supplied details of her new address. The address was her sister's home in Town A. It is not known if Elizabeth actually moved to Kent or went to live in Essex immediately; school records indicate that Elaine was registered at a school in Kent for a short period of time before commencing school in Essex. CSS do have an obligation to inform other areas if a child, who is subject to a Child Protection Plan moves to another area, however this does not apply to children where there is no active involvement. Accepting that the guidance did not require CSS to inform anyone of the family move; it is recognised good practice for agencies to notify the new authority if there have been significant concerns, however this must be done openly and with the consent of the family.
- 7.91 The case was discussed at the MARAC in Greenwich on 3rd June 2009. The meeting was attended by various agencies including CSS and the police. The minutes of MARACs normally only record attendance/apologies and the outcomes/actions; however the minutes of this meeting did not

- record any actions regarding this case. It was one of nineteen cases discussed. According to notes made by the CSS representative the reason why no action was taken was that both parties had both moved from Greenwich to two separate local authorities. At the time there was no formal process for transferring cases between MARACs when victims moved and this only came into place in January 2011. The MARAC process was still very new for all agencies and they were in the process of developing an understanding and new way of working with a high number of cases requiring actions. It is understandable that no action was taken to follow this up, although it was an opportunity missed to inform the new area of this high risk victim.
- 7.92 There is no national policy outside of MARAC and the Multi-Agency Public Protection Arrangements (MAPPA) cases for the police to inform their counterparts when a victim or offender in domestic abuse cases moves from their area.
- 7.93 On 12th June 2009 Christopher was seen by staff at the Birmingham and Solihull Mental Health Foundation Trust. He reported life stresses of divorce, children in care, death of his father and that he had moved from London to live with his step-mother. After being screened he was prescribed a regime of anti-anxiety medication, anti-depressants and medication to relieve insomnia. Christopher had a review appointment on 17th June 2009 when he reported not feeling any better, voices present, appetite poor, sleep poor and thought he was being watched. As a result of this he was prescribed anti-psychotic medication and a further appointment made for 22nd June 2009 which he did not keep. Christopher's family stated that he moved to Birmingham to be with a friend whose father was seriously ill and who subsequently died, as well as to get away from the situation with Elizabeth. There is no other detail of his stay in Birmingham.
- 7.94 On 26th June 2009 CSS in Greenwich formally closed the case in respect of Elaine although they did remain involved with Peter supporting the placement with his paternal grandmother.
- 7.95 On 27th August 2009 Kent Police in Town A attended a call to a disturbance in the street involving a man and a woman; a child was also present. On attendance police discovered that the argument had been between Christopher and Elizabeth and they were now in Elizabeth's sister's house. No offences were identified by the police and the couple refused to answer any questions in connection with a SPECSS+ Risk Assessment. There was no record of any children being present and the matter was not recorded as a domestic abuse incident. Even if it had been recorded as a domestic abuse incident, as all of the previous domestic abuse incidents involving the two of them had been recorded in London, any research would have been limited to a search on local databases which would have been negative. Any searches on any police national databases would not have automatically identified the history of the relationship unless the officer

requested specialised searches and by making contact with the Metropolitan Police. Elizabeth gave her address in Essex and Christopher gave his address in Greenwich. This was an opportunity missed and certainly poor practice regarding the failure to identify the child who was allegedly present.

- 7.96 On the 11th September 2009 Elizabeth, Christopher and Elaine were all registered at the same GP surgery in Essex.
- 7.97 On 16th September 2009 Elizabeth had a new patient screening at the GP surgery in Essex and as part of that process she stated she was a social drinker. On 21st September 2009 the GP made a referral to the psychiatry service and planned to refer her to the Improving Access to Psychological Therapies Service for counselling. The GP had seen her on 18th September 2009 when it was identified that anxiety was the main issue.
- 7.98 On 26th September 2009 Kent Police were again called to Elizabeth's sister's home in Town A in Kent. On arrival of the police Elizabeth alleged that Christopher had beaten her up a week before and that day he had threatened her. She stated that she did not want to support a prosecution. The two of them had been arguing leading to the police being called and as a result Christopher had left the premises prior to police arrival. Elaine was present in the house but had not witnessed the incident; it was not recorded if the officers saw Elaine. The officers recorded the matter as a domestic abuse incident and concluded that no offences had been disclosed; although they recorded details of a visible injury to Elizabeth's arm which they said appeared to be relatively new. No statements were taken. Elizabeth asked the officers to inform Essex Police of the incident as she wanted them to be aware and attend quickly if she had to call them. The officers carried out a SPECSS+ Risk Assessment concluding that the risk classification was high and noted the following points of concern:-
- The couple had separated.
 - There were previous acts of domestic abuse.
 - Christopher persistently called and made contact with Elizabeth.
 - In the past Christopher had put his hands around Elizabeth's throat.
 - There were previous threats to kill.
 - Christopher was excessively jealous and attempted to stop Elizabeth seeing family, friends etc.
 - Christopher had previously breached injunctions/court orders.

- 7.99 The report made reference to Elaine and stated that Christopher had not hurt her. No mention was made of Peter. The risk assessment also included that neither Christopher nor Elizabeth had issues with alcohol, drugs or any medical or mental health issues. It was not recorded if Kent Police informed their colleagues in Essex.
- 7.100 A few hours later on the same day 26th September 2009; Essex Police had their first involvement with this family, they were not previously aware that Elizabeth and Elaine had moved into their area. At 22:53 hours the police were called to an incident of domestic abuse at their house and when police arrived they arrested Christopher for assault on Elizabeth as she alleged that he had grabbed her arm and caused bruising. The assault had actually occurred on the 21st September 2009. Elizabeth was drunk at the time of the reporting and said she would provide a statement when sober. She did not supply a statement and therefore Christopher was released without charge. The matter was recorded as a domestic abuse incident and safety planning was discussed with Elizabeth by a police officer but she declined any support and she stated that Christopher lived in London. It was recorded that Elaine was resident at the address but had not witnessed the assault. A risk assessment using the South Wales Police Victim Initial Risk Indicator Form (SWP) (see Appendix D for explanation) was carried out and the risk was classified as high. At this time only very high risk cases were referred to the MARAC. The MARAC process had been piloted in Essex in 2007 and they were then rolled out across the whole of the county including the two unitary authorities.
- 7.101 This incident was automatically notified to Essex Children's Social Care (CSC) and Community Health (school nurse) by Essex Police. The policy of notifying Essex CSC of incidents of domestic abuse where a child is resident in the same household commenced in 2006 by sending photocopies of domestic abuse incident forms to CSC. In 2007 the Essex Police IT system started to automatically inform Essex CSC of all incidents fitting the criteria at 00:01 hours each day that had occurred in the preceding twenty four hours. Essex CSC record all notifications onto an electronic system and a check is made to see if the family is known, all notifications are recorded as a contact unless it is deemed to be a referral and the decision making for that decision is also recorded. If the case is open to Essex CSC then the notification is forwarded to the worker/team. Over the years the process of notification and assessment has changed; since 2010 all notifications have been considered by the Initial Response Team where specialist domestic abuse workers consider each notification and assess both risk factors and the overall level of risk to the child/young person. If it is considered that the threshold of risk justifies a referral, the notification and decision making rationale for the referral is sent to the relevant Assessment and Intervention Team. In 2007 Essex Police also commenced sending relevant notifications to health by way of an email. The automatic notification of domestic abuse incidents to CSC where children are resident is good practice as is the notification to health.

However the sheer numbers of notifications has had a knock on effect for the work of CSC and health. Not all areas in England have had such a system in place for as long as Essex has.

- 7.102 When Essex CSC received the notification of the domestic abuse incident a decision was made to record it as a contact and to take no further action. This was a questionable decision; as although the family were not known; the incident was classified by the police as high risk leading to the arrest of Christopher for assault and Elizabeth was drunk at the time of making the allegation. The incident was serious enough to warrant an initial assessment which may have established that the family were well known to agencies in Greenwich and may have prompted CSC to provide a service to assist Elaine and Elizabeth.
- 7.103 Between 1st October 2009 and 1st March 2010 Elizabeth did not attend three appointments at the GP surgery in Essex.
- 7.104 At 19:50 hours on 10th October 2009 police attended a further domestic abuse incident in Essex involving Elizabeth and Christopher arguing in the street. Although no offences were identified; the matter was recorded as a domestic abuse incident and safety planning was discussed with Elizabeth. Elaine was recorded as being resident with Elizabeth and so the details were automatically notified to CSC and community health (school nurse) in Essex. The incident was risk assessed using SWP and was classified as high risk.
- 7.105 When the notification was received by Essex CSC they recorded it as a contact and made a decision to take no further action. Based purely on the facts of the incident this was an understandable decision, however there had been a previous incident only two weeks before. Taken together this may have justified an initial assessment which may have led to CSC in Essex establishing the full history of this family and then providing a service to support them.
- 7.106 Five days later on 15th October 2009 Essex Police attended a domestic abuse incident involving Elizabeth and Christopher at her home. No offences were recorded however the matter was identified correctly as a domestic abuse incident and was recorded as such. The incident was risk assessed and was classified as high risk. Again Elaine's details were recorded and this led to an automatic notification to CSC and community health (school nurse) in Essex. As this was the third incident in four weeks consideration could have been given by Essex Police to refer the case to the MARAC or making further enquiries with agencies in Greenwich to establish the full history of this family.
- 7.107 When the notification was received by Essex CSC they recorded it as a contact and made a decision to take no further action. This was the third incident of domestic abuse involving this family in a four week period and

- the decision not to carry out an initial assessment is questionable; bearing in mind that the police had classified them all as being high risk and the period of time between incidents was decreasing. If an initial assessment had been carried out Essex CSC it may have established the full history regarding this family and then been able to provide a service to Elaine and Elizabeth.
- 7.108 On 22nd October 2009 the GP in Greenwich referred Christopher to the psychiatry service as he had been seen on 17th September and 16th October with a depressive disorder which was worsening. This was an appropriate response by the GP. The referral was received by the mental health service who attempted to make contact with Christopher by telephone and letter without success.
- 7.109 On 26th October 2009 Christopher presented himself to the Rapid Response Team of Greenwich Mental Health Services and complained that he was depressed because of his relationship breakdown with Elizabeth and that he was homeless. Christopher informed the worker that Elizabeth was living in Essex and had 'kicked' him out. Christopher stated that he was desperate and thinking of suicide. The Assessment and Shared Care Team referred him to the Home Treatment Team but he left before they could assess him.
- 7.110 On 29th October 2009 the Home Treatment Team telephoned Christopher and asked him to return to hospital; he had been prescribed anti-psychotic and anti-depressant medication. On 30th October 2009 Christopher was admitted to a psychiatric ward in a hospital in Greenwich and a urine drug screen that was carried out was positive for cannabis.
- 7.111 On 2nd November 2009 a worker from the Greenwich Mental Health Services Assessment and Shared Care Team attempted to carry out a home visit on Elizabeth at her address in Greenwich. The worker discovered from a neighbour that she had moved, which was confirmed by speaking to the housing department who informed them that she had moved in September 2009. The worker then made contact with Greenwich CSC and the health visitor and established that Elizabeth had moved to Town A in Kent. They also established that Elaine had been discharged from Greenwich CSC. The new address was known but it was not to be disclosed to Christopher. The Greenwich Mental Health Services made no inquiries with Kent to facilitate a transfer of care. In addition, as they knew from their recent dealings with Christopher that Elizabeth had moved to Essex they made no attempt to contact mental health services in Essex. This was poor practice especially as they knew of the considerable history of this family and knew of their vulnerabilities.
- 7.112 On 4th November 2009 the housing department in Greenwich received a referral from the mental health service in Greenwich regarding Christopher who was an informal inpatient in their care. This was the start of a programme of support that the housing department provided to Christopher

- over the next ten months. As part of the assessment Christopher disclosed a history of being a domestic violence offender and victim as well as alcohol and drug misuse; his criminal past as well as his mental health issues. When Christopher was discharged from hospital on 10th November 2009 the housing department provided him with temporary accommodation.
- 7.113 On 13th November 2009 the school nurse at Elaine's school in Essex contacted Essex CSC as they had received three domestic abuse reports from the police and previous medical notes from Greenwich which indicated that there had been significant child protection concerns when the family lived in Greenwich. The school nurse enquired what action CSC was going to take. This was good practice by the school nurse who had reviewed the notes and then took positive action to safeguard Elaine.
- 7.114 It has not been possible to establish how notifications from the police to child health in Essex are processed. It is known that in this case the school nurse was notified; however it does not appear that the GP for Elaine or Elizabeth was ever informed of the domestic abuse incidents.
- 7.115 On 16th November 2009 Christopher registered with a new GP in Greenwich and stated on his registration form that he had a past medical history of bi-polar and that he was taking anti-psychotic medication and medication to assist with night sedation. He was not taking any medication usually associated with a diagnosis of bi-polar disorder. He also stated that he was a smoker and did not consume any alcohol.
- 7.116 On 17th November 2009 Christopher attended his post discharge from hospital appointment with Greenwich Mental Health Services.
- 7.117 On 20th November 2009 police and ambulance personnel were called to Elizabeth's home in Essex as Christopher, who was visiting, had taken an overdose of prescription medication and a quantity of alcohol. Christopher was taken to hospital and after initial assessment he stayed in the Accident and Emergency Department for about two hours before discharging himself. The matter was reported to the police who located him and returned him to the hospital. He was further assessed by the emergency staff and referred appropriately to the mental health services for an assessment.
- 7.118 On the same day the mental health service in Essex carried out a Care Programme Approach (CPA) Assessment and referred him back to his GP in Greenwich and the community mental health services in Greenwich. He was provided with a crisis card. This was appropriate action as he was only visiting the area. He had good insight and was not suicidal. There is no requirement for the health services involved in his care for this episode or the police to have told the CSC in Essex. A record of this assessment was placed in his GP file.

- 7.119 As a result of the telephone call from the school nurse; Essex CSC made a decision to carry out an initial assessment and on 24th November 2009 a social worker saw Christopher, Elizabeth and Elaine at the house in Essex. They presented as a couple and disclosed a history of domestic abuse and alcohol misuse. A decision was then made to have a Core Assessment and both Elizabeth and Elaine were seen on two more occasions at home. There was a plan to carry out some direct work with Elaine; however there is no record of this actually taking place. Some information about the family was obtained from Essex Police and the school as well as Greenwich CSC.
- 7.120 On the 1st December 2009 according to the Greenwich GP IMR; Christopher was seen by the Assessment and Shared Care Team when he was diagnosed as having a mental and behavioural disorder due to harmful use of alcohol and cannabis and suffering an adjustment disorder. He was recorded as having strong dissocial traits and that some of the factors affecting him were difficulties around his accommodation, relationships, finances and lifestyle. Clinically he was slightly agitated and suffered sleep disturbance, he was experiencing low mood and thoughts of worthlessness but denied thoughts of self harm or suicide. The anti-psychotic medication and sedation medication were stopped and he was prescribed anti-anxiety medication. Christopher was assessed as having low risk of self harm at that time.
- 7.121 Christopher did not attend his outpatient appointments with Greenwich Mental Health Services on 21st January 2010 and 23rd February 2010.
- 7.122 On 1st March 2010 Elizabeth saw her GP in Essex and spoke of her long mental health history and they increased her medication.
- 7.123 On 2nd March 2010 the Essex CSC Core Assessment stated that Elizabeth and Elaine lived alone and there were concerns around domestic abuse committed by Christopher and that Elizabeth had alcohol and mental health issues. There were ongoing concerns regarding Christopher's mental health and the nature of contact he may have with Elaine. The report concluded that although Elizabeth could provide Elaine's basic needs, there were concerns regarding keeping her safe if Christopher was allowed back into the home. The assessment stated that Elizabeth had suffered depression for a long time however it was now under control with medication. The report also stated that Elizabeth recognised that Christopher posed a physical and emotional risk to Elaine and would not allow him any unsupervised contact and that she would not allow him back into the home. The assessment also stated that there was no evidence since October 2009 that Elizabeth had allowed him back into the family home. This was incorrect as on 20th November 2009 Christopher had been visiting Elizabeth's home as he was taken from there when he took an overdose. A written agreement with Elizabeth was completed regarding contact between Elaine and Christopher and that she would not let him back into the family home. The agreement also stated that if there were further

concerns or breach of the agreement then the case would be dealt with as a child protection matter. The case was understandably closed by CSC on 15th March 2010; however there was no clarity for any of the agencies about ongoing support and monitoring of the family. This highlights the assumption often made in domestic abuse cases that when individuals say they have separated from their partners that risks have been reduced which is not the case. This can create a mindset amongst workers which is misleading and can be falsely optimistic.

- 7.124 On 12th March 2010 Christopher had an annual review for his depressive state with his GP in Greenwich. During that review it was noted that he had good eye contact; had suicidal thoughts with no intention and that he had self harmed during the Christmas period using a butter knife however there were no visible scars. The GP notes recorded that he admitted to being an alcoholic and that he declared he was a 'lifelong teetotaler'. It was also recorded that he was seen by a counsellor and was referred to a psychiatrist. According to the GP record he was seen that day by a member of the Rapid Response Team from Greenwich Mental Health Services and Christopher stated that he had depressive feelings, was paranoid about people and that the police were out to hurt him. This made him afraid of leaving the flat. He admitted to being an alcoholic and to using cannabis to help him sleep. Christopher requested medication and was advised to visit the GP surgery. It was felt that Christopher was low risk. The conflicting information regarding his alcohol consumption may have been an error in recording by the staff at the GP practice, although when he registered in November 2009 he declared that he did not consume alcohol.
- 7.125 On 12th April 2010 Christopher had an appointment with the GP in Greenwich and complained of depression. He was prescribed anti-psychotic medication and anti-anxiety medication which was later changed to insomnia medication. In June 2010 Christopher had an appointment with his GP regarding weakness in his legs and he was referred to hospital but failed to attend two appointments and in September 2010 he had an MRI scan.
- 7.126 On 2nd July 2010 Elizabeth saw her GP in Essex for a medication review and she reported low mood. She declined a referral to a consultant psychiatrist.
- 7.127 On 9th August 2010 Essex Police were called to Elizabeth's house as she had alleged that Christopher was armed with a kitchen knife and was refusing to leave. Christopher was arrested. Elizabeth was heavily intoxicated; drugs paraphernalia and a dead rat were seen in the premises. Elaine was present and the police took her into police protection as Elizabeth was not in a fit state to look after her and Elaine was placed into the care of Essex CSC later that day. A notification of the incident was made to community health (school nurse). The school nurse has recorded

that the police notification stated Christopher was using cannabis and cocaine daily.

- 7.128 This matter was effectively dealt with by the police with positive action by arresting Christopher and removing Elaine. They acted in accordance with national and local guidance. The incident was risk assessed using the DASH-RIC tool which Essex Police had adopted in May 2010; and correctly classified the risk as high citing the ongoing and escalating violence, coupled with the use of a weapon, as well as concerns about Elaine. Christopher was charged with assault and released on bail with conditions.
- 7.129 A discussion took place between the Essex Police CAIT and Essex CSC and a decision was made not to investigate the matter as a child protection investigation in accordance with Section 47 of the Children Act 1989 either by the police or CSC. This was an inappropriate decision by both agencies and this matter should have been investigated as a Section 47 investigation. A comprehensive assessment was carried out by CSC and there was continuous social work involvement with Elaine as a looked after child in accordance with Section 20 of the Children Act 1989. It is not clear from the social work records what the plan for Elaine was. There were meetings between CSC staff with Christopher and Elizabeth and legal advice was sought. It is accepted that Elaine was protected, however the emphasis of the enquiry should have been safeguarding and not as a child in need. Despite this decision it is doubtful if the outcome would have been any different. The school nurse was made aware of the involvement by CSC with Elaine and was then involved working with CSC and others in developing a plan for Elaine.
- 7.130 On 11th August 2010 Elizabeth saw her GP and for the first time disclosed domestic abuse and that her daughter had been taken away. She stated that she had thoughts of suicide but nothing definite. The GP diagnosed her as suffering from ongoing depression.
- 7.131 On 12th August 2010 when the incident was being reassessed by a member of the police Domestic Abuse Safeguarding Team (DAST); it was downgraded to medium risk citing that the knife was not used, only threatened, the assault was minor and he only assaulted her once, that she had called the police and that both parties had drunk copious amounts of alcohol. In addition he had been charged and was subjected to bail conditions not to have contact with Elizabeth or attend the address. Taking into account all of the history and the seriousness of this incident the downgrading was incorrect. The consequence of the downgrading was that this case was not referred to a MARAC which would have been an opportunity for all the agencies to have had a fuller understanding of the long and complex history of this family. Since April 2012 the policy in Essex Police has changed and all decisions to downgrade risk assessments have to be agreed by a DAST supervisor, normally of the rank of sergeant

- 7.132 On 16th August 2010 the GP referred Elizabeth to the Essex Community Mental Health Team (CMHT). On the 2nd September she saw the GP and stated she had missed the CMHT appointment as she had been away and had telephoned to rearrange. She made a request for counselling. The records indicated that she was not suicidal.
- 7.133 On 23rd August 2010 Elizabeth was seen by a community psychiatric nurse from the mental health services in Essex for an assessment. Elizabeth disclosed a ten year history of mental health problems and that she had moved to Essex to get away from an abusive ex-husband. Elizabeth also informed them that she had been under the care of Greenwich Mental Health Services as well as details of the recent incident with Christopher leading to Elaine being taken into voluntary foster care to protect her. Elizabeth stated that she thought she was being watched as small cameras had been placed in her house. The diagnosis was depression with anxiety/paranoid thoughts. It was recorded that Elizabeth was seeking help from a number of organisations. Elizabeth was referred to the consultant psychiatrist however the report from the Essex Mental Health Service does not record if this took place. The report stated Elizabeth did attend appointments on 4th October, 15th November and 17th December 2010, unfortunately the report does not make it clear what the assessment and treatment was on each of these subsequent appointments. The report also stated that Elizabeth had no known forensic or criminal history; that she had not made any suicide attempts in the past but has had suicidal thoughts as not having her daughter made her feel she had no purpose in life. It was recorded that she had a low risk of aggression or violence. There was no detail of any treatment provision.
- 7.134 On 24th August 2010 Christopher contacted the Rapid Response Team of Greenwich Mental Health Services and stated that he had been feeling low in mood and finding it harder to cope since his daughter had been taken into care two weeks earlier.
- 7.135 On 31st August 2010 Essex Victim Support received a referral from Essex Police regarding Elizabeth as a result of a burglary that had occurred at her accommodation and because she was a victim of domestic abuse. Victim Support made contact on two occasions with Elizabeth and provided advice.
- 7.136 On 8th September 2010 Elizabeth made contact with Open Road Essex which provides a drug and alcohol service. She was offered an initial assessment appointment for 15th September 2010 which she did not attend.
- 7.137 On 10th September 2010 Elizabeth contacted Women's Aid in Essex and disclosed the incident on the 9th August 2010, her history of domestic abuse and that Elaine was in the care of the local authority. She declined the offer of a refuge place and requested to go on the Women's Integrated Support

Programme (WISP). Appropriate general safety advice was given. Elizabeth was concerned as she did not know where Christopher was and that he had breached his bail conditions, however she stated she was 'ok' and that she was at her mother's home in Kent. The response by the service was timely and appropriate.

- 7.138 On 10th September 2010 the housing department in Greenwich withdrew their support for Christopher as it was felt that he no longer required it.
- 7.139 On 26th September 2010 CSC in Essex decided to apply for a Care Order for Elaine, however after consultation with their legal department a decision was made to proceed within the Public Law Outline and not to immediately initiate care proceedings. The Public Law Outline is a process through which the local authority's intention to issue care proceedings are formally and legally outlined to the family, along with a letter of expectations in relation to what needs to change, expected levels of cooperation and actions to be undertaken. If things change for the better then the next step of formally issuing proceedings may be avoided.
- 7.140 On 29th September 2010 Elizabeth attended an assessment session with Open Road Essex. Elizabeth disclosed that she had been advised by CSC to contact Open Road because of her binge drinking and as part of the plan to obtain custody of Elaine. She stated that she had consumed alcohol once in the last twenty eight days and had drunk eighteen units of alcohol. She stated that alcohol use led to anger and frustration. Elizabeth disclosed a history of domestic abuse with her ex-husband and stated that she was in a new non-abusive relationship. Elizabeth also disclosed details of a recent incident with her ex-husband involving the police being called and that he had a problem with alcohol and drug misuse. Elizabeth was scored as high risk for her binge drinking. Elizabeth failed to attend subsequent appointments and the file was kept open at the request of Essex CSC. A domestic abuse assessment was not carried out as there appeared to be no immediate risk. The assessment of her drinking concluded that her drinking did not pose an excessive risk to herself or others and it was noted that she was well presented, appeared sober, coherent and focussed.
- 7.141 On 7th October 2010 Essex Police were called to an incident where Elizabeth had assaulted the daughter of a household and was trying to get into the house by banging and kicking the door. Elizabeth was arrested and received a police caution for assault; the victim was an adult. It was recorded that she was under the influence of alcohol. This matter did not fit the criteria for notification to CSC as it was not a domestic abuse incident.
- 7.142 On 1st November 2010 Elizabeth met with the outreach worker from Essex Women's Aid at her home in Essex. During the meeting she provided more information about the history of domestic abuse. Elizabeth then cancelled her next two appointments in November 2010 and had no further contact until May 2011 when she requested information about services in Kent as

- she had moved; information was provided. In their IMR Women's Aid have identified that there was an opportunity for the service to have made contact after Elizabeth had cancelled appointments to remind her of the service and encourage her to make contact and engage. However; it is accepted that some victims will choose not to engage and that must be respected, as well as the fact that smaller organisations have limited resources which are often stretched.
- 7.143 On 22nd November 2010 Elizabeth saw her GP in Essex with a shadow under the left eye. The records do not contain any diagnosis or if abuse was considered or suspected.
- 7.144 On 2nd December 2010 Essex Police attended Elizabeth's house where she was present with her new partner. A domestic abuse report was completed although this was endorsed by the DAST to the effect that no domestic abuse had taken place and so no entry was made on the Essex Police domestic and child abuse database. Although this incident may not have fitted the police definition of domestic abuse and so was not recorded as such, there is a danger that pre-cursor incidents are not noted and passed to other agencies especially as there was a child connected with this family who was being looked after by CSC.
- 7.145 By December 2010 Elaine was having unsupervised contact with Elizabeth twice weekly after school and every second weekend from Friday afternoon until Sunday afternoon. During the weekend contact; Elizabeth and Elaine would travel from Essex to Town B in Kent to stay with Elizabeth's older sister. Elaine was also having weekend overnight contact with her paternal grandmother and her husband in Medway. During this contact Christopher had contact with Elaine supervised by his mother and her husband. Both Kent and Medway CSC were unaware that a looked after child was having contact visits in their area. This was poor practice by Essex CSC who had not carried out any form of assessment of the suitability of these addresses by contacting the relevant agencies such as CSC and the police.
- 7.146 On 14th January 2011 the CPS withdrew the prosecution of Christopher for the assault on Elizabeth that had occurred on 9th August 2010 by offering no evidence. Neither the CPS nor Essex Police can locate the file in this prosecution so they are unable to establish why no evidence was offered.
- 7.147 On 14th January 2011 Elizabeth did not attend her appointment with Essex Mental Health Services and as a result her case was closed.
- 7.148 Between 27th January and 16th March 2011 Elizabeth failed to attend three GP appointments in Essex.
- 7.149 On 3rd February 2011 Elizabeth made contact again with Open Road in Essex and was offered an appointment on 10th March 2011 for re-assessment.

- 7.150 On 7th February 2011 the family centre assessment which had been commissioned by Essex CSC in November 2010 commenced.
- 7.151 On 18th February 2011 Essex Police attended a domestic incident at Elizabeth's house involving her and her new partner. No offences were identified and the incident was recorded as domestic abuse and a risk assessment took place and the risk was classified as standard. When the report was considered by the DAST they confirmed the risk as being standard and as Elaine was recorded as being resident at the premises an automatic notification was passed to Essex CSC and child health. This notification did not take place until 8th June 2011 as the report was only entered onto the computerised system that day. At this time Elaine was still in foster care and such a delay of sharing relevant information was poor practice. The new policy in Essex Police now requires for all domestic abuse records to be entered onto the database within twenty four hours and since this incident staffing levels in the DASTs has increased and the back log that had existed has been cleared. There is now a daily monitoring process in place for inputting and risk assessment of domestic abuse reports.
- 7.152 By the 2nd March 2011 Elizabeth had attended a number of Parenting Assessment sessions and CSC had contacted a local alcohol support service to arrange a place to be offered to her on a support group. A report from Women's Aid to CSC stated that Elizabeth had been engaging well and was willing to attend group work.
- 7.153 On the 4th March 2011 the CSC team manager granted Elizabeth's request to have unsupervised weekend contact with Elaine at her house in Essex. They did however warn the social worker to guard against optimism.
- 7.154 On 10th March 2011 Elizabeth was reassessed by Open Road in Essex, she did not disclose any further information. As a result of that meeting she was offered a care planning meeting on 17th March 2011 which she attended. Part of the Care Plan that was agreed was for Elizabeth to attend counselling provided by Open Road and her name was added to the waiting list. Elizabeth was advised to keep away from her ex-husband. The confidentiality agreement was explained and a signed copy placed on file. Treatment was focussed on her drinking and attachment issues, as well as understanding the triggers for her alcohol misuse and learning to deal with emotional and problematic issues without alcohol. Elizabeth stated that she was worried that information from Open Road would be used by CSC to judge her.
- 7.155 On 21st March 2011 Essex Police were called to the house of Elizabeth's new boyfriend's ex-partner. On attendance she made allegations of being assaulted by Elizabeth and her ex-partner which had come about over access to their children. This was recorded as a domestic abuse incident

and risk assessed. The risk was classified as medium. As there were children resident at the premises and some had witnessed the incident an automatic notification was sent to CSC and a further notification to health.

- 7.156 There is no record of the notification on Elaine's CSC file regarding this incident as the notification was under the victim's name and no mention of Elizabeth's name. There is information from the partner's children's school regarding this incident however the information was not cross referenced to Elaine's file. Other than this, there are no records of CSC in Essex being aware of any of the incidents involving Elizabeth and her new boyfriend. However, the social worker when interviewed as part of the IMR process stated that there had been a notification from the police about an incident between Elizabeth and her new partner sometime between August 2010 and April 2011. This is a significant incident as it is evidence of Elizabeth's violent nature and that it was in the presence of children. It was also recorded that the victim in this case had alleged that Elizabeth had in the past attempted to stab the boyfriend.
- 7.157 On 1st April 2011 Essex CSC became aware that Elizabeth had moved to Town B in Kent.
- 7.158 On 2nd April 2011 Elizabeth was arrested by Essex Police for the assault that had occurred on 21st March 2011 and was bailed. On 18th May 2011 she was charged with common assault. Her partner was also charged with common assault. The police did not update the CSC regarding the charging of Elizabeth. The case had not been dealt with by the time of the murder.
- 7.159 On 23rd April 2011 Kent Police in Town B were called to Elizabeth's new accommodation where she had recently moved to with her partner. The police officer described Elizabeth as incredibly intoxicated and she reported that they had been having a verbal argument as her partner had been watching teenage pornography. Elizabeth informed the police that she had only moved to the area two weeks previously from Essex and that she had been in this relationship for five months. She also stated that she had been in another violent relationship for ten years. The officer correctly recorded this matter as a domestic abuse incident with a risk assessment being completed and the matter was dealt with appropriately. No offences were disclosed. The police were not aware that Elizabeth had a child who visited and so did not refer the incident to CSC either in Kent or Essex.
- 7.160 On 30th April 2011 Kent Police in Town B attended Elizabeth's home where she alleged that her partner had assaulted her earlier that evening. Elizabeth made a statement and her partner was arrested. The matter was recorded as a domestic abuse incident and a risk assessment took place. Elizabeth later withdrew her support for a prosecution stating that she had reunited with her partner and that she no longer wished to engage with the police domestic abuse officer. The police were not aware that Elizabeth had a daughter that visited and more significantly was that Essex CSC now

- knew that she had moved into Kent but had not told the police or CSC in Kent.
- 7.161 On 4th May 2011 Christopher self presented to the Greenwich Mental Health Services but did not wait to be seen. Despite several attempts by telephone and letter to contact him; Christopher did not make contact with the Assessment and Shared Care Team.
- 7.162 In early May 2011 Christopher was seen by his GP in Greenwich for injuries he had suffered in a road traffic collision, he was prescribed medication and referred to a specialist. Christopher did not attend the specialist appointment.
- 7.163 On 16th May 2011 Elizabeth cancelled her first counselling session with Open Road in Essex; she gave no reason for not attending and she was offered a further appointment.
- 7.164 On 18th May 2011 Elizabeth saw her GP in Kent for the first time and she requested a continued prescription of anti-depressants. She disclosed that she had moved to the area to avoid domestic abuse.
- 7.165 On 19th May 2011 Elizabeth had her first meeting with the domestic abuse support service in Kent having self referred on 11th May 2011; she provided information about her violent relationship with Christopher and her plan to gain custody of Elaine. The service carried out a risk assessment based on the historic information using DASH-RIC and appropriately classified the historic risk as being high. Safety planning was discussed. The service attempted to contact CSC in Essex with no success. This was not followed up as the policy at the time was only to follow up cases that were currently high risk in accordance with the MARAC guidelines. The service has changed the policy since this case and now will make contact with agencies that they are aware of that are in contact with victims. This will ensure they have all relevant information to enable risk assessments to take place. This contact will now occur in all out of area cases irrespective of the initial risk assessment. The service remained in telephone contact with Elizabeth until 27th July 2011 when a decision was made to close the case. During the contact, advice regarding other support organisations to help Elizabeth with her parenting and alcohol misuse was provided. When the case was closed a new DASH-RIC Risk Assessment was carried out and the classification was medium. As a result of this case the service has introduced a new case management system which will enable the line manager to review and monitor all the cases held by each team. The service has also adopted the CAADA principle of treating any victim with ten ticks as a result of the risk assessment when using DASH-RIC as being high risk.
- 7.166 The family centre assessment report commissioned by Essex CSC was completed on 20th May 2011. The assessment detailed the history of domestic abuse and that Elizabeth's attendance at sessions had been

sporadic. The assessment highlighted the severity of the domestic abuse as well as the enduring nature of the violence. Elizabeth stated that she felt it was hard living alone, she missed Christopher not being there and that he did come to the home at her invitation. Elizabeth accepted that her need to maintain a relationship with Christopher had led to Elaine's removal and she had neglected Elaine's emotional and psychological needs. Elizabeth also commented that her depression was linked to the knowledge that if Elaine did return home she would not be able to see Christopher. In addition, she said that although she had a new boyfriend who she had been with for six months, the possibility of not seeing Christopher was depressing her. The family assessment recommended:-

- Elaine remain being looked after by the local authority.
- That Elizabeth completed a Women's Intervention Support Programme.
- That Elizabeth completed a counselling course in relation to her binge drinking.
- That cognitive therapy is considered following the above work in order to encourage a more realistic form of thinking.

7.167 On 24th May 2011 Essex CSC held a statutory review meeting regarding Elaine which Elizabeth did not attend. The Parenting Assessment report was discussed at this meeting.

7.168 On 25th May 2011 Elizabeth did not attend the re-arranged counselling session with Open Road in Essex; no reason for non-attendance was recorded. A worker then made several attempts to make contact with her by letter and leaving messages on her telephone. As Elizabeth did not make contact and after informing Essex CSC that she was not engaging with the service; a decision was made to close the case. About two weeks after the case was closed Elizabeth contacted Open Road and informed them that she had moved to Kent and would engage with a local service. Open Road worked appropriately with Elizabeth in an attempt to treat her alcohol misuse issues, however due to her failure to engage with the service and her moving out of the area the treatment programme never commenced.

7.169 Elizabeth did not attend a planned appointment with Essex CSC at the family centre on 7th June 2011.

7.170 On 9th June 2011 Essex CSC received notification of the domestic abuse incident from Essex Police that occurred on 18th February 2011 and it was forwarded to Elaine's social worker.

7.171 On 22nd June 2011 a letter before proceedings was sent by Essex CSC to Elizabeth requiring her to engage with Women's Aid, counselling and to have cognitive therapy regarding her alcohol use.

- 7.172 On 5th July 2011 Elizabeth saw her GP in Kent, she requested counselling and a letter to evidence her engagement with services to assist her case to obtain custody of Elaine. The GP appropriately referred her to a counsellor who was employed by the surgery. It is accepted practice for a GP to make such a referral based on the history disclosed by a patient without liaison with previous GPs or specialist mental health services. It is good practice for a GP to make such contact in complex cases in order to review/discuss any previous regime of care.
- 7.173 On 7th July 2011, when Elizabeth attended Crime Reduction Initiative (CRI) which provides an alcohol treatment service in Kent having self referred on 21st June 2011, she was free of alcohol. All clients with the service are subject to a breathalyser test for alcohol to ensure they are alcohol free when attending appointments. She reported her binge drinking history; stating it was originally to cope with domestic abuse. She also disclosed her mental health issues and medication. In addition she spoke about herself becoming violent and the recent arrests and pending court case. She stated that she was waiting for her case to be transferred from Essex Mental Health Services to the mental health services In Kent. The worker appropriately made contact with Essex CSC and shared information, including about Elizabeth's pending court case for the assault which the social worker was unaware of. There is no record on the CSC file about this conversation regarding the pending court case
- 7.174 On 8th July 2011 CRI informed Essex CSC that Elizabeth had been assessed and referred for individual therapy and group support. In addition the domestic abuse service in Kent reported to Essex CSC good engagement by Elizabeth.
- 7.175 On 15th July 2011 Elizabeth attended her first staff led alcohol support group run by CRI; which she then attended on 29th July, 11th August, 17th August, 2nd and 7th September 2011. Elizabeth also attended one to one sessions with the service. The service updated the GP appropriately. During her contact with the service Elizabeth did not disclose any current issues regarding domestic abuse and so her treatment focussed on her alcohol misuse. The service has a resource pack that they provide to victims of domestic abuse and would make any appropriate referrals if new information had been disclosed. The service did not make any attempt to link in with Essex's Mental Health Services to speed up the transfer of her case to Kent. However, they were aware that Elizabeth was seeing her GP therefore this was an additional piece of work that may have been undertaken; however it is not a requirement of the service's policy. Also Essex Mental Health Services had in fact closed the case in January 2011 because of Elizabeth's non- attendance.

- 7.176 On 19th August 2011 the cognitive therapist from the GP surgery in Kent reported to Essex CSC that Elizabeth attended the assessment session but her engagement was superficial and in their view she was only there in order to obtain custody of Elaine. Therefore the therapist was not willing to offer her anymore sessions. This was an appropriate decision.
- 7.177 On 22nd August 2011 Elizabeth saw her GP and asked for medication to stop her craving for alcohol, the GP did not prescribe any medication. The GP agreed to refer her to the local alcohol treatment service. After she left the GP noticed that a letter was on file dated 8th July 2011 stating that she was already engaged with the alcohol treatment service. This letter was significant as it provided some detail of Elizabeth's past, including mental ill health, domestic abuse, her own increased use of violence and pending court case. The GP then wrote to CRI asking for confirmation that she was receiving the appropriate services.
- 7.178 On 28th August 2011 Elizabeth called Kent Police to her home stating that Christopher was there, he was refusing to leave, he was wanted by the police and that he should not be visiting her. When the police arrived they identified that he was wanted on warrant and so he was arrested. The matter was not dealt with as a domestic abuse incident and therefore this was an opportunity missed to record the details of the relationship and carry out a risk assessment.
- 7.179 On 30th August 2011 Christopher was sent to prison for one hundred and eighty days for dishonesty and motoring offences. When he went to prison appropriate checks were carried out by the Prison Public Protection Team on the databases available to them to see if there were any public protection issues recorded. There was no public protection matters recorded.
- 7.180 As his sentence was under twelve months Christopher was automatically considered for release on Home Detention Curfew (HDC); this meant that he would serve the final weeks of his sentence in the community. As part of the pre-release process; the prison carried out internal checks on their records to see if there were any reasons why he should not be released on a presumptive HDC. The conditions for a presumptive HDC include; sentence less than twelve months, not serving a sentence for certain offences – mainly violent and sex offences, not convicted of certain offences in the last three years and no history of sexual offending. As long as a prisoner meets the criteria there is a presumption that the HDC will be granted, although HDC can be granted in cases for those who do not meet the criteria.
- 7.181 When Christopher's case for HDC was processed the prison did not identify that he had been convicted of a battery committed in December 2009 which was dealt with in August 2010, therefore he was not eligible for a presumptive HDC. On that basis his case should have been subjected to a standard assessment process, then considered by a board and the HDC

- approved by the Governor. The only information available to the prison was that he was fined £100 for the assault and had to pay a victim surcharge and costs. The assault did not involve domestic abuse. If the case had been referred for standard assessment it is still likely that he would have been granted HDC as there was no other information available to the prison about the history of domestic abuse and the involvement of other agencies such as social services.
- 7.182 As part of the HDC process Christopher was asked to nominate an address for his curfew and where the electronic monitoring device would be installed. He completed the form and gave Elizabeth's address with her details as the only person living there and identified her as being his partner. Even though Christopher was still privately renting accommodation in Greenwich it was his decision to nominate an address. He also stated on that form that he had never been convicted or cautioned for an offence against anyone living there or any neighbours to that address. Christopher had been convicted in January 2003 for an assault in 2002 on Elizabeth. Elaine was also due to stay at the address as well. It was later established that Christopher had been in contact with Elizabeth by telephone to agree that he could come and live with her, as well as about the HDC and the requirements. They also discussed about the impact this would have on Elizabeth's plans to regain custody of Elaine.
- 7.183 On the 15th September 2011 Elizabeth attended a legal meeting convened by Essex CSC and a decision was made to return Elaine to her care in a planned way. This was a very questionable decision as the CSC had not gathered all the information that was available to them from the police in Essex and Kent as well as from health. The decision is difficult to understand, especially in light of all the issues highlighted only two months previously in the family centre assessment, coupled with Elizabeth's continued lack of consistent engagement with CSC, Open Road and Essex Women's Aid. In addition the cognitive therapist from the GP Surgery in Kent had informed CSC of their view that Elizabeth had demonstrated no real commitment to change.
- 7.184 On 23rd September 2011 Elizabeth failed to attend her appointment at CRI in Kent.
- 7.185 On 27th September 2011 details of the proposed address for a home circumstances report were faxed by the Prison Service to the Kent Probation Trust. A probation officer telephoned Elizabeth on the 4th October 2011 to check that she was in agreement for Christopher to be released on HDC to her home. The procedural and technical details were explained to her and she stated that she was keen for him to return home and be reunited as a family with her and her seven year old daughter. The probation officer who completed the report stated there were no victim issues as far as the Probation Trust were aware. The probation officer, when he spoke to Elizabeth, did not ask if there had been any history of

domestic abuse or any safeguarding matters regarding Elaine. The probation officer, on receipt of the request for address assessment, had checked their records and saw that Christopher was not known to the Kent Probation Trust. As Christopher was serving a short sentence there was no involvement by the Kent Probation Trust other than the assessment of the address for the HDC.

- 7.186 The officer also stated that he did not routinely check with the police or social services to see if anything of relevance to the release was known and this was because of a lack of time. The officer did state that some HDC requests are accompanied by a national probation service checklist which prompts them to consider issues such as domestic abuse. The assessing officer has discretion on how detailed an assessment they make. The officer stated that he did not as a matter of routine use the check list. As a result of this case it is now the policy of the Kent Probation Trust to use this checklist on all HDC cases. Previous convictions are not routinely checked as part of the assessment and they were not in this case. If the previous convictions had been checked then they would not have necessarily indicated any domestic abuse issues as the list would have just had the offence such as assault recorded. The list would have shown if there had been any offences of non-compliance with court orders, bail or if he had committed offences whilst subject to such an order. If the list had been checked then his previous non-compliance with orders would have been identified. It is normal practice for probation officers in Kent to carry out home address assessments for HDCs over the telephone. The same day the probation officer faxed the completed assessment back to the prison including the information that Elaine was to be living at the premises. This was not identified by the prison staff as being different information from which Christopher had provided. This was an opportunity missed for the prison service to have made further enquiries.
- 7.187 In addition, the prison security department stated that there were no internal matters or public protection issues that they were aware of that would affect the release of Christopher on HDC. On 6th October 2011 the Head of the Offender Management Unit authorised Christopher's release on HDC. A Governor can refuse a release on HDC if there are exceptional and compelling reasons which include clear evidence that the prisoner is planning further crime whilst in custody, evidence of violence or threats of violence in prison and on a number of occasions or matters of similar gravity relating to public safety. If the prison had been aware of the history of the violent relationship between Christopher and Elizabeth, then in all probability, they would not have approved Elizabeth's address as being suitable for HDC. However, there would not have been sufficient grounds to refuse him HDC if he had provided another suitable address.

- 7.188 On 29th September 2011 CSC in Essex convened a family group conference to discuss the possible re-unification programme for Elaine and Elizabeth as long as the planned visit to Elizabeth's home was positive. The decision by Essex CSC to return Elaine to her mother's care is questionable. They state they were unaware of the assault on 21st March 2011 however the police state they sent a notification. The alcohol treatment service in Kent also stated they informed the social worker that Elizabeth was awaiting a court appearance for assault when they telephoned them on 7th July 2011. Christopher's mother has stated that the social worker for Elaine informed her that they were aware of the assault as a colleague had shown the social worker a newspaper article about the court case.
- 7.189 On 7th October 2011 Elaine had unsupervised contact, overnight, for the weekend with Elizabeth for the first time at her home in Town B in Kent. CSC from Essex had carried out a home visit previously to assess the home conditions. Elaine should have returned to her foster carer on 9th October, however she did not return until 10th October 2011. Elizabeth blamed bad weather and work on the railway line. As a result the next weekend contact scheduled for 14th October was cancelled by Essex CSC.
- 7.190 On 14th October 2011 the social worker in charge of Elaine's case reported to their supervisor that work focussing on Elizabeth's alcohol use was continuing and the whereabouts of Christopher was unknown, although no checks had been made with the police or in Greenwich to ascertain his location. The same day Elizabeth telephoned the social worker requesting telephone contact with Elaine that night or at the weekend. The social worker agreed to contact at the weekend.
- 7.191 Christopher was released on a presumptive HDC on 14th October 2011 and the prison notified the Prison Updates Section at New Scotland Yard and the security monitoring company. Kent Police were aware of the release via the Prison Updates Section at New Scotland Yard. The notification is an administrative process whereby the details of the release are recorded on the electronic intelligence file of the offender. There is no risk assessment or information sharing process unless there is some relevant information already held by the police regarding a prisoner's likelihood to commit further offences or if they posed a risk to public safety. The information held on Christopher in Kent was limited and nothing was automatically available to them to suggest they should take any further action. Christopher was not well known to Kent Police as a domestic abuse offender as there had been only two domestic abuse incidents involving him in Kent, one of which was dealt with by Essex Police and the other was not dealt with as a domestic incident as he was wanted on warrant for other matters and was dealt with as such. All of the other domestic abuse incidents had occurred either in London or Essex and were recorded on their systems.

- 7.192 As Probation Trusts have no involvement in short term HDC cases, the only supervision of Christopher was by way of the electronic tag which was monitored by the installation of a monitoring station in the nominated address. This device was installed at Elizabeth's home by the security monitoring company who have the government contract to carry out the installation and monitoring, if there is a breach they inform the Probation Trust. The installation took place at 18:39 hours on 14th October 2011.
- 7.193 When the two members of staff from the security company attended Elizabeth's home in Town B in Kent, they noted that both Elizabeth and Christopher had been drinking and there were alcohol cans and bottles on a table. Christopher asked if the monitoring station could be placed out of the way as his daughter was living at the premises. There was a disagreement between Elizabeth and Christopher over the monitoring station and the mood between them fluctuated.
- 7.194 About 21:10 hours the same day the police and ambulance services were called by Elizabeth's sister stating that Elizabeth had stabbed Christopher. This incident was investigated and Elizabeth was subsequently charged with murder. After a crown court trial she was convicted of murder and sentenced to life imprisonment.

8. Summary of agency involvement

8.1 Kent Police

Kent Police first had dealings with Elizabeth in May 2003 when they dealt with one domestic abuse incident between Elizabeth and her sister. The next time they had contact was in September 2009 when they dealt with the first of two domestic abuse incidents involving Elizabeth and Christopher. They also dealt with two domestic abuse incidents between Elizabeth and another partner arresting the partner on one occasion. Most of the incidents involved alcohol misuse. Christopher was arrested twice by the police in Kent for matters not related to domestic abuse.

- 8.2 In May 2003 Kent Police did not make any enquiries regarding Peter who was on the Child Protection Register in Greenwich when they attended a domestic abuse incident involving Elizabeth and her sister. Both were drunk and had been fighting. This was poor practice. At the time it was not the policy of the police in Kent to refer incidents of domestic abuse to CSS if there were children in the household. This practice for some domestic abuse cases only came into place in 2011.

- 8.3 When Kent Police were notified of the release of Christopher on HDC it was dealt with appropriately as there was no reason for them to take any action.

8.4 GP Kent

The GP in town B in Kent had several contacts with Elizabeth between May and October 2011 and saw her on the day of the murder. When she saw the GP it was either for a physical complaint or asking for assistance regarding her child custody case; she did not raise any concerns about her mental state. The surgery is innovative that it uses an alcohol use audit questionnaire at time of registration, although it appears Elizabeth under reported her alcohol use when completing it as the score did not require any intervention. This contradiction does not appear to have been identified by the GP when she later asked for medication to stop her alcohol craving.

8.5 The GP did make enquiries with Elizabeth regarding her ex-partner, presumably as a way of assessing risk. The surgery, as a consequence of this review, has identified that it did not have a policy regarding domestic abuse and as a result is carrying out a review of their procedures and to formulate and adopt a policy incorporating the Royal College of General Practitioners (RCGP) guidance on the GP's role published in June 2012.

8.6 Crime Reduction Initiative - alcohol treatment service - Kent

Elizabeth engaged with the service for an intensive three months between June and September 2011, always presenting free of alcohol at both one to one and group sessions. The service had created a detailed and appropriate programme for her. They liaised with other agencies regarding the custody case. The only possible additional work they could have done was to broker the provision of a more local mental health provider, although the mental health services in Essex had in fact closed her case in January 2011.

8.7 Women's Domestic Abuse Support Service Kent

This service had limited contact with Elizabeth between May and July 2011 and she only disclosed some of the issues in her life. The worker did attempt to obtain information from Essex CSC but did not follow this up when a telephone call was not responded to. As a consequence of this case they have now mandated that all cases that are new to the area will be followed up by contact with relevant agencies to ensure full risk assessments can take place. An improved monitoring and review regime of case loads has also been introduced. The response to Elizabeth by this service was both timely and appropriate.

8.8 Housing Service Kent

The housing service in town B in Kent had only one contact with Elizabeth just before she had moved to the area in March 2011, she was seeking help being re-housed as she said she was homeless through not paying her rent. She disclosed a history of domestic abuse and the situation regarding

Elaine being in care. As Elizabeth did not make an application for housing and was only seeking advice the service correctly did not make any enquiries with other agencies.

8.9 Her Majesty's Prison Service

The prison service had dealings with Christopher throughout the period of this review, however all of the matters that he was sentenced for were not related to domestic abuse and in the main were for motoring offences and therefore he was never considered to be a risk to public safety.

The prison service have acknowledged that the process for a presumptive HDC should not have been used in this case as Christopher did have a previous conviction for assault that occurred in 2009 and so his case should have been considered by a board and approved by the Governor of the prison. That aside the panel concur with the prison service's view that Christopher would have in all probability still been released on HDC. There is currently no process for a prison to access the information held by other agencies unless the prisoner has been deemed to be one who poses a risk. Based on his previous convictions and the other information available, he did not fit that criteria and even if he had remained in prison for the duration of his sentence it is more than likely he would have resumed his relationship with Elizabeth. As far as can be established this is the only recorded incident of a person being released on HDC that has then been the subject of a domestic homicide, although there is no requirement for such incidents to be collated by the Ministry of Justice.

8.10 Kent Probation Trust

The role of the Probation Trust was restricted to carrying out an assessment of the address provided by Christopher as to its suitability for the monitoring station for the electronic tag. In addition the assessment considered the suitability of the premises for an offender to reside in terms of any risk he/she may pose to the residents or neighbours. In line with accepted practice this was carried out by way of a telephone conversation with Elizabeth. It is the practice of some probation officers to do background checks with local agencies to see if there is any indication there may be some risk in approving the address given. This is usually based on the person's previous convictions; however these are not always available as they were not in this case. Even if the previous convictions had been available then it is doubtful if there was anything that would have prompted the officer to carry out any further checks. If the officer had carried out checks and then in order to obtain a full picture of Christopher he would have had to contact the three police forces and the two CSCs as a minimum who were involved in this case. Bearing in mind the circumstances surrounding his conviction then it is unlikely that the probation officer would have carried out this research. The response by the Probation Trust was proportionate taking into account the offences for which he had been convicted.

8.11 Essex Police

Essex Police attended the first of twelve incidents involving Elizabeth in September 2009. Six of which were domestic abuse related, four involved Christopher and two involved a different partner. The majority of the calls involved consumption of alcohol.

Their initial response to the incidents was timely and appropriate with risk assessments taking place and positive action.

It has been the practice of the Essex Police to inform CSC and child health of incidents of domestic abuse where children are resident in the same household since 2006 to CSC and 2007 to health. This worked very effectively and if it had not been for this process the school nurse at Elaine's school would not have alerted CSC having identified previous child protection concerns and a pattern of domestic abuse incidents.

Essex Police did miss an opportunity to consider referring Elizabeth to a MARAC after the third incident in four weeks in October 2009. Although only one of the incidents involved an assault, as the school nurse had identified a pattern, the police could have obtained further information regarding this family by discussing the case at a MARAC.

Essex Police did take decisive action to protect both Elizabeth and Elaine when they attended the incident on 9th August 2010 by arresting Christopher and removing Elaine. It was surprising that the Police Child Abuse Investigation Team agreed that CSC should deal with the matter and not investigate it jointly as a Section 47 child protection investigation, as again this would have been an opportunity for both agencies to obtain a full history of this family and respond accordingly.

It is the view of Essex Police, that because significant changes have occurred in the policies of that force regarding their response to domestic abuse since these events, there are no issues that need to be addressed by the way of recommendations. However, there are some generic issues such as use of chronologies and review outlined later in this report that they should consider as good practice.

8.12 Essex CSC

At the time of their involvement in this case Essex CSC was in special measures. They were not aware that this family had moved into their area sometime in 2009 and when they received the first three notifications from the police in September 2009 they recorded the incidents as contacts and made the decision to take no further action. Consequently they did not identify the pattern of domestic abuse or identify that Elaine had been subject to a child protection investigation when the family lived in Greenwich and did not take any action until the school nurse highlighted it.

- 8.13 A chronology of events in Elaine's life was never completed by Essex CSC which would have identified the complex history of this family. A Core Assessment for Elaine was undertaken and a safeguarding agreement signed by Elizabeth was put into place.
- 8.14 In February 2010 some information regarding the background to this family was obtained from Greenwich CSC.
- 8.15 Essex CSC became involved again with Elaine in August 2010, when she was taken into police protection and then accommodated by Essex CSC after a domestic abuse incident between Christopher and Elizabeth. Elaine remained in foster care and was living with foster carers at the time of the homicide. In June 2011 a decision was made to go to Greenwich to access the files for more detailed information. An appointment was made to visit Greenwich and read the files, however this was cancelled by the social worker from Essex due to a crisis situation in another case and this was never rearranged. This was poor practice.
- 8.16 Essex CSC did not inform Kent CSC that Elaine was having visiting contact with Elizabeth when she moved into the area. In addition the social worker did not make any contact with the Kent Police to enquire if anything was known regarding Elizabeth or anyone else connected with that address. These two actions are good practice and not doing them was a failing. This is significant as one of the reasons for Elaine coming into foster care was domestic abuse.
- 8.17 Essex CSC had planned to unify Elaine with her mother. The decision to return Elaine to Elizabeth's care was questionable as Essex CSC did not have all the information that was available to them if they had made checks with other agencies such as the police in Essex and Kent.
- 8.18 At times the social care response by Essex CSC to safeguarding Elaine was not authoritative and did not evidence clear or reflective decision making. The entrenched relationship between Elizabeth and Christopher was not fully considered in the context of the systemic links between domestic abuse, drug and alcohol misuse and mental health difficulties.
- 8.19 GP Essex

The GP in Essex had contact with Elizabeth between September 2009 and November 2010 regarding her depression. The GP made appropriate referrals to the mental health services during that time. They did not appear to be aware of the significant domestic abuse history and there was no information about her alcohol misuse. Elizabeth did not attend ten appointments during this time and there was no record of any action to follow up why this was; this was poor practice, especially as she was suffering from mental ill health and had a significant mental health history.

8.20 According to their records Christopher reported he was a teetotaler. He was only seen twice by the GP in Essex in September and October 2009 with mental health issues and the GP made an appropriate referral to the psychiatry service.

8.21 There were minimal references to Elaine's involvement with the GP in Essex in their IMR.

8.22 School Nursing Service Essex

The school nurse in Essex acted very professionally in November 2009 when they identified that there had been three domestic abuse incidents between Elizabeth and Christopher where Elaine had been resident in the same household and the previous child protection issues in Greenwich. On identifying this pattern they took positive action by asking Essex CSC what action they were going to take. Without this pro-activity Essex CSC would not have known about the child protection history regarding Elaine. This is evidence of the need and benefit of reviewing notes on new clients and then making appropriate judgements regarding safeguarding and liaison with other agencies.

8.23 The school nurse also had consistent attendance at the review meetings held by Essex CSC regarding Elaine.

8.24 Mental Health Services Essex

The mental health services in Essex had dealings with both Elizabeth and Christopher. The contact with Christopher in 2009 was limited as he did not live in the area for very long and he made no attempt to engage with the service.

8.25 Elizabeth had contact with the service for only four months in 2010 and during that time Elizabeth disclosed her mental health history but did not disclose her alcohol misuse. There is no record of the service making contact with the mental health service in Greenwich where Elizabeth had been a patient at various times since 2002. Accepting that Elizabeth did not fully engage with the service, the professionals working with her were not aware of the history of this family and only responded to the matters presented to them.

8.26 Women's Aid Essex

Elizabeth had limited contact with this service between September and November 2010 and they provided appropriate advice and support, after initial engagement Elizabeth then stopped contact which is not uncommon. The service could have followed up by a letter encouraging her to make

contact; however this would be an additional demand on a stretched service.

8.27 Open Road (Substance Misuse Services) Essex

This service had limited contact with Elizabeth between September 2010 and June 2011 however she did not fully engage other than attending for assessment and planning; she did not attend a number of appointments for counselling. They responded appropriately based on the limited information they were provided with by Elizabeth and they made appropriate contact with Essex CSC.

8.28 Metropolitan Police Service

The MPS attended a total of nineteen domestic abuse incidents involving Christopher and Elizabeth between 2002 and 2009. Elizabeth called fourteen times and Christopher called once, the remainder of times the police were called by neighbours. In the main these incidents were arguments and public disturbances. Alcohol was a factor in many of the incidents and in all cases it would appear that Elizabeth was the victim. On six occasions allegations of assault were made and Christopher was arrested for three of these assaults and charged with two of them. In the vast majority of cases Elizabeth did not want to support a prosecution and declined to make a statement. Ten of the incidents occurred before September 2004 and so before the Metropolitan Police's policy of positive action. In the main the matters were dealt with appropriately, although there were opportunities between 2007 and 2009 for the MPS to have referred Elizabeth to other agencies, including Women's Aid and the local drop in centre for domestic abuse or floating support. Christopher was given a harassment warning on one occasion. However, there were other times when he could have been given similar warnings, and then if he did not comply with them; could have been followed up by arrest and presenting the case to the Crown Prosecution Service to consider taking him to court.

8.29 The MPS were consistent in identifying the children of the family and appropriately referred the incidents of domestic abuse to CSS which has been the policy of the MPS since 2002. CSS in Greenwich have stated that not all of these notifications were received by them and it has not been possible because of the length of time since then to establish what happened to these notifications.

8.30 Comment was made previously about specialist officers not identifying all of the previous domestic abuse incidents when they researched new incidents; it is believed that this was due to error by the operators carrying out the searches of the database.

8.31 The MPS made appropriate utilisation of the risk assessment models SPECSS+ and DASH- RIC that were in use at the time. In the main the risk assessments were correctly used by the officers on initial attendance. However, when the specialist officers reviewed the grading they did not identify all of the previous history as mentioned before and so opportunities were missed to increase the grading. This would have allowed consideration for further work by the police and or other agencies with Elizabeth to protect her.

8.32 In addition there were five other domestic abuse incidents which involved other partners or family members. Christopher was involved in a further fifty one incidents of which he was a witness or victim on thirteen occasions. He was arrested thirty times for non-domestic abuse matters.

8.33 Greenwich Children's Social Services/Children's Social Care

The department had significant contact with Christopher, Elizabeth and their two children. When CSS first became involved in July 2002 they gathered information from agencies but they did not take any positive action to reduce the risk that he was exposed to and this response was inadequate to safeguard Peter. There were four referrals before Peter was protected when he was placed in voluntary foster care in late January 2003. During this time there were concerns about Elizabeth's mental health, as well as three incidents of domestic abuse and concerns regarding alcohol misuse by both parents.

8.34 It was surprising that Peter's name was removed from the Child Protection Register in January 2004 and that the un-born child (Elaine) details were not placed on the Register, as there had been no significant improvement in the parenting ability of Elizabeth or Christopher. In addition pregnancy and birth of a new baby, coupled with caring for a young sibling are all factors for increased risk in both child protection and domestic abuse cases. In addition the failure of CSS to act in response to the domestic abuse incident just prior to Elaine's birth was poor practice. Following further child protection interventions, Peter was made subject of care proceedings and was eventually placed with extended family members through the court process. Elaine remained in the care of her mother Elizabeth.

8.35 Greenwich Housing

The housing service had extensive contact with this family for the duration of the time examined by this review for a number of reasons, including domestic abuse. Unfortunately their detailed records which are more than six years old have been destroyed in line with their retention policy. The contact they did have with both Elizabeth and Christopher was timely and appropriate. They worked with other agencies when appropriate. The IMR author has observed the importance of retaining more detailed case records for the purposes of these types of review. They also commented that it is

the normal practice that when members of staff deal with victims of domestic abuse they should offer a referral to other agencies. The records do not indicate if this happened when they dealt with Elizabeth and this maybe because the service was aware that she was already in contact with other agencies.

8.36 KCA (Substance Misuse Service) London

This service had minimal contact with Christopher in 2005 when he was in prison and on his release. It has not been possible to retrieve the records regarding this contact. This review has identified for the service the difficulties they have in retrieving archived documentation and this has led to a review and improvements of their case management and storage systems.

8.37 GP Greenwich

This review has only considered an IMR regarding contact that Christopher had with a GP in Greenwich between 2009 and 2011. It has not been possible to obtain details of any GP contact prior to this time. During this time the GP had limited dealings with Christopher for his mental ill health, alcohol misuse and some physical ailments. The GP was never aware of his full history; however they made appropriate referrals to specialist services. On registration with the practice Christopher declared that he did not consume alcohol which was untrue.

8.38 Oxleas NHS Foundation Trust (Mental Health Services Greenwich)

Elizabeth had contact with the mental health services in Greenwich between 2002 and 2009. Christopher had his first contact in 1999 although he had been referred to a child psychologist in 1994; he then had on and off contact until his death. It has not been possible to fully analyse the service as the report submitted by them did not provide detail of all contact, treatment and liaison with other agencies. They were aware of all the major issues in this family, particularly in 2009 when their specialist clinic carried out a Forensic Parenting Assessment of both Elizabeth and Christopher in respect of care proceedings and assessment of risk to Elizabeth. This assessment was commissioned by Greenwich CSS. It is unfortunate that this service did not fully participate in the DHR as they were in a unique position where they could have engaged with Elizabeth and Christopher as a couple and worked with other agencies to try and address some of the issues. Elizabeth failed to attend fourteen appointments between 2007 and 2009. In 2009 the services lack of any follow up to liaise with professionals in Essex after Elizabeth left Greenwich was poor practice.

8.39 CAFCASS

CAFCASS's role was limited to interviewing the family members in respect of civil law proceedings with regards to Peter and Elaine. They did not discover any new information regarding domestic abuse during these contacts. Their involvement with the family was only between February 2008 and February 2009.

9. Information from the deceased's family

9.1 Christopher's mother has provided information about the family during the DHR process and when she read the draft final report. She was aware of many of the incidents included in the report and some of that information has been included within the report. In addition she has stated:-

- Elizabeth did use cocaine and possibly other drugs in the later years.
- Christopher stated that he was not an alcoholic as he never drank before midday.
- Elizabeth would drink in the mornings and Christopher's mother remembers her being under the influence of alcohol one day when Elizabeth was appearing at court charged with an offence.
- She saw injuries on Christopher that had been caused by Elizabeth.
- Both children used to say that their parents drank 'Stella' rather than refer to it as beer.
- She stated that the children were often hungry and she recalls once she went to the home and the only food was frozen bread.
- Christopher's mother initially gave Elizabeth money for food and rent, however this would often be used by Christopher and Elizabeth to purchase drugs and alcohol, therefore she would buy the food and give it to them and would load the electric and gas card as well.
- When Elizabeth moved to Essex it was always the plan that Christopher would go as well, as he obtained the money for the deposit on the house from his grandparents and Elizabeth was given money by her parents.
- Christopher's mother was always trying to help by looking after the children and going to meetings with social services where she would try to persuade the authorities to take action to protect the children.
- Christopher's maternal grandmother was also very supportive financially and emotionally to Elaine and Peter.

- When Elizabeth was living in Town B, Kent and Christopher was still living in south London, he asked a friend to take him to Elizabeth's home and the friend refused as they knew what would happen if the two of them got back together.
- Christopher was living at the flat in Town B, Kent and this was confirmed as Elaine had commented that a fridge magnet she had made for her father was on the fridge in Elizabeth's flat.
- Christopher did bully Elizabeth, however she would goad him into fights by saying men had 'touched her up'.
- Elizabeth was jealous of the relationship that Christopher had with his mother.
- Elizabeth did not have a good relationship with her parents who moved away as she was such a problem, and when Christopher's mother told them of the domestic abuse by her son early in the relationship they refused to get involved.
- Elizabeth would often contact Christopher's mother after he assaulted her and she would advise Elizabeth to call the police.
- Elizabeth and Christopher were manipulative in the way they would obtain money or alcohol, meeting up with Christopher's mother and her partner and allow them to buy them drinks.
- Christopher would keep his promises of presents for the children even if it meant obtaining them by dubious means. Elizabeth would not always keep her promises.
- Elizabeth did not stop drinking alcohol during her pregnancy with Peter.
- Christopher did not drink so much when he was apart from Elizabeth.
- Elizabeth sold items, including the children's toys to purchase alcohol.
- They were both binge drinkers.
- Neither of them were capable parents and they both struggled to look after themselves.
- Both of them were poor at taking their medication for their mental health issues.

- Elizabeth said they obtained a divorce as part of the plan to get social services 'off their backs' and they planned to stay together and have more children.
- Elizabeth did not enjoy living on her own.
- Elizabeth appeared to have some hold over Christopher who would usually respond to her demands wherever he was and irrespective of the time of day.

9.2 Christopher's mother also summarised the situation as follows:-

- All the time they were together there was a likelihood of further violence by one or the other.
- Alcohol was the biggest problem.
- She believed the violence would get worse.
- She was worried about Elaine.
- They were always going to continue the relationship in some form.
- She appreciates that even if Christopher had not been permitted to use Elizabeth's address for the HDC that they would have still seen each other.

9.3 Christopher's mother feels let down by most of the agencies involved in providing services to Christopher, Elizabeth and their children, as well as to herself and other members of the family. She does not blame anyone other than Elizabeth for the murder of her son. She is of the view that as Christopher and Elizabeth were adults they were responsible for their actions in the way that they conducted their lives, regarding their alcohol and substance misuse, as well as their criminal behaviour including both of their violent outbursts. She has stated that neither of them were capable of looking after the children and believes that agencies should have intervened far earlier to protect both of the children. Christopher's mother has stated that agencies should have worked harder to obtain information from other agencies and to have shared information. She hopes that agencies and individuals will learn from this case and that the review may prevent further deaths. She understands that some of the agencies were working in accordance with their policies; however she feels that these policies should be changed. It was explained to her about the different computerised filing systems that individual agencies have and the process of accessing that information. In particular she has made the following comments.

- Both children should have been removed earlier by social services.
- The Probation Trust and Prison Service should carry out more thorough HDC assessments and the home check should have been done in person and not on the telephone.
- The Prison Service and the Probation Trust should have been aware that Elizabeth's address was where he was arrested for breach of bail and therefore was not a suitable address.
- When carrying out HDC Assessments, the staff involved should consider that a domestic abuse victim may be too frightened to say no and that background checks should always be carried out.
- Essex Social Services should not have agreed to Elaine returning to Elizabeth's care.
- That Essex CSC should have been aware of the assaults carried out by Elizabeth in 2011 and shared that information with her as she was involved in contact visits with Elaine. In addition, information about the incidents involving Elizabeth and her new partner should also have been shared.
- That most of the agencies should have known that both Elizabeth and Christopher told lies and were not truthful about continuing their relationship.
- That Essex CSC should have taken more notice of the GP counsellor who said that Elizabeth was not willing to change.
- She hopes that workers will read the report and that it will help them to improve their practice.

9.4 Christopher's mother has also shared the following information about the massive impact that domestic abuse has had on Peter and Elaine, both prior to and after the homicide;-

- Both have a mistrust of family and professionals and have a fear of being taken into care again.
- Both have displayed violent behaviour referring to the way their parents acted as being acceptable.
- Peter has serious behavioural difficulties.

- Christopher's mother has been unable to grieve for her son as she has had to focus on the care of the two innocent victims in this case; Peter and Elaine.

10. Conclusions

This review is probably the only time that the majority of agencies that have been involved with this family have contributed to a single analysis of what was happening in this complex family. It is unfortunate that not all the agencies that had contact with this family could be identified to participate in this review, and that some of those that did assist were unwilling to provide all of the information requested by the Community Safety Partnership (CSP) and the Independent Chair. As a consequence the complete history of what was known by agencies about this family is still not known. This lack of participation by the agencies should be highlighted by the Kent CSP to the relevant CSPs in Greenwich and Essex.

- 10.1 All reviews are conducted with the benefit of hindsight and it is accepted that appropriately current practice does not allow all agencies to be automatically aware of information held by other organisations. However, there must come a time when one or more agencies or a professional realises that to work effectively with either a family or single member of the family; they need to look back and scope widely to obtain the information that is available subject to the law and information sharing guidance. Other reviews have highlighted that professionals do not seek out the information, nor do they analyse sufficiently the information that is available to them, both within their own organisation and from other agencies. Individuals and organisations still cite that the various laws and guidance prevents this when in fact it encourages it. This review has identified that none of the agencies involved had the full picture because they were only working with one member of the family and often only regarding one of their issues such as alcohol consumption or mental health and not the person or family as a whole. This was often exacerbated by the fact that often neither of the adults disclosed all of their history. Also and more importantly they did not disclose the truth about the current status of their relationship which did make it difficult for agencies to protect them and their children. Each member of this family was vulnerable in some way from another member of the family. There was a need for all agencies to consider the family as a whole and work together with all of them to improve their quality of life.
- 10.2 Christopher and Elizabeth were often selective in the detail that they disclosed to professionals in relation to the issues affecting their lives, in particular about when the relationship had resumed and who was working with them. At times they denied that they had an alcohol problem, for example Elizabeth, when she registered with the GP in Essex in 2009 she stated that she was a social drinker and Christopher was recorded as being teetotal. Coupled with them moving between and within local authorities it

did not make it easy for professionals to establish the truth about the extent of the problems in this complex family.

- 10.3 In the ten years of their relationship Christopher, Elizabeth and their children had contact with over forty different services, some of which were separate departments within an organisation. Several of those services were for matters other than domestic abuse or child protection. During those contacts they had dealings with many professionals, especially those services that had long term involvement such as housing and the mental health services in Greenwich.
- 10.4 The creation, maintenance and then regular analysis of a chronology by individual agencies, particularly in complex cases and those where families have been known to an agency for a long time, has been highlighted in other reviews as good practice. This process will also assist in identifying which other agencies may be involved with the family and may have information to assist in any risk assessment. The failure to do this was particularly relevant to the questionable decision to return Elaine to Elizabeth's care just before the murder.
- 10.5 At the time of the murder the only organisations that knew Elizabeth and Christopher were intending to live as a couple and that they had resumed their relationship were the Prison Service, Kent Probation Trust, the electronic monitoring company and Kent Police. It is accepted that the police only knew this as part of an administrative process. However none of those agencies were aware of the full history of this family and the dangers that Elizabeth and Christopher posed to each other and to their children, especially when under the influence of alcohol or drugs. Therefore there is no criticism of them based on current practice which they adhered to.
- 10.6 There is no national database that contains all details of an individual and which agencies have information regarding them. The majority of agencies hold information in silos, for example there is no integrated health database either nationally or within a local area. Therefore a department in a hospital treating a person may not be aware of another department who is also working with the same individual as the departments are controlled by different trusts even though they are in the same building. It becomes even more difficult when families move to a new area as there can often be a delay in transferring records. An example of this is that in October and November 2009, the GP in Essex and mental health services in Essex were attempting to treat Christopher and at the same time he had registered with a different GP in Greenwich and the mental health services in Greenwich were also treating him. Each police force also has separate databases, although the development of the Police National Database will address some of these issues. It is easier to obtain information once a person has been convicted, although some of that information is limited as only basic detail appears on the Police National Computer. There is no offence of domestic violence/abuse and so the record will state that the conviction, for

example, is for an assault and not the detail of the victim. The tracking of victims is more problematic and would require contact with each force area that the victim has lived in to identify any previous police contact.

10.7 The review panel was of the opinion that there was sufficient information available for agencies to have predicted that the domestic abuse would continue. It was also predictable that the consumption of alcohol was likely to precede any acts of violence.

10.8 The panel identified the following factors to support that conclusion:-

- There had been at least twenty five incidents of domestic abuse involving Elizabeth and Christopher that were reported to agencies.
- There were other incidents of domestic abuse that were not reported.
- Elizabeth and Christopher had been involved in other relationships where domestic abuse had occurred.
- Elizabeth and Christopher suffered from mental ill health for a long time.
- Elizabeth had a long history of serious alcohol misuse.
- Christopher had a long history of serious alcohol and drug misuse.
- The incidents of domestic abuse had escalated from physical assaults to use of knives.
- Elizabeth had become more violent in the twelve months preceding the murder.
- There had been at least two occasions where Elizabeth had possession of a knife during a domestic abuse incident.
- Elizabeth and Christopher had difficulty in maintaining engagement with services and neither indicated any real commitment to change.
- The relationship was not likely to end.
- Christopher had made threats to kill Elizabeth.
- There was tension over Elizabeth obtaining custody of Elaine as they both knew that it was partly dependent on their relationship not resuming.
- Christopher and Elizabeth both had a criminal history.

- There were financial problems; neither had ever been employed for any significant length of time and both had failed to pay housing rent in the past.
 - Elizabeth and Christopher both had suicidal thoughts at times and Christopher had overdosed on one occasion as well as self harming.
- 10.9 There was overwhelming evidence over the ten years that Elizabeth and Christopher had been together that the relationship had not ended; however some agencies and professionals did not appear to acknowledge this. All of the time that these two individuals maintained a relationship/contact in whatever form, there was always going to be a risk of continued excessive alcohol consumption which invariably would lead to violence. The indicators of the co-dependency of Elizabeth and Christopher's relationship and the issue of separation sometimes heightening risk were not always understood.
- 10.10 The panel concluded that there could have been improvements to the risk assessment processes conducted by the Prison and Kent Probation Trust. However, they carried out their roles in accordance with the current practices other than the oversight of the previous assault conviction. It is believed that Christopher would still have been released on HDC. If the prison had known of the significance of the address given and the history of the relationship with Elizabeth then they would not have approved the address, however this would not have prevented them getting together. The evidence obtained in this review and presented at the criminal trial confirmed that they intended to resume their relationship and therefore the panel concluded that domestic abuse would have continued to be a significant feature.
- 10.11 During the ten years of their relationship there were many examples of positive action taken by individuals, single agencies and agencies working together to protect each member of the family and also attempts to change the behaviour of Christopher and Elizabeth. As agencies' knowledge of domestic abuse has increased and the benefits of working together have been accepted, so have responses improved and this can be seen in this case. In addition the numbers of agencies who take an active role in the prevention of domestic abuse has increased such as housing and GPs.
- 10.12 However, there are still improvements that can be made by more information sharing and joined up working. In cases such as this one where agencies are treating separate issues such as alcohol misuse and mental health, unless there is a MARAC, there is no mechanism for an agreed complimentary programme of treatment and there is the possibility of agencies unknowingly working against each other. In such cases the identification of a lead professional would benefit both the victim and the professionals involved.

- 10.13 The period between May and September 2009 may have been a critical time for intervention as the relationship appeared to have ended with Christopher moving to Birmingham and being on bail conditions not to have contact with Elizabeth. In addition it appeared that Elizabeth did not want the relationship to resume as she moved to Kent and then to Essex. It was during this period that this was the only time this case was presented to a MARAC and although it was understandable why no actions were agreed as the parties had moved away, with hindsight it was a significant opportunity missed. When the relationship resumed in September 2009 it commenced on a downward spiral with violence, alcohol, drugs, mental ill health, suicidal thoughts/attempt, child protection issues, as well as a failure to attend appointments by both Elizabeth and Christopher. This continued into 2010 with a further significant assault occurring in August. This incident was another opportunity for the case to be presented to a MARAC and it was a poor decision by the Essex Police to down grade the risk assessment. All of the previous issues were still present and it would have been appropriate to have referred the case for a full multi-agency risk assessment and safety planning.
- 10.14 The only process where a victim of domestic abuse is the focus of a multi-agency meeting is the MARAC and when they were established there was no agreed process of formally transferring information between them when a victim moved. A clear process was published in January 2011. Other meetings may discuss families where domestic abuse is occurring, however the focus is usually the children and the agencies at these strategy meetings or Child Protection Case Conferences only have a statutory responsibility for the children; consequently the victim may not always receive the full services that are available. The MARACs do have criteria that have to be met for automatic consideration; however there is always the option for a professional to use their professional judgement to refer a case to the MARAC.
- 10.15 There was no concrete evidence that either Christopher or Elizabeth displayed any real desire to change their lifestyle.. Without that commitment and all the time they maintained a relationship it was highly unlikely that the risk of further violence would be reduced despite the involvement with agencies.
- 10.16 The panel has concluded that the response by agencies to the child protection issues of both Peter and Elaine whilst they were living in Essex and Greenwich did not, on several occasions, gather all relevant information to enable a full risk assessment to take place. Therefore they were exposed unnecessarily to continued violence between Elizabeth and Christopher as well as when they had new partners. The lack of positive action on several occasions by CSS, police and health professionals was poor practice. Guidance within and between agencies was not followed and there were opportunities for agencies to have challenged the lack of decisive action by others.

- 10.17 The response to domestic abuse has changed considerably over the period of this review with far more multi-agency working, for example the Metropolitan Police have automatically referred families to CSC where children were in the same household when a domestic abuse incident occurs since 2004. Other forces such as the Kent Police have only done this since 2011 and then only in limited cases and only to CSC. They are currently in discussion with health on how best to roll this out. Essex Police have automatically informed Essex CSC since 2006 and health since 2007 of all domestic abuse cases where children are resident.
- 10.18 Elizabeth and Christopher both had a history of failing to attend appointments which is not uncommon for individuals with mental health problems and substance misuse issues. In the main these were not followed up by agencies
- 10.19 Elizabeth, Christopher and their two children are White British and have no recorded disabilities. Elizabeth, Christopher and Peter have all been treated for different mental health issues. There was no evidence presented to this review that there were any ethnic, cultural, religious or linguistic issues that affected the services that agencies delivered to this family.
- 10.20 The Independent Chair of this review has liaised with the family of the victim in this case and they have provided additional information. The family have been supported by a homicide worker from Victim Support and this has been invaluable in facilitating contact and the provision of information. The family of the offender were spoken to by the police regarding participation in the review and they declined. As in some domestic homicide cases this murder involved the person who was recorded as being the victim in previous incidents becoming the offender. There is no guidance as to whether the offender in domestic homicides, and in particular under these circumstances, should be approached to participate in the review. This is an issue that the Home Office should consider as these previous victims may have a valuable insight into the provision of domestic abuse services. It is accepted that if the offender is in prison then any such contact would have to be through the prison service and dealt with in a sensitive manner.
- 10.21 This report has identified some issues for a number of national and local organisations/groups that are not directly involved in this case or domestic abuse and that are outside of Kent, therefore the Kent Community Safety Partnership are not in a position to monitor any response to the recommendations. A copy of the report has been sent to them to consider. A list of those organisations can be found at Appendix F.

11 Lessons Learnt

11.1 This review has highlighted issues of good and poor practice that have been identified previously in other reviews of domestic abuse prior to the inception of DHRs as well as serious case reviews of child and adult protection cases. Rather than turn those items of poor practice into recommendations which are reminders to staff to apply current procedures and act in accordance with good practice the issues are listed below. Agencies should encourage all staff that may come into contact with families involved in domestic abuse to read this report. Some of these issues are specific to children's services and are outside of the scope of the DHR but they have been included in this list. In addition all agencies in Kent, Medway, Essex and Greenwich should ensure that the findings of this review are incorporated into their existing and any new training in the response to domestic abuse. These matters should also be considered when any policy, guidance or process is being reviewed. The main issues are:

1. The benefit of the creation and maintenance of a chronology which is reviewed at six monthly intervals and always considered before the decision to close a case is made, or when making significant decisions such as child contact/custody.
2. When families move to an area agencies are to make full enquiries with agencies from the previous area and to read previous records. This is particularly important when individuals have multiple issues such as mental ill health and substance misuse. This will provide a better understanding of the patient/client and previous services supplied rather than rely on them to disclose their history or to rely on their files.
3. To transfer records to the new area in a timely fashion when individuals move.
4. When children are placed out of area children's social care must inform the CSC where they are placed.
5. Before a final decision to return a child in domestic abuse cases CSC must check with the police and other agencies regarding any new incidents or concerns. This is particularly important when children are placed out of area.
6. Referrals to MARAC should be considered using professional judgement for complex cases, such as those involving mental ill health and substance misuse coupled with abuse that has endured for a long time and violence is escalating.
7. To liaise with other agencies that are providing services to an individual to ensure treatment is complimentary.

8. To consider the family as a whole especially when a service is treating two or more individuals in a family for mental health issues and substance misuse. In addition there is a need to consider the involvement of victims and offenders, as well as having appropriate focus on the needs of the child, the adult and the child/adult relationship.
9. To have current domestic abuse policies.
10. To have an awareness of chronic co-dependent relationships (the 'cannot live together but cannot live apart' relationships).
11. To record details of all information/referrals/services offered and responses from victims and offenders even if it is understood that an agency may already be involved.
12. When there are issues of domestic abuse, mental ill health and substance misuse which are known as the 'toxic trio' then there is an increased risk of harm to children.
13. All staff who may come into contact with those affected by domestic abuse to have undergone basic domestic abuse awareness training.
14. The importance of sharing information in all domestic abuse and children's safeguarding cases.

11 **Recommendations**

This review has made the following recommendations

11.1 **Recommendations for agencies**

1. KCA and Greenwich Housing Service to review their policy/method of retention of records to ensure they are able to fully participate in future DHRs and other reviews.

11.2 **Recommendation for the Kent and Medway Community Safety Partnerships**

1. To review the process for obtaining IMRs and information from agencies and develop an escalation process when an agency from outside Kent and Medway fails to participate in a DHR.

11.3 **Recommendations for Government Departments**

1. The Ministry of Justice to consider the creation of a good practice guide, including a check list for Probation Trusts for all HDC Assessments to include domestic abuse and child protection.

2. The Home Office to consider issuing guidance to police forces regarding transfer of information between police forces when victims and offenders involved in domestic abuse move.
3. The Home Office to work with the NHS National Commissioning Board and Clinical Commissioning Groups regarding publication of guidance for the commissioning and writing of IMRs from health providers, in particular developing a protocol for obtaining information from other areas.
4. The Home Office, the NHS National Commissioning Board and Clinical Commissioning Groups to develop a training programme for IMR authors from the health economy.
5. Home Office to issue guidance to Independent Chairs and Authors regarding involvement in a DHR of persons convicted of domestic homicide who have been victims of domestic abuse.
6. The Home Office consider developing guidance regarding the identification of a lead professional in cases of domestic abuse where there are other significant issues such as mental ill-health, alcohol or drug misuse especially when one or more of those issues affects both victim and offender. The process could be similar to the one that already exists in the Care Programme Approach for the mentally ill or in the Child Assessment Framework.