DOMESTIC HOMICIDE REVIEW

The Case of AA

London Borough of Barking and Dagenham

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Domestic Homicide Review – AA

Executive Summary

1. **Outline of the Incident**

2. Police were called by the ambulance service to the address where AA lived; attending paramedics pronounced AA dead.

3. It has been reported that AA was at home on that day with her child, getting ready to go and look at properties for her and her child to move into; her mother and brother were at work. AA's mother called her, and AA informed her that BB was outside, ringing the doorbell; AA had ignored BB as he had not arranged to come round.

4. BB was arrested for the murder of AA, and subsequently pleaded guilty to murder and was sentenced to life imprisonment with a recommendation that he serve at least 17 years imprisonment.

5. These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Community Safety Partnership (CSP) in Barking and Dagenham.

6. **The Domestic Homicide Review Process**

7. Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

8. The purpose of these reviews is to:
9. Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

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

11. Apply those lessons to service responses including changes to policies and procedures as appropriate.

12. Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

13. This review process does not take the place of the criminal or coroners

courts nor does it take the form of a disciplinary process.

14. **Terms of Reference**

15. The full terms of reference are included at Annex 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

16. The first meeting of the Review Panel was held on 5 July 2013. The Review Panel were asked to review events from 1 January 2007 up to the homicide. Agencies were asked to summarise any contact they had had with AA or BB prior to 1 January 2007.

17. Home Office guidance states that the Review should be completed within six months of the initial decision to establish one. This Review has been delayed by waiting to ensure that AA's mother was able to contribute when she felt able to; and to allow time for the interview with BB to take place.

18. **Independence**

19. At the start of the review, the independent chair of the DHR was Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the London Borough of Barking and Dagenham or any of the agencies involved in this case.

20. Anthony was shadowed on the DHR by Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Anthony resigned from Standing Together while the Review was progressing, and the Panel agreed for Althea to continue and complete the review as independent chair.

21. Althea has over seven years experience working in the domestic violence sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence. Althea received training from Anthony Wills. Although Althea previously worked in the Domestic Violence Team in Barking and Dagenham Council (2007-2009), she has no current connection with the London Borough of Barking and Dagenham or any of the agencies involved in this case.

22. **Parallel Reviews**

23. There were no reviews conducted contemporaneously that impacted upon this review.

24. **Methodology**

25. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with AA, her child, or BB. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

26. IMRs were provided by the Metropolitan Police's Specialist Crime Review Group, North East London Foundation Trust, Barking Havering and Redbridge University Hospitals NHS Trust, and Broad Street Medical Practice, as they were the only agencies or services known to have had contact with the victim and/or the perpetrator in the time specified in the Terms of Reference.

27. The London Borough of Barking and Dagenham confirmed information about AA's housing application, however an IMR was not sought due to the very minimal contact.

28. London Probation Trust, Victim Support Barking and Dagenham and Refuge, reviewed their files and notified the DHR Review Panel that they had no involvement with AA or BB and therefore had no information for an IMR.

29. The Crown Prosecution Service was contacted for further information about the incidents in which BB was arrested. No response was received. (Information requested is at Annex 4.)

30. Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

31. All IMRs included chronologies of each agency's contacts with the victim or perpetrator. The Police and NELFT IMRs provided were comprehensive and the analysis supported the findings. The IMRs from BHRUT and the GP surgery were felt by the Panel to initially be lacking in analysis and findings / recommendations. However following comments, questions and suggestions the BHRUT IMR was redrafted and once complete was comprehensive and high quality.

32. Following receipt of the IMR from the General Practice, written and telephone contact took please between the Practice Manager and the independent Chair, aiming to ensure that all available information and analysis had been provided. Unfortunately at the time of submitting the Report the additional information requested had not been received. (See Annex 3.)

33. Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and

issues were then explored. This report is the product of that process.

34. The Review Panel members and chair are:
- Standing Together, Chair
- Metropolitan Police Service (Chief Inspector Partnership and Safer Neighbourhoods, Barking and Dagenham & Specialist Crime Review Group)
- London Borough of Barking and Dagenham
- London Probation Trust
- Victim Support
- Barking and Dagenham Clinical Commissioning Group
- NHS England

35. The chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

36. **Contact with the family**

37. The independent chair made contact with AA's mother via the police family liaison officer, and an interview was conducted over the phone. AA's mother also saw the final draft of the report, and her comments have been incorporated.

38. The Review Panel extends its sympathy to the family of AA at this difficult time.

39. The independent chair also made contact with BB, and an interview was held with him in prison.

40. The Panel agreed that an interview with BB's previous partner could assist the findings of the review in relation to Police involvement and BB's abusive and violent behaviour. An approach was made, but the individual concerned declined to be involved in the Review. As this was outside the immediate remit of the Review, no further attempts at contact were made.

41. **Summary of the case**

42. AA was 30 at the time of her death. AA's mother described AA as loving, supportive, down to earth; she knew family values and was "a child that other parents would crave for". She treasured her pregnancy and child, was a "get up and go" person and an academically qualified fashion designer.

43. AA and BB had been in a relationship for approximately three years until BB ended the relationship while AA was pregnant with their child in 2010. From the child's birth to when the child reached approximately 16 months, there was little or no contact between AA and BB. At this point AA contacted BB to encourage contact, believing this to be in the best interests of the child.

However, BB also wanted a relationship with AA, which AA did not want.

44. AA lived in Barking and Dagenham with her two year old child, her mother and her brother. She had attended the London College of Fashion and had a BA Honours in Fashion Design. At the time of her death she was planning to move to a property for herself and her child, out of borough. Barking and Dagenham Council had facilitated this, however they had not had direct contact with AA.

45. There were no relevant contacts made by AA to the Police, and no contacts in relation to BB and AA together.

46. AA's contact with her GP, maternity services, accident and emergency and health visiting were routine, and no practitioner was prompted by her actions or any other trigger to ask about domestic violence.

47. Information provided by AA's mother suggested that, while BB's behaviour towards AA was unacceptable, it was not perceived as abusive or violent. BB is reported as displaying a "temper" and jealousy, however AA did not appear to be in fear of BB. From her family's perspective, the incident came "out of the blue".

48. BB was 35 at the time of the incident. He had a nine-year old child from a previous relationship, with who he was not in regular contact. He was a trained chef; although not in full-time employment he undertook work on an irregular basis through an agency. His address at the time of AA's murder is not known.

49. The MPS, albeit not in Barking and Dagenham, had multiple contacts with BB due to allegations and charges of domestic violence against a previous partner. The majority of these however did not lead to charges.

50. It is not clear if BB was registered with a GP – no information could be found – and he was not in contact with any agencies.

51. Information provided by BB as part of this review support the information provided above that there had been no violence in the relationship but many verbal arguments. Indeed there was little in his behaviour, from AA's mother's perspective or from his own descriptions, which would have led anyone to believe that he could have been heading for such an extreme act of violence towards AA.

52. **Issues raised by the review**

Missed Opportunities to ask about AA's relationship

53. There were missed opportunities in 2010 (maternity service) and 2010-11 (health visiting service) to proactively enquire with AA about her

relationship situation, to explore issues of domestic violence, and potentially to offer her support; this is especially important in light of the fact that AA, and her family, did not recognise BB's behaviour as abusive. However the IMRs from these services, and this review, show that significant changes have been made since that suggest these opportunities would no longer be missed. Recommendations are detailed below to audit and review the impact of these changes.

Missed Opportunities to hold BB accountable / offer support

54. There were also missed opportunities from 2005-2009 in holding BB to account for his abusive and violent behaviour towards the partner he had before AA (by the Police, albeit not Barking and Dagenham Police). For example, had she been offered some immediate support that may have helped her to support prosecutions; or had evidence been gathered that could have allowed a prosecution to proceed without her involvement. The Police IMR outlines improvements that have been implemented across the MPS since this time in responding to domestic violence perpetrators and victims. A recommendation is detailed below to audit and review the impact of these changes locally.

55. These were also missed opportunities to offer support to BB to address his behaviours. This is raised through the feedback provided by BB as part of the review, in which he states that, given the number of times he was arrested, he could have been offered support. There are options in place for men concerned about their behaviour towards a partner, it is not clear what would have been available to BB or what information is provided by the Police to perpetrators, particularly repeat perpetrators.

Awareness of the range of behaviours that constitute domestic violence

56. It is clear from the information provided by AA's mother as part of this review that none of the behaviours displayed by BB towards her daughter were perceived as domestic violence, either at the time or in hindsight. Given AA's lack of fear, the chair has sympathy with this position.

57. However, it does raise the question of what public awareness raising campaigns or information has been available that may have alerted AA, or her family, to the unacceptability of BB's behaviour and the support available. It is key for these campaigns to be carried out, and that they emphasise the non-physical violence aspects of domestic violence.

58. **Recommendations**

59. *Recommendation 1*

60. The recommendations below should be acted on, in addition to the actions identified in individual IMRs. Initial reports on progress should be made to the Community Safety Partnership within six months of the Review being approved by the CSP.

61. *Recommendation 2*

62. Community Safety Partnership to undertake a review of victimless prosecutions, working with the local criminal justice agencies (Police, CPS and HMCTS) looking at interactions between agencies, barriers and areas of learning and development. Also to include seeking the views of victims/survivors in relation to victimless prosecutions.
NB: the police involvement in this case was not by Barking and Dagenham Police; however the Panel felt that this recommendation was appropriate given the ongoing MPS-wide issues around victimless prosecutions highlighted by the findings of this case and Panel discussions.

63. *Recommendation 3*

64. BHRUT to conduct an audit of case files in Maternity Services to establish: the percentage of women routinely asked about domestic violence; the percentage of women who disclose; how this latter figure compares with what research would suggest the disclosure rate should be; and to identify any development needs in relation to when, how and how often the question is being asked. The audit should aim to establish whether the routine enquiry / response is improved compared to the findings of the IMR and this Review.

65. *Recommendation 4*

66. BHRUT, IDSVA service commissioner and provider to monitor and report to the CSP on the development of the new IDSVA service, and any impact on the response/support to victims following the end of the co-location with health providers.

67. *Recommendation 5*

68. NELFT to conduct an audit of the enquiry that is taking place in the Health Visiting service, to establish the extent to which it is taking place, the number of disclosures and what the response is. NELFT should also report on the training available for and taken up by the Service.

69. *Recommendation 6*

70. BHRUT & NELFT to reflect on current policy and training in the light of the introduction of the Domestic Violence Disclosure Scheme and report back to the Community Safety Partnership on any developments to be made.

71. *Recommendation 7*

72. Community Safety Partnership to review its recent public awareness raising campaigns and information to ensure that they draw attention to non-physically violent behaviours from domestic violence perpetrators. The CSP should consider approaching AA's family, via the Police Family Liaison Officer or other trusted agency (e.g. Victim Support Homicide Service), to

explore whether they would like to be part of future awareness raising[1]. The CSP should also ensure that plans are in place to promote the new Domestic Violence Disclosure Scheme.

73. *Recommendation 8*

74. The Community Safety Partnership should nominate an agency (e.g. the Police Family Liaison Officer, or Victim Support Homicide Service) to update AA's mother on the local roll out of the Domestic Violence Disclosure Scheme (reference paragraph 164).
http://content.met.police.uk/Article/Domestic-Violence-Disclosure-Scheme---Clares-Law/1400022792812/1400022792812

75. *Recommendation 9*

76. The Community Safety Partnership to review and report on the support and pathways available and offered to perpetrators of domestic violence, particularly where repeat arrests are being made with no or few charges following.

77. *Recommendation 10*

78. The CCG to raise awareness of the new Domestic Violence Disclosure Scheme to all health providers.

79. *Recommendation 11*

80. The GP practice to review its policy and procedures for identifying and responding to domestic abuse and ensure all staff receive appropriate training to support contemporary practice for healthcare practitioners, and to report to the Community Safety Partnership on this.

81. *Recommendation 12*

82. NHS England to ensure identifying and responding to domestic abuse is discussed with General Practitioners from this Practice during Appraisal and Revalidation

83. *Recommendation 13*

84. In light of the lack of involvement of the CPS in this review, for the Home Office to review nationally and regionally CPS engagement with Domestic Homicide Reviews, and improve consistency.

[1] NB: AA's mother reviewed this Overview Report prior to submission, and indicated that she would be interested in being part of future awareness raising