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DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF Adult A

Report produced by:
Haringey Domestic Homicide Review Panel

Date: 26.03.14

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Section One: Context

1.1 Introduction

This is a report of a domestic homicide review (DHR) that examines the circumstances leading up to the deaths of Adult A and Adult B at their home in Tottenham, Haringey on 21 May 2012. The review will consider all contact/ involvement of agencies with Adult A and Adult B from 21 May 2011 to 21 May 2012 and any earlier contacts that have relevance for the review, e.g. have connection with offending or domestic violence.

Adults A and B have two children, aged 20 and 15 at the time of the homicide.

1.2 Reason for conducting the review

Domestic homicide reviews were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act 2004 that came into force on 13 April 2011.

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way local professionals and organisations work individually and together to safeguard victims and hold perpetrators to account
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

This DHR was recommended and commissioned by the Haringey Community Safety Partnership (CSP), in line with the requirements of the *Multi-Agency Statutory Guidance for the Conduct of the Domestic Homicide Reviews 2011*[1].

It is yet to be decided whether there is cause to commission a serious case review with respect to this case.

A specific Domestic Violence Homicide Review Panel met initially on 14 June 2012 and on a further seven occasions: 2 August, 27 September, 25 October, 29 November, 12 December 2012, and 16 January and 6 February 2013.

[1] http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-violence/domestic-homicide-reviews/

The DHR Panel consisted of:

Name	Representing	Position
Claire Kowalska	Community Safety Partnership	Community Safety Partnership Strategic Manager
Marion Wheeler	Children & Young People's Service, Haringey Council	Assistant Director, Children & Young People's Service
Deirdre Cregan	Children & Young People's Service, Haringey Council	Domestic and Gender Based Violence Co-ordinator
Lisa Redfern	Adult and Community Services, Haringey Council	Deputy Director
Duncan Paterson	Safeguarding Adults Service, Haringey Council	Head of Safeguarding Adults Service
Jeanelle de Gruchy	Public Health, Haringey Council	Director of Public Health
Raymond Prince	Legal Services, Haringey Council	Assistant Head of Legal Services
Liz Marnham	Policy and Equalities, Haringey Council	Senior Policy Officer
DI Paul Gardner	Metropolitan Police Service, Critical Incident Advisory Team	Detective Inspector
DS Angie Barton	Metropolitan Police Service, Critical Incident Advisory Team	Detective Sergeant
DI Julie Willats	Metropolitan Police Service, Haringey Community Safety Unit	Detective Inspector
Karen Baggaley	NHS North Central London, Haringey	Designated Nurse, Child Protection
Joe Benmore	London Probation Trust	Senior Probation Officer
Berna Vardar	Nia	IDVA Service Manager
Michele Stokes	Haringey Women's Forum	Executive Director

The following agencies were asked to secure their records and to identify an independent author of sufficient experience to undertake an individual management review (IMR):

- School
- University A
- University B
- North Middlesex University Hospital NHS Trust (NMUHT)
- London Probation Trust (LPT)
- Haringey Advisory Group on Alcohol (HAGA)
- Circle 33 Housing Association
- GP
- Metropolitan Police
- Adult and Community Services

Additional sources of information for the work of the Review Panel

The paralegal at the firm of solicitors used by Adult A was interviewed in person by the Chair of the DHR and had additional contact with the Chair by phone and email

during the review process. The pastor of the church used by a number of the family members was also interviewed in person by the Chair and later via telephone. Each IMR was scrutinised by the Panel and, where appropriate, IMR authors were invited to attend a Panel meeting to answer questions directly from Panel members. Two organisations were visited by Panel members and further information and clarification was sought from six agencies to support the Panel in its work.

The Chair and author of the DHR overview report is Neil Blacklock, who is the Development Director at Respect and has no previous involvement with the subjects. Neil has a background in developing intervention programmes for perpetrators of domestic violence. He was involved in establishing and managing the Domestic Violence Intervention Project between 1991 and 2006, before moving to Respect, where he has written the Respect Service Standard for organisations working with domestic violence perpetrators and leads on Respect's work with young people and on workplace responses to domestic violence.

1.4 Timescales

This review began on 15 June 2012 and was concluded on 23 February 2013. An extension to the time was sought after the son of Adults A and B met with the Chair of the Review Panel and stated that he and his sister would consider contributing to the review. The Panel wanted to give every opportunity for the family to contribute.

1.5 Terms of reference

The terms of reference agreed at the second DHR Panel meeting includes the purpose of the review as set out in section 1.2 and the scope of the review which was to review the events in the twelve months up to the date of the deaths of Adult A and Adult B and any relevant events outside of this time period, most significantly Adult B's involvement with the London Probation Trust (LPT) and Haringey Advisory Group on Alcohol (HAGA) in 2007.

In addition, the Panel was asked to focus on the following areas of concern, with a particular focus on paragraph vi:

i. Was there evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, was it not shared with others and/or was it not acted upon in accordance with their recognised best professional practice.

ii. Did any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved?

iii. Whether the homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.

iv. Whether the homicide appears to have implications/reputational issues for a range of agencies and professionals.

v. Does the homicide suggest that national or local procedures or protocols may need to change or are not adequately understood or followed?

vi. Where the victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

The Panel would also consider other information and evidence that it considered to relevant.

1.6 Individual management review (IMR) authors

The DHR Panel received and considered the following IMRs:

Organisation	Author name	Author title
School	Ada Petty	Family Support Co-ordinator
University A	Redacted	Director, Learning Resources and Student Services
University B	Redacted	Deputy University Secretary (Board)
North Middlesex University Hospital NHS Trust (NMUHT)	Sandy Kirkham	Independent Reviewer, NMUHT
London Probation Trust (LPT)	Joe Benmore	Senior Probation Officer
Haringey Advisory Group on Alcohol (HAGA)	Ian McGregor	Clinical Director
Circle 33 Housing Association	Leo Stanislaus	Assistant Director, Neighbourhoods
GP	Dr Helene Brown	Deputy Medical Director, NHS North and Central London
Metropolitan Police Service	Angie Barton	Detective Sergeant, Critical Incident Advisory Team
Adult and Community Services	Lisa Redfern	Deputy Director, Adult and Community Services

The Panel received written confirmation that no members of the family were known to Haringey's Adult and Community Services or to Haringey's Children and Young People's Services.

1.7 Development of individual management reviews (IMRs)

Individual management reviews form the backbone of the DHR and are expected to provide an accurate account of each agency's response to Adult A and her family. They are also expected to reflect on this response and evaluate whether this was in line with their policy and procedure, whether that policy and procedure is best practice and, if necessary, put forward improvements for the future. The IMRs have also looked at changes in practice and policy that have occurred during the time frame of the review and considered the impact these have had on an agency's current response.

IMRs were seen by the Chair and scrutinised by the Panel as a whole. Some IMR authors were asked to present their reports to the Panel and the Panel sought clarifications and further evidence. On two occasions, Panel members visited

agencies to support the IMR author and the agency in reflecting on current practice and to aid the Panel in developing the recommendations to this report.

The report's recommendations represent the consensus view of the DHR Panel and are the product of full and frank discussion of all the significant issues arising from the review.

1.8 Confidentiality

The findings of each review are confidential with information available only to participating officers/professionals. Following acceptance of this report by Haringey CSP, a confidential briefing note encapsulating the key messages and recommendations will be circulated to relevant managers in each of the agencies that contributed to this DHR.

The report's recommendations attached to specific agencies have been shared with those agencies to enable them to make progress on these at the earliest opportunity.

1.9 Dissemination

While it is important that key issues arising from the review are shared with organisations that need to act on these so as to improve responses to domestic violence, the report will not be disseminated until clearance is received from the Home Office Quality Assurance Group.

In order to progress towards agreement on the contents of the report, drafts were seen by the membership of the DHR Panel and relevant aspects of the report were seen by the IMR writers as listed in 1.6 and the membership of the Haringey CSP. The Chair and Panel discussed any points raised by IMR authors in order to achieve agreement, although this was not possible with one agency and their concern is noted in the report.

The content of the report and its executive summary will be anonymised in order to protect the identity of all family members, staff and others and to comply with data protection requirements.

The anonymised DHR report will be published after clearance from the Home Office Quality Assurance Group. The recommendations from the review have been incorporated into an action plan which will be followed up on by the Community Safety Partnership to ensure that recommendations are acted upon and lessons from the review are learned.

The overview report will be produced in a form suitable for publication and redacted in line with the framework set out in Appendix 3.

1.10 Subjects of the review

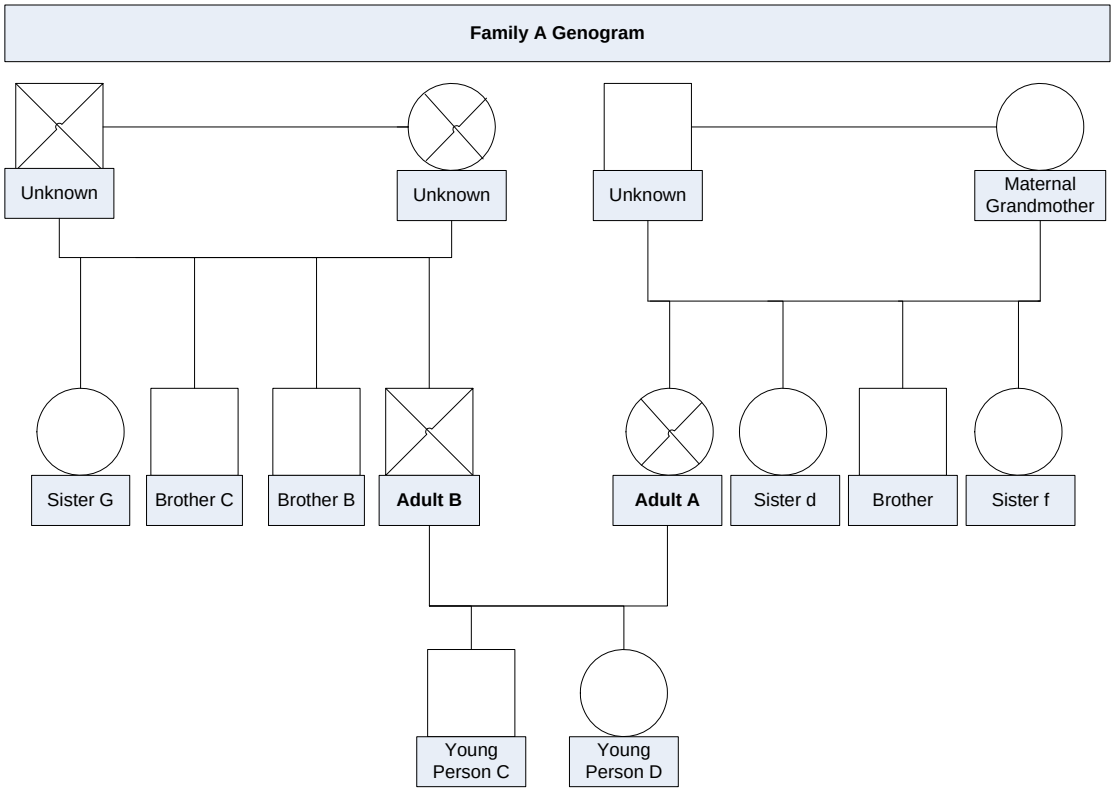
Deceased (victim female)	**Adult A**
Deceased (perpetrator male)	**Adult B**

Both subjects are Ghanaian.

Children of Adult A and Adult B:

Young Person C (Year of birth 1992)
Young Person D (Year of birth 1996)
Both young people are Black British.

1.11 Family genogram



1.12 Involvement with family and friends

In DHRs, the involvement of the family, friends and colleagues can provide an insight into the victim's experience. The Panel considered carefully the potential benefits of their involvement, as well as the demands this asks of them, and that the time frame of the review may not be the time that is right for them during a very difficult period.

The Chair of the DHR approached the children of Adult A and Adult B and family friends at the start of the review and met with one family friend early in the process and again towards its conclusion. While Young People C and D did not respond to the initial approach, the Chair tried to keep in contact with them both through the professionals supporting the family. Young Person C did meet with the Chair and the Social Worker supporting the family late in the review process and further attempts were made to establish another meeting. On 4 January 2013, the Chair was informed by Victim Support, who are supporting Young Persons C and D that they did not wish to participate in the review.

The Chair has also had contact with the brother and sister of Adult B this has taken place towards to end of the review.

The Chair also met with a pastor who had involvement with the family.

Section Two: Haringey Domestic Homicide Review Panel Report

2.1 Introduction

This review report is an anthology of information and facts from twelve agencies, all of which were potential support agencies for Adult A or agencies with the opportunity to reduce the risk posed by Adult B or able to offer support to Young People C and D.

The twelve agencies that had contact with the family and contributed to the review through IMRs are:

- School A
- University A
- University B
- North Middlesex University Hospital NHS Trust (NMUHT)
- London Probation Trust (LPT)
- Haringey Advisory Group on Alcohol (HAGA)
- Circle 33 Housing Association
- GP
- Metropolitan Police Service
- Adult and Community Services

Two organisations contributed to the review through interviews:

- Tyrer Roxburgh Solicitors
- Church attended by the family

The risk to Adult A was not clear to, or identified by, any of the professionals and others contributing to this review; the report highlights the task facing professionals who are not providing a specialist domestic violence service but who are consulted by those at risk from domestic violence. Recognising this risk and hearing the often hidden or indirectly expressed concerns of those at risk within the busy day to day environment of a public facing service is a significant task. However, many of those at risk may not recognise this or seek help from specialist services but seek to address the problems created by the abuse they are experiencing through a range of services. This review recognises the crucial role of staff working in services where the primary objective is not responding to domestic violence but who have a vital role in providing a route to safety for those at risk.

Three of the above agencies – Tyrer Roxburgh Solicitors, Circle 33 and the family GP – had direct contact with Adult A in the year prior to her death and had opportunities to identify and explore the risk to Adult A. Adult A was not known to Haringey's specialist domestic abuse agencies. HAGA and LPT both had contact with Adult B because of his drinking and his offences in relation to driving under the influence of alcohol. Although, these offences occurred in 2006, they were brought within the scope of the review due to the contribution of alcohol abuse to the murder of Adult A. The church was attended by all four family members for differing lengths of time and differing levels of frequency over the last five years.

The family were not known to either Haringey Council's Children's Social Care Service or to Adult and Community Services.

In reviewing the IMRs, there did not appear to be any racial/ethnic, cultural, linguistic or religious identity issues that required agencies to make adjustments to their practice.

2.2 Summary of the case

Adult A was aged 46 years at the time of her homicide by her husband, Adult B, who was aged 48. They have two children: a son, Young Person C, and daughter, Young Person D, aged 20 and 15 respectively on 21 May 2012.

On 21 May 2012, Young Person D was living at the family home with Adult A and Adult B; Young Person C was living away from the family, studying at university. Adults A and B married in the UK in 2002, although it is understood from family members that they met and married in Ghana before coming separately to the UK in the early 1990s.

Adults A and B had been living at their current address since November 2003, following an internal transfer with Circle 33 Housing Association from another property in the borough.

Adult B had a history of problem drinking leading to a conviction for driving whilst unfit to do so through drink in 2006; this resulted in a twelve month Community Order with a condition to attend a Drink Impaired Drivers course. This order was breached and he was sentenced in December 2006 to a further nine month Community Order with a requirement to attend an Alcohol Treatment Programme. While Adult B did attend the Alcohol Treatment Programme, it is known that he continued to drink. In March 2007, Adults A and B began living separately, with Adult B living downstairs and Adult A and Young Person D living in the upstairs parts of the house.

Adults A and B would frequently argue about Adult B's drinking and financial problems. Adult B would threaten to harm himself if not given money by Adult A, which was at times witnessed by the children and neighbours. While there is no record of reports to professionals of physical violence, Adult A stated in 2010 that Adult B was aggressive and she had spoken to friends and family about her fears that Adult B would kill himself, her, and the children if she left him.

Adult B owned a business that failed in February 2012, his mother died in March 2012 and Adult A started divorce proceedings in April 2012. Adult B had agreed to leave the family home at the end of April but did not. On 16 May, Adult A informed her solicitor that Adult B was drinking, returning home drunk, and that he kept changing his mind about the date he would move out.

In the period leading up to 21 May, Adult A was seen to be stressed and tearful by her children. Around lunchtime on 21 May, Adult A contacted her solicitor reporting an incident from the previous night where Adult B had returned home, turned on the cooker and left the gas running, which Adult A was concerned about. The solicitor/paralegal advised her that he would write to her with legal options for removing Adult B from the home.

Later on 21 May, Young Person D returned home from school without her key and was unable to gain access to the home. Young Person D went to the nearby home of a friend and when she was still unable to gain access to the home later, the police were called at 21.27 hours. The police forced entry to the home and found the bodies of Adult A and B. Adult A had died due to incised injuries consistent with an axe and a knife, with chemical burns (from drain cleaner) to the upper body. Some of Adult A's wounds were defensive and consistent with a struggle. Adult B died of a self-inflicted, incised wound to the neck with chemical burns to the upper and lower body and marks around his mouth. Adult B was found to have 265mg per 100ml of alcohol in his blood[2], there was no alcohol detected in Adult A's blood.

2.3 The national and local context of service involvement

The purpose of this section is to provide the service context in which the homicide occurred and to indicate any changes to that service provision that have occurred within the time frame of this review. It will provide an understanding of any specific factors that impacted on the way practitioners were working during the time period covered by the review and will provide a reference point in which to consider actions to be taken.

2.3.1 Relevant national context

The new government definition of domestic violence and abuse will be implemented in March 2013 and states:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

"This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

"Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so-called 'honour'-based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

[2] 80 milligrammes of alcohol in 100 millilitres of blood is the drink drive limit: https://www.gov.uk/drink-drive-limit

The inclusion of "patterns of incidents of controlling behaviour" has been broadly welcomed, placing a greater emphasis on patterns of behaviour rather than a definition that is incident focussed.

This has particular relevance for this review as there was a persistent, long standing pattern of Adult B's behaviour which made it difficult for Adult A to establish a home with her children independent of Adult B (the new definition could focus the attention of professionals on the accumulative impact of these patterns of behaviour in relation to both risk and harm).

The guiding principles in the government's strategic vision as set out in the *Call to End Violence Against Women and Girls*[3] are:

- Prevent violence from happening in the first place by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it
- Provide adequate levels of support where violence does occur
- Work in partnership to obtain the best outcome for victims and their families
- Take action to reduce the risk to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice.

Of particular relevance for this DHR is the commitment *to intervene as early as possible* and *to take action to reduce risk to women and girls who are victims of these crimes.*

2.3.2 Domestic and gender based violence responses in Haringey relevant to this DHR

Domestic and gender based violence (DGBV) constitutes 35 per cent of all violent crime in Haringey, a rise from 30 per cent in the previous year[4]; this is significantly higher than the national figure but also high when compared to other London boroughs. The estimated cost of this to Haringey is £27.6 million[5] in terms of physical and mental health care, criminal justice, social services, housing and refuges, civil legal remedies and lost economic output.

Haringey published a comprehensive joint strategic needs assessment (JSNA) on DGBV (June 2012) to inform the strategic priorities for the borough and to support commissioners in decision-making around budget allocation. It also provides a basis for the borough to move towards developing a coherent vision and strategy for addressing DGBV.

The report sets out nine priorities for consideration in the 2013-16 action plan:

- Effective engagement, including with children and young people to tackle the impact of DGBV
- Addressing teenage relationship violence and sexual violence related to gang activity
- Provision of independent domestic violence advocates

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[3] http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls/vawg-action-plan?view=Binary

[4] http://www.haringey.gov.uk/index/social_care_and_health/health/jsna/jsna-wider-determinants/jsna-domestic_violence.htm

[5] Based on 2009 figures from the Trust for London and Henry Smith Foundation http://www.avaproject.org.uk/media/60461/costs%20of%20dv%20by%20local%20authority.pdf

- Helping potential victim-survivors and professionals identify the need to seek help as early as possible
- Providing services to victim-survivors to help break the cycle of violence; this includes self-esteem and confidence building support
- Greater access to accredited programmes for domestic violence perpetrators, alongside support for victims
- Easy to find information in a single web-based directory, with clear signposting for victim-survivors to approach the most appropriate service as rapidly as possible
- Evaluation of the effectiveness of the reporting pathway and of awareness-raising training among health and other professionals in contact with vulnerable groups, e.g. pregnant teenagers
- A co-ordinated approach to the collection, sharing, analysis and reporting of DGBV data across statutory agencies and other relevant groups/partners.

There is additional work planned on strengthening family and teenage relationships and joint between community safety, children's services and the police to strengthen peer mentoring schemes.

A number of these priorities are echoed in the recommendations in this review and all have value in addressing DGBV. There is a clear commitment to addressing DGBV within the borough and a plan of activity to implement a coherent vision and action plan for commissioning and service provision from 2013 onwards.

While there are other services responding to domestic violence, the key services in Haringey responding to domestic violence and relevant for this review are:

Independent Domestic Violence Advocate (IDVA) – with Nia (formerly the Nia Project).

In 2011-12, there were 109 referrals to this service. Forty three per cent of IDVA clients were advised about civil injunctions and 33 per cent of this number applied for an injunction. Forty three per cent of IDVA clients were referred to Haringey's Multi-Agency Risk Assessment Conference (MARAC).

Hearthstone – Hearthstone is a service provided by Haringey Council which works with a number of statutory and voluntary sector organisations to provide a holistic package of emotional and practical support for survivors of domestic violence in Haringey. This package includes:

- Legal advice on a range of civil remedies such as injunctions
- Housing advice including access to refuge accommodation
- Access to counselling
- Safety planning
- Sanctuary home security improvement scheme.

Of the 379 Hearthstone service users between April and December 2011, 19.5 per cent were referred to MARAC and 37 per cent were referred for legal advice. While these figures are not surprising, the number of referrals for legal advice has particular relevance to the recommendations in relation to family law solicitors.

Hearthstone also report that 44 per cent of their clients say the perpetrator has alcohol or drug issues.

MARAC – in the last two quarters of 2010-11, the MARAC looked at 220 cases, 22.3 per cent referred by the police.

Provision of perpetrator interventions – there is provision for convicted offenders who meet the eligibility criteria for LPT's Integrated Domestic Abuse Programme Accelerated (IDAPA) and a small amount of spot purchased provision outside of this with the Respect-accredited Domestic Violence Intervention Project.

Specialist Domestic Violence Court (SDVC) – accredited by the Ministry of Justice in January 2011, the court clusters cases on a particular day with tailored support from the IDVA and the Victim Support Witness Service.

Victim Support – providing the Witness Service for the SDVC and support for those affected by crime, including murder.

Haringey Advisory Group on Alcohol (HAGA) – has a dedicated domestic violence post[6] working with women with drug and alcohol-related problems and women involved in prostitution who are also substance misusers and at high risk of sexual violence.

Haringey has some well-established services responding to the needs of victims of domestic violence. These services would benefit from a more solid funding base and the forward planning that is underway for the strategic vision for 2013-16.

At the end of 2012, the borough brought together service providers and commissioners to develop a shared commitment to the priorities for the 2013-16 strategy. Some of the priorities in the JSNA are reflected in this report's recommendations and require a level of co-ordination to make them happen.

London Probation Trust (LPT)

Since the period of Adult B's probation supervision in 2006/07, LPT have sought to further enhance risk management practice around domestic violence, victims, child safeguarding, self-harm and mental health for all offenders including those convicted of non-violent and or unrelated offences (e.g. domestic violence, child protection). It is now standard practice with all offenders that opportunities to investigate further the family circumstances would be pursued. This could be by way of referral to local authority children's services, use of home visiting and through borough intelligence unit checks. For further discussion, see section 2.4.6.

Haringey Advisory Group on Alcohol (HAGA)

HAGA remains the provider of the Alcohol Treatment Programme for LPT but since Adult B attended the service, HAGA have developed a service working with women who are experiencing violence. This was not in place at the time when Adult B was attending HAGA.

Changes affecting individual agencies during the time frame of the review

The review brought into the scope the involvement of Adult B with the LPT and HAGA in 2006/07 and there have been significant changes within both services during this time frame.

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[6] http://www.haga.co.uk/Domestic_Violence.htm

2.4 Analyses of individual management reviews (IMRs)

This section of the report will provide an analysis of services' responses to the family, what decisions were made and why, what actions were taken or not taken and how, and if services were providing help-seeking opportunities. The issues or concerns identified are based on the evidence supplied to the review, or through follow up interviews and information requests.

The IMR authors and the DHR author have attempted to provide an analysis of the information obtained and to cross reference where possible to increase the confidence in the findings. The DHR author would like to thank all the agencies that provided frank accounts of their involvement and acknowledges the willingness of all agencies to engage with the process of the review in order to learn lessons.

In order to present the process of agency involvement with the family and to manage the information of the DHR, the author will describe the involvement of each agency separately. The accounts of agencies' involvement with family members cover different time periods prior to the deaths of Adult A and Adult B and some accounts have more significance than others.

In the initial stages of the review, there was little indication that any agencies had knowledge of the risk posed to Adult A by Adult B, or indeed involvement with the family. From the information supplied and the willingness of agencies to engage with the work of the Review Panel, a number of ways to improve service provision have been identified. These are, of course, with the benefit of hindsight, but are also a testament to the value of the DHR process.

2.4.1 Information from family and friends

The DHR Chair met with one family friend and with Young Person C, the son of Adult A and Adult B on one occasion. A number of attempts (by letter, phone calls and through professionals working with the family) have been made to engage with the children and with the wider family.

Where appropriate, information from these meetings is referenced in the analysis of the IMRs.

2.4.2 Education – school attended by Young Person D

The IMR writers were asked to look at events in the twelve month period before the deaths of Adults A and B and to include events outside this period if relevant to the review.

Young Person D had attended the school from 2007 to July 2012 and the IMR covered the period from the end of year 10 to the beginning of year 11. The following staff were interviewed as part of the IMR process: the Deputy Head, the two Form Teachers covering this period and the Head of Year. Young Person C had also been a pupil at this school and they were viewed by staff as a "model family".

Young Person D was seen on a daily basis by her Form Teachers and had regular contact with the Head of Year and less frequent contact with the Deputy Head. All

stated that they had no concerns in relation to her development or emotional wellbeing during the period covered by the IMR. They also stated that they had no concerns prior to this.

The school had contact with Adult A at a parents' evening in September 2011, as well as around the time Young Person D was preparing for GCSE exams and when completing sixth form applications. There were no reports of the school having contact with Adult B. The school reported contact with Adult A as positive. Young Person D was achieving well academically, quiet and focussed on her exams. This view of Young Person D is echoed in the reports of others who know her.

The school stated that Young Person D had been appropriately supported within the school.

Following submission of the IMR and discussion at Panel, the DHR Chair and one member of the Panel met with the Deputy Head, at the school, to explore the school's work around domestic violence. The school has a peer mentor scheme and makes it clear to pupils that pastoral care support is available. Pupils are told how to access support and information is provided in assemblies and displayed on classroom walls.

The peer mentoring training does not cover domestic violence or issues related to parental separation. During the visit to the school by Panel members, they observed information on a classroom wall that made it clear to pupils who they could contact in the school if they had safeguarding concerns.

Analysis and conclusions

From the information available to the IMR author, there does not seem to be any reason for the school to have suspected domestic violence within the home or that Young Person D may have been at risk. It is the Review Panel's view that there were no obvious missed opportunities to intervene which might have prevented the deaths of Adults A and B.

From the follow up visit to the school and interview with the Deputy Head, the Panel believes there are areas where the school's awareness around domestic violence and parental separation could be strengthened and the accessibility and value of its offer of support to pupils around these issues improved.

The Children's Society, in its evidence to the Education Select Committee, commented on help-seeking by older children and argued that "peer-led safeguarding forums in schools, or peer safeguarding mentors in secondary schools or colleges could play a really significant role"[7]. Given that older children may be more likely to confide in or seek help from a peer, this avenue of support has particular value.

In addition to peer mentoring, the Personal, Social and Health Education (PSHE) curriculum is another area where issues of abusive behaviour in relationships can be addressed effectively. The new Ofsted inspection arrangements from January 2012

[7] Children First Report (2012) section 3, paragraph 141.
http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/13706.htm#a32

provide subject-specific guidance including PSHE[8]. This presents an opportunity to review the breadth of this area of the school's work.

Haringey Local Safeguarding Children Board (LSCB) is committed to restarting its link with secondary schools and this will provide a further opportunity to share safeguarding issues and improve practice.

2.4.3 University A – attended by Young Person C

Young Person C has attended University A since September 2011. The IMR author reviewed the records of the Student Support Service and the Faculty Manager, and enquiries were made with the course team and Young Person C's personal tutor. It is the personal tutor who would have made referrals to support services if there were concerns about welfare issues.

The University's client group is an adult one and interactions with relatives are often minimal. Therefore, the university had no record of interaction with Adults A or B.

University A has a counselling service, engagement advisors supporting students who have difficulties engaging with or completing their studies and a full-time chaplaincy service.

The IMR did not discover interactions with Young Person C beyond those related to his academic work and there was no record of Young Person C using any of the university's support services. If concerns had been raised about Adult B's risk to himself or others, the University A protocol would have been to report this to the relevant community services.

The university did express concern that the take-up by male students of the university's support services was lower than that of female students.

Analysis and conclusions

University A provides support and counselling services in line with that of similar institutions and the Review Panel's view is that the IMR showed no missed opportunities to intervene and offer support to Young Person C.

University A's view that its support services are not accessed in the same number by male students as they are by female students is not an uncommon finding. There is a significant body of research showing gender differences in help-seeking across a broad range of personal difficulties. Improving the way in which male students are invited to access the support may improve its take-up and the DHR Chair welcomes University A's intention do this. This should include visible information about domestic violence.

2.4.4 University B – attended by Adult A

Adult A was a full-time student at University B between September 2007 and March 2011 and was due to start a part-time MSc course in September 2012, had she lived to do so.

The IMR author sought information from Adult A's Personal Academic Advisor (PAA), the university counselling service, the disabilities and dyslexia services team and the university chaplaincy.

[8] http://www.pshe-association.org.uk/uploads/media/17/7604.pdf

Every student at University B is allocated a PAA. When Adult A had contact with her PAA, in February 2012, the discussion focussed on academic concerns and there is no record of more personal issues being raised.

Both the counselling and chaplaincy services had no record or recall of any contact with Adult A. Adult A registered with the disabilities and dyslexia service, where she discussed issues relating to financial support, her educational psychology assessment for dyslexia (showing mild dyslexia) and academic matters. No other concerns were recorded in Adult A's file.

Analysis and conclusions

University B was not in possession of any information that could have led to an intervention to reduce the likelihood of the deaths of Adult A and B. The Review Panel's opinion is that University B acted in accordance with their procedures and guidelines.

The DHR Chair explored what information on domestic violence is available across University B sites and, while in many places this is very good, it is not consistent across all sites.

2.4.5 North Middlesex University Hospital NHS Trust (NMUHT)

The NMUHT is an acute hospital located in the borough of Enfield mainly serving the populations of Enfield and Haringey. A comprehensive search of all documentation in relation to Adult A and Adult B was received from the Trust records.

Adult A had attended NMUHT on two occasions in 2001 for abdominal pain and on one occasion in 2004 for an outpatient's appointment. No concerns in relation to domestic abuse or the welfare of the children were indicated.

Following treatment in 1996 at NMUHT, Adult B attended NMUHT once in 2010 and again in 2011, on both occasions complaining of abdominal pain. On his attendance at Accident and Emergency (A&E) in 2010 when he was asked about his alcohol consumption, Adult B responded that he drank ten units per week. In 2011 he left A&E prior to assessment by a doctor. No concerns in relation to domestic abuse or the welfare of the children were indicated on either occasion.

Analysis and conclusions

The Review Panel noted the quality of the IMR and the author's attempts to draw lessons from the information available.

The Panel is of the opinion that NMUHT did not miss opportunities to intervene to increase the safety of Adult A or reduce the risk posed by Adult B. NMUHT appears to have acted in accordance with its guidelines (2008) in relation to domestic violence and its guidelines in relation to safeguarding.

After discussion of the IMR at the Review Panel, further clarification was provided about NMUHT's procedures where domestic violence is a concern. One of the actions required is to make a vulnerable adults referral to the relevant social service department. Additional referral pathways were also mentioned; these were Solace Women's Aid and Victim Support.

The view of the Review Panel is that there is a lack of clarity in policy and on the ground about the appropriate referral pathway in relation to domestic violence.

There could be greater clarity about when to refer to vulnerable adults and when to refer or signpost to other support services.

NMUHT is an acute Trust, working across borough boundaries, dealing with large volumes of people. A realistic solution should be sought to ensure that NMUHT has up-to-date, clear and workable guidance on where to refer those at risk from domestic violence and those at risk of perpetrating domestic violence. This lack of clarity did not extend to concerns in relation to the safeguarding of children.

2.4.6 London Probation Trust (LPT)

The period in which LPT were involved with Adult B dates from March 2006 when he was convicted for an offence, committed in February of that year, for driving or attempting to drive whilst unfit through drink or drugs. LPT continued to hold a Supervision Order for Adult B until November 2007. While this took place some six years prior to the homicide, they were brought into the scope of the review for a number of reasons: there was a scarcity of agency contact with the family and Adult B's alcohol use is likely to have been a contributory factor to the deaths of himself and Adult A. It was also during this time that Adult B and Adult A started to live separately.

In March 2006, Adult B was sentenced to a twelve month Community Order with the requirement to attend probation supervision and to participate in the Drink Impaired Drivers Programme.

It was also noted that Adult B was convicted of driving with excess alcohol in 2000 and in 2005 he was arrested following a motor vehicle accident where he failed to provide a breath sample and was charged with driving whilst unfit through drink or drugs, indicating a long standing issue with alcohol misuse.

During his contact with the Probation Service, Adult B maintained a consistent level of denial about the extent of his alcohol misuse issues. This is consistent with his report to NMUHT in 2010 (see section 2.4.5).

Adult B breached his Community Order following an incident at the Drink Impaired Drivers Programme on 21 October 2006. Adult B attended the programme late and was told that he could not join the programme. He refused to leave and forced his way into the restricted area attempting to gain entry to the group room. Staff had previously complained about him attending smelling of alcohol and behaving in a disruptive manner.

As a result of the breach, Adult B appeared before Haringey Breach Court on 22 December 2006 where his previous Community Order was revoked and where he was sentenced to a new Community Order for nine months' supervision with an Alcohol Treatment Requirement.

Despite Adult B's protestation that he was the victim of the Criminal Justice System and had been wrongly convicted, he complied with the Alcohol Treatment Requirement and attended the HAGA Abstinence Programme. Further information in relation to HAGA is in section 2.4.7.

Adult B asserted that he was abstinent from alcohol in the latter part of 2007, but there is no separate verification of this through a liver function test.

Adult B was assessed as posing a medium risk of serious harm to the public and low risk of harm to known adults. LPT records show no details of Adult B's children.

The handling of Adult B's case by LPT was in line with policy and standards of practice at the time.

Analysis and conclusions

The Panel would like to thank the IMR author for a full and frank consideration of the work of LPT in supervising Adult B in 2006-07.

It is the opinion of the Panel that opportunities to further investigate family circumstances and the possible risk posed by Adult B were missed in 2007. These were:

- Ensuring that information about the family of Adult B was recorded
- Checking to see if the children were known to the local authority
- Undertaking a home visit, exploring issues of hidden harm
- Seeking information from borough intelligence.

Since 2007, lessons have been learnt and LPT has sought to enhance risk management practice in relation to safeguarding, domestic violence, victims, mental and self-harm and the above are now part of the standards of practice for LPT. If the above had been undertaken it is difficult to say whether they would have picked up the risks that Adult B was later to pose to Adult A.

Given Adult B's behaviour and very likely continued misuse of alcohol, a referral to community mental health services could have explored whether there were underlying mental health problems.

The Panel's opinion is that supervision of Adult B was in line with the existing standards of LPT at the time. The current standards place significantly more demands on LPT and the Panel has sought reassurance that home visits and the exploration of possible hidden harm is taking place with offenders, specifically those with alcohol treatment orders. LPT have confirmed that analysis of 150 records has indicated that this happened in 47 per cent of cases where there was a risk of safeguarding. Further detail is being looked at; there may be issues with accuracy of recording which will affect data reliability.

During the process of the review it became evident that health services, particularly Adult B's GP, had no knowledge of his long standing alcohol problem. Information about offenders who are sentenced to attend an alcohol or drug treatment programme is not routinely shared with health professionals, specifically their GP. The sharing of this information may have raised awareness with the GP of the possible impact a long standing alcohol problem may have had on the wider family and risks associated with this.

2.4.7 Haringey Alcohol Advisory Group (HAGA)

HAGA is commissioned by Haringey's Drug and Alcohol Action Team (DAAT). Adult B was referred to HAGA by LPT in 2007 to participate in treatment for his alcohol misuse (see section 2.4.6). HAGA'S policy of record keeping is that all records are destroyed after two years so there are no records of Adult B's attendance at HAGA and the work that was undertaken with him.

Given the above, the report author and the DHR Panel decided to explore with HAGA how they currently respond to domestic violence issues and, by extension, how they may respond to Adult B if he was attending HAGA in 2012.

The author requested information from HAGA on their:

- assessment process and how domestic violence is identified within this
- level of domestic violence identified within the HAGA case load
- responses to domestic violence available to HAGA.

This was followed by a visit to HAGA by the author and two members of the Review Panel on 14 November 2012 during which we met with the HAGA Clinical Lead. We explored the following areas:

- information collected during the HAGA assessment
- contact with family members and local authority checks
- how HAGA service users who are using domestic violence are engaged in addressing this
- information sharing between HAGA and GPs and between HAGA and LPT.

HAGA routinely collects information as to whether their service users are resident with children and checks to see if the children are known to local authority children's services. The current assessment form used by HAGA is the one provided by the Haringey DAAT and requires that the person undertaking the assessment seeks information about the service user's experience of domestic violence, both as victim and/or as perpetrator. After further exploration at the meeting on 14 November 2012, it became clear that questions about domestic violence were asked in a manner that was likely to elicit a yes or no answer.

In responding to service users who are experiencing domestic violence, HAGA have a dedicated post and participate in the local MARAC. In responding to service users who are perpetrators of domestic violence, HAGA stated that this would be reviewed at case management meetings and in supervision. However, HAGA do not claim to have expertise in this area.

HAGA often have cause to refer service users to community mental health services. HAGA stated that service users with acute and enduring mental health issues do get a good response but beyond this specific group the referral pathway to mental health services could be strengthened.

HAGA seek consent from service users to share information with the GP at the assessment stage. However, even where this is given, HAGA will share information with the GP only when they need to seek medical support for the service user, for example, for support around detoxing.

HAGA has a worker based within LPT taking referrals of offenders subject to an Alcohol Treatment Requirement.

Analysis and conclusions

It is not possible to say if HAGA's intervention with Adult B was appropriate or whether HAGA acted in accordance with their procedures and guidelines as there

are no records available. There are a number of aspects of the current HAGA response to domestic violence that can be improved.

The current policy around the retention of case files is unsatisfactory given the level of risk posed by some HAGA service users. The policy of retaining files for two years is too short a period especially, as in this case, information in relation to risk is lost when these records are destroyed.
The assessment process employed by HAGA is not able to effectively identify service users who are perpetrating domestic violence and present a risk to their families. Three out of 347 service users between April 2012 and 20 November 2012 answered "yes" to the assessment question about using domestic violence.

The response to domestic violence provided by HAGA is focussed on addressing the needs of service users who are experiencing domestic violence, while skills and experience in working with service users who perpetrators of domestic violence are significantly less well developed.

The referral pathways between HAGA and community mental health services could be strengthened, thus improving the confidence of HAGA staff in making these referrals.

2.4.8 Circle 33 Housing Association

The family was granted an internal transfer by Circle 33 Housing Association on 21 November 2003, as the house they were living in was overcrowded and they moved to the address where the homicide occurred. Adult A was the sole tenant and Adult B was named as a household member. The Circle 33 IMR provided a list of dates and details of the contacts between Adult A and Circle 33 covering the period between 21 May 2010 and 19 April 2012. Information relating to these contacts was recorded on the Orchard Housing IT system.

There were nine contacts between Adult A and Circle 33 between 21 May 2010 and 19 April 2012. Seven of these contacts were in relation to rent arrears and benefit claims, one was concerning a defective boiler and one was requesting a transfer dated 21 May 2010.

Adult A's request for a transfer from Circle 33 cited the behaviour of her ex-partner Adult B as the reason, stating he was "giving her a hard time emotionally" and that "things get out of hand" when she wanted him out of the house. She went on to state that Adult B "is an aggressive person with a drinking problem". She requested a transfer as she believed that would end the "emotional problem she faces".

A transfer request, when received by Circle 33, would be scanned on to the Orchard Housing IT system as incoming post. The system would then notify the relevant person to take action in response to the transfer request.

The transfer would have been responded to by the Customer Service Manager, who would have contacted Adult A and investigated the request in line with Circle 33 policies. As sole tenant, if Adult A had supported the concerns she raised in her transfer request, she would have been considered for a transfer and received an offer of support around the abuse she was experiencing.

However, Adult A's request for a transfer was not responded to in this way. It was scanned, electronically filed on the tenancy file and never acted upon by Circle 33.

Adult A eventually sought legal advice to remove Adult B from the family home (see section 2.4.10).

Analysis and conclusions

The view of the Panel is that Circle 33 missed an opportunity to intervene in contravention of their existing procedures when they failed to act upon Adult A's request for transfer in 2010. This is the only occasion that the Panel is aware of where Adult A makes an explicit request for help, citing the abuse she is experiencing from Adult B as the reason for requesting help. Circle 33's procedures exist to provide protection for tenants at risk, their failure to respond on this occasion means that this protection was not extended to Adult A at this time.

While it is not possible to eradicate human error, and the DHR process is not one of apportioning blame, the Review Panel have noted that Circle 33 have responded to the concerns raised and state their commitment to improve responses to domestic violence.

Circle 33 acted prior to the start of this DHR to address the administration system failing that led to the lack of response to Adult A's transfer request.

It was the Panel's view that Circle 33 should take steps to ensure that other transfer requests had not been missed during the time when their administration systems were weak. The Panel also sought information on the training available to Circle 33 staff in responding to domestic violence and noted that this could have a greater reach and include all relevant C33 staff. The panel has had sight of the Circle 33 domestic violence policy.

The Chair and Panel were unable to reach agreement with Circle 33 on the analysis of the Circle 33 IMR, and Circle 33 have requested that the following statement is inserted into the report:

"Circle 33 wish to make it clear that they do not accept that the administrative error in any way caused or contributed to Adult A's death."

2.4.9 The General Practice for Adult A and Adult B

The IMR was prepared from the computerised notes for both Adults A and B and from interview with the GP at the practice.

GP contact with Adult A

The IMR provides information on Adult A's contact with the General Practice between 24 June 2011 and 24 April 2012. Adult A visited her General Practice on twelve occasions during this period and saw a doctor on ten of these occasions and the administrator on two. The majority of these visits were in relation to abdominal pain that Adult A was experiencing with two visits being recorded as prompted by a sore throat and cough.

On one of Adult A's visits to the GP on 6 February 2012, records show Adult A reported feeling stressed at home and her blood pressure was high. This was not followed up on at this visit, or at a subsequent one.

There are no recorded concerns in relation to the children or domestic violence. The GP stated that at no point did they suspect Adult A was at risk from domestic violence.

GP contact with Adult B

The IMR provides details of five contacts between Adult B and the General Practice between 30 June 2011 and 1 November 2011. On three of these occasions he saw a doctor presenting with epigastric pain and on one of these visits he received smoking cessation advice and was given varenicline to aid stopping smoking.

There is no record of concerns in relation to domestic violence or the children.

The IMR author notes that there was no information or posters for patients at the general practice as to where they could access help if they were at risk from domestic violence.

Analysis and conclusions

The Review Panel's opinion is that the GP did not receive information about the risk of domestic violence or other information that they had a duty to disclose or act on. However, it is the Review Panel's view that the GP missed an opportunity to explore the factors behind Adult A's statement that she was stressed at home, which could have led to disclosures about the risk Adult B posed.

The GP was unaware of Adult B's alcohol problem and had not been informed of Adult B's referral to alcohol treatment in 2007. This may have aided the GP in being alert to other risks for this family.

There were few awareness raising materials within the Practice about domestic violence, its prevalence and impact on health. For many people, their General Practice is a place where they go to access help for a broad range of problems, including domestic violence. This is true for both perpetrators of domestic violence and victims[9].

Domestic violence has correlations to poor health in both victims and perpetrators. An awareness of this and an ability to enquire sensitively as to whether there are domestic violence risks for adults and children can improve the safety of patients and their children, as demonstrated by the IRIS research[10]. When the GP was asked why they did not follow up at the next appointment on Adult A's statement that she was experiencing stress at home, the GP stated that Adult A had a "cheerful demeanour". The role of Adult A's demeanour and presentation on professionals' responses is reflected in a statement from the solicitor, see section 2.4.10).

The General Practice would benefit from having a policy on domestic violence and for all staff within the Practice to be aware of their responsibilities under the policy. This should include a commitment to making information available to patients on sources of help for both victims of abuse and perpetrators.

2.4.10 Tyrer Roxburgh Solicitors

Tyrer Roxburgh Solicitors were not asked to undertake an IMR as, when the IMR process began, the role of the solicitor was unclear. The paralegal involved was effectively interviewed in person by the report author and the solicitors have been open and frank about their involvement with Adult A. The paralegal and Tyrer

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[9] Hester, M. Westmarland, N. Gangoli, G. Wilkinson, M. O'Kelly, C. Kent, A. and Diamond, A. (2006) *Perpetrators: identifying needs to inform early intervention* pub Northern Rock

[10] Feder, G. Et al (2011) Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised control trial. Pub www.thelancet.com

Roxburgh's contribution to the review has been significant in developing the lessons learned and recommendations from the Review Panel.

On 11 April 2012, a paralegal at Tyrer Roxburgh opened a file to assist Adult A in applying for a divorce from Adult B. Adult A was seeking a divorce on the grounds that they had been living separate lives for five years. Adult A stated that Adult B had agreed to move out by the end of April 2012. Adult A told the paralegal she did not call the police more often because Adult B threatened her and she did not feel protected, although the Metropolitan Police Service (MPS) has no evidence that Adult A ever called the police.

On 17 April 2012, Adult A again met with the paralegal and approved the petition for divorce. On 25 April 2012, the court issued the divorce petition and on 30 April 2012 Adult B signed the acknowledgement and the statement of arrangement for the children. Adult B was not contesting the divorce.

On 16 April 2012 Adult A completed the application for decree nisi with the paralegal and this was sent to the court. Adult A informed the solicitor that Adult B had not left the home and was asking for more time, that he was still drinking and had said "if you want me to go you won't see me again" and "who will protect you". Adult A wanted advice from the paralegal on how to remove Adult B from the home. The paralegal stated that Adult A did not say that she felt threatened by Adult B.

On 21 May 2012 at around lunchtime, Adult A contacted the paralegal by telephone to tell him that Adult B had returned home the night before, turned on the cooker to warm some food and left the gas running. Adult A did not present this as a threat to harm her or Young Person D, who was present in the home at the time. The paralegal informed Adult A that he would write to her with options for removing Adult B from the family home.

The report author met with the paralegal on 25 September 2012 to discuss his involvement with Adult A. The author discussed if the paralegal had received training on domestic violence, specifically the identification of risk, and whether in his view this would be of value.

The paralegal had gained experience about domestic violence on the job and when he was concerned about a particular case he would discuss it in supervision with one of the Partners. The paralegal talked about the link between Hearthstone and Tyrer Roxburgh and how this provided an important source of help for clients that were concerned about their safety. The paralegal had no specific training on the identification of risks associated with domestic violence, but could see the value in this.

The author asked the paralegal how he would know that someone was at risk and needed additional support. He said you "develop a feel for this, for when someone is worried or scared", developed through experience and supervision. He said that Adult A did not seem scared, or state that she was frightened, but seemed fed up with Adult B's drinking and his not leaving the house.

Analysis and conclusions

It is the Panel's view that there was a missed opportunity to further explore the risk to Adult A and what actions may have reduced these risks.

Solicitors and their paralegals working in family law are working with people in relationships where they are in dispute, and sometimes there is high risk or a rapidly escalating risk of domestic violence. The current arrangement within the borough where solicitors and domestic violence agencies work together is a good one. Clients of both services benefit from this close working.

One of the benefits of the development of domestic violence risk assessment tools is that professionals can enhance their judgement as to whether someone is at risk. Risk assessment tools have been shown to improve the identification of risk beyond that based on professional judgement. Professional judgement is shown to be overly influenced by the presentation of the client. Both for experienced specialist staff and for non-specialists, risk assessment tools and training add greatly to their ability to identify risk. Given the risk faced by clients approaching family law solicitors, a working knowledge of how to identify domestic violence risks and how to access help would seem a key skill for solicitors and paralegals.

The Panel acknowledges the challenges that are faced by frontline services responding to a range of needs. The Panel supports the role that Tyrer Roxburgh has played in becoming a valued part of the range of responses available to those experiencing domestic violence within the borough.

Tyrer Roxburgh's response to Adult A is in keeping with current good practice guidelines and there is no suggestion that the paralegal's response was not in line with current best practice. However, if a client is seeking legal help to remove an ex-partner from their home, it would seem evident that there may be risks in this situation and a request for help around this should trigger a response that seeks to identify and respond to risk in addition to providing the appropriate legal advice and support.

2.4.11 Metropolitan Police Service (MPS)

The MPS reviewed their contact with Adult A and Adult B over the last ten years, looking at domestic violence issues or other issues that may inform the review.

One incident was identified where the police were called to the family home by the London Ambulance Service on 26 June 2011, after they were called by Adult B. Adult B explained that he called the Ambulance Service because he had a nose bleed and was noted as being very drunk. Adult A was upstairs and is reported as not being aware that police or the ambulance service had been called. The matter was recorded as not domestic violence. No check was made in relation to the children and a Merlin[11] was not generated from this call out.

This is the only reported police contact with Adult A and Adult B that has bearing on the work of the review.

Analysis and conclusion

The Review Panel was of the opinion that the MPS acted in accordance with their own guidance and that no opportunities to intervene to reduce the risk to Adult A and others had been missed.

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[11] Merlin is the term used for the form used to make referrals to Children's Service Referral and Assessment teams see http://www.haringeylscb.org/police_and_childrens_service_joint_protocol.pdf

The panel was of the view that, on 26 June 2011 where one parent was very drunk and injured, the police officers attending should have made enquiries as to whether there were children present in the home. Officers should always be mindful that domestic violence can be hidden and that there may be children in the household which would then merit further enquiries If they had discovered that this was the case, this should have led to Merlin notification to Haringey Children's Services.

2.4.12 Church

The DHR Chair met with the pastor at the church who has the most involvement with the family. All family members had involvement with this church at different times. Adult A joined the congregation in 2005 and was a member of the pastor's house group. The house group provides a mechanism for the church to create a supportive faith community outside of the church service. In recent years, Adult A had not been attending this church.

The church also runs a *redacted sensitive* project and Young Person C had been active in this until late 2011. Adult B had briefly attended a men's meeting offered through the church.

The pastor did not have any suspicion that Adult A may have been at risk and the news of the deaths of Adult A and Adult B had come "out of the blue". While there was awareness that Adult B was drinking, they did not have any knowledge of the extent of this and offers of support to Adult A were general in nature.

If concerns about domestic violence had come to the attention of the pastor, he would have sought advice from elders in the church. As part of the review process, the pastor did this and the advice was to facilitate a meeting with the police. The church has good connections with the police due to the work they do within the community.

Discussion

The view of the Panel is that the church did not miss any opportunities to intervention to reduce the risk to Adult A. The church continues to offer support to the family.

Section Three: Lessons learned

This section of the report will address the specific sections of the terms of reference (in the boxes below) and then draw out themes arising from the review that can inform the implementation of the recommendations.

i.	*Was there evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, was it not shared with others and/or was it not acted upon in accordance with their recognised best professional practice?*

There were two occasions where there was evidence that Adult A could be at risk of harm and these were not recognised, explored further or acted upon. One of these was due to the administration system error by the housing association and is discussed in 2.4.8 and the other was when the paralegal did not explore further the possible risks, explored further in 2.4.10. In the later incident, the paralegal responded in a way similar to most other paralegals, and there is no implication that the response was not in accordance with recognised good professional practice. This issue is more systemic in nature and one of the themes throughout the work of this review, which is what response to domestic violence, should be expected, or can realistically be achieved, from non-specialist frontline staff, which I will explore further below.

ii.	*Did any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved?*

There were no occasions where an agency or professional raised a concern about the family.

iii.	*Whether the homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.*

The risk to Adult A and the risk of Adult B to himself were not identified by any professional and no reports were made by professionals that would trigger the enacting of procedures, formal or otherwise. Circle 33 did not follow their own procedure in responding to Adult A's transfer request (see section 2.4.8). There were two missed opportunities to explore and identify risk but these do not point to a *failure* of procedure, more to a *lack* of procedure.

iv.	*Where the homicide appears to have implications/reputational issues for a range of agencies and professionals.*

There are a number of recommendations from the Review Panel that have implications beyond the individual agencies named in the review. These are concerned with improving the response of professionals who are not domestic violence specialists but nevertheless have a critical role in providing a route to safety for those at risk. The recommendations to improve the response of family law solicitors and GPs have implications beyond the individual agencies concerned.

There are additional implications for the commissioning of services, where requirements for a high quality response to domestic violence could be embedded within the service specifications and supported through quality assurance monitoring. The response to domestic violence should also look at both victimisation and perpetration with an expectation that commissioned services, where appropriate, have the skills to respond to perpetrators of domestic violence, as well as those at risk.

v. Does the homicide suggest that national or local procedures or protocols may need to change or are not adequately understood or followed?

The review highlighted two areas that benefit from being addressed at national level:

1. The review noted that there was no protocol for sharing of information with an offender's GP when an offender is sentenced to attend a substance misuse treatment programme. While LPT have acted quickly to address this, the most effective place to address this is within the National Standard.

2. The review noted that there is lack of guidance for family law solicitors on recognising and responding to domestic violence risk, in a way that moves beyond a response focussed on legal remedies. This is an issue for the bodies (The Law Society and Resolution) that run accreditation schemes and provide guidance for solicitors on effective services.

vi. Where the victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

Haringey has a strong, well regarded group of specialist domestic violence agencies working within the borough and these are active across multi-agency settings and to the public. However, more can be done to ensure the visibility of information on domestic violence and sources of help in non-specialist agencies. Improving the quantity of visible information needs to go alongside increasing awareness within non-specialist services and the wider public of the vital role they have in early identification of domestic violence.

Use of the language of domestic violence and access to help

No one in the family was known to the domestic violence or safeguarding agencies. It was suggested by a family friend that Adult A may not have named what she was experiencing as domestic violence and therefore may not have seen domestic violence agencies as a source of help for her.

The Panel has considered whether the language used to raise awareness of domestic violence is in itself a barrier to help-seeking. Although this was not the view of the Panel, there does seem to be a need for awareness-raising on the broad spectrum of what is domestic violence, to challenge any perceptions that experiencing physical violence is what defines domestic violence. There is also a need to dispel myths about victims of domestic violence. In some of the interviews and IMR reports there is mention that Adult A came across as calm and confident and therefore not fitting many commonly held perceptions of someone at risk.

The role of service providers who are not specialist domestic violence agencies

The task of naming domestic violence and recognising the indicators of abuse, in order to increase the safety of those at risk and to support help-seeking, is the responsibility of all professionals, not only those whose explicit remit is management of risk and safeguarding. The value of this is clearly evident where Adult A did raise concerns, although not explicitly, about what was happening in her relationship with Adult B and those concerns were not explored further, responded to, or followed up on. As a result, opportunities to identify risk were missed.

Many people experiencing domestic violence will not necessarily name their experience as domestic violence, although they may seek help to reduce risk and create a better life, as Adult A did when she requested a housing transfer, sought legal help, and raised concerns about the stress she was experiencing with her GP.

The ability of non-specialist staff to recognise indicators of domestic violence (whether this is with victims or perpetrators of domestic violence), to respond sensitively and appropriately, to understand risk and to refer on to specialist agencies is essential in a community response to domestic violence. This model of **Recognise, Respond, Risk assess and Refer** has been referred to as the four Rs.

Professionals who provide services to the public that are likely to be used by people experiencing domestic violence would benefit from having the basic skills around the four Rs model, together with a policy that supports them in providing an effective response to domestic violence. Turning this into a reality presents challenges for busy service providers. However, there are good models to draw on of context-specific effective domestic violence responses from non-specialist agencies. The IRIS initiative[12] for GP practices, enhanced domestic violence response from employers[13] and responses developed by some housing associations[14] are all excellent examples of how to develop a four Rs approach that is fit for the context of the service provider.

Identification of risk

If Adult A had been identified as experiencing domestic violence and been the subject of the most commonly used risk assessment tool, the DASH[15] (or any of the commonly used risk assessment tools), it is unlikely that this would have resulted in a high risk score. Providers of risk assessment tools advocate that people undertaking assessments also use their professional judgement[16] and do not rely solely on the risk assessment score.

Preceding this homicide, there was a cluster of risk indicators: problematic drinking, threats of suicide and threats to kill, set against the situational indicator of contested imminent separation, all of which would give rise to concerns about short term,

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[12] http://www.irisdomesticviolence.org.uk/

[13] Respect and Refuge gave awards in 2011 to Edinburgh City Council and Lancashire County Council for their work in creating workplace responses to domestic violence. Also see http://www.respect.uk.net/pages/the-domestic-violence-resource-manual-for-employers.html

[14] See http://www.insidehousing.co.uk/care/light-bulb-moment/6521715.article

[15] http://www.caada.org.uk/dvservices/RIC_and_severity_of_abuse_grid_and_IDVA_practice_guidance.pdf

[16] See page 2 http://www.caada.org.uk/dvservices/RIC_and_severity_of_abuse_grid_and_IDVA_practice_guidance.pdf

acute, high risk. These are the risk indicators commonly identified by researchers[17] specifically looking at that sub-section of perpetrators who commit intimate partner homicide-suicide.

In developing better responses to domestic violence from non-specialist service providers, understanding of risk is critical. This can be greatly enhanced by the use of risk assessment tools like the DASH tool. Alongside this, there needs to be recognition of where an acute risk exists, which because of a low level of previous physical violence, may not score as high risk in the commonly used assessment tools.

[17] Aldridge, M.L. and Brown, K.D. (2003) Perpetrators of Spousal Homicide: A Review. *Trauma, Violence and Abuse,* 4, 265-276 Also- Bossarte, R.M. and Rying, M. (2004) Characteristics of homicide followed by suicide incidents in multiple states, *Injury Prevention 12, 33-38*

Section Four: Recommendations

4.1 School

- The school can be commended for having a peer mentoring scheme. This could be strengthened by ensuring that domestic violence and issues around parental separation are covered as part of the peer mentor training. The school should explore effective ways of developing this.
- The visibility of sources of advice and help, and invitations to pupils to access these, should be reviewed. The school may wish to consider using the peer mentors to shape and inform this review.
- The school should review the breadth of its PSHE curriculum to ensure that issues on domestic violence, risk and sources of help are effectively covered.
- The school to participate in the LSCB's link with secondary schools in sharing best practice in relation to safeguarding.

4.2 University A

- University A to explore ways to promote its support services in ways that speak specifically to young men, to consult with agencies with expertise in engaging with men and access appropriate materials.

4.3 University B

- University B to improve consistency across university sites of the information displayed about sources of help for domestic violence.

4.4 North Middlesex University Hospital Trust (NMUHT)

- NMUHT to review its guidance on how the Trust will respond where domestic violence is identified, upon referral or subsequently and specifically where perpetrators and victims of domestic violence will be referred or signposted.

4.5 London Probation Trust (LPT)

- There is no mechanism for an offender's GP to be informed that he or she has received a sentence requiring that they attend a substance or alcohol treatment programme. LPT should establish such a mechanism so that in the future GPs will be informed when their patient is sentenced to attend a treatment programme.
- LPT to be satisfied that there is compliance with enhanced risk management processes and put in place quality assurance processes that ensure practice in line with procedures when in responding to hidden harm.

4.6 Haringey Alcohol Advisory Group (HAGA)

- HAGA to change their records retention policy and bring this in line with other agencies attending the Haringey MARAC.

- HAGA to improve the assessment process in relation to domestic violence. This will require improving the skills and knowledge of staff undertaking these assessments, including skills in exploring abusive behaviour with those who may be perpetrating domestic violence. The approach will need to be both risk and intervention focussed.
- HAGA to improve the level of expertise of staff in responding to domestic violence, specifically skills in responding to domestic violence perpetrators. This will require external expertise and training, particularly in relation to risk assessment and management.
- HAGA to develop a service response to perpetrators of domestic violence that responds to the risk, alcohol issues and use of violence and abuse in relationships.
- HAGA to work with community mental health services to strengthen and clarify referral pathways and joint working arrangements, ensuring these are clear and understood across the service.

4.7 Haringey Drug and Alcohol Action Team (DAAT)

- The DAAT to require commissioned services to have training on identifying domestic violence perpetrators and victims, in line with the Recognise, Respond, Risk Assess and Refer model.
- DAAT to monitor the level of service users of DAAT commissioned services identified as experiencing domestic violence or perpetrating domestic violence to ensure that current screening processes are effective.
- DAAT to ensure that commissioned services are in no doubt as to the need to respond effectively to service users who are using domestic violence by referring to and working with Respect Accredited Services and the LPT.
- All DAAT commissioned services should have a clear contractual direction regarding their file retention policy.

4.8 Circle 33 Housing Association

- Circle 33 to check all records to ensure that no other requests for transfer or support were missed during the period of time where administration systems were weak.
- Circle 33 to ensure that current systems and procedures are able to identify tenants who may be at risk of domestic violence as early as possible.
- All Circle 33 staff to have domestic violence training that is commensurate with their role; this includes administration staff where appropriate.
- Circle 33 to review its current domestic violence and safeguarding policy to ensure it is fit for purpose and in line with best practice in the housing sector.
- Circle 33 to seek out learning from other housing associations on how to improve responses to domestic violence and adopt best practice from elsewhere (e.g. Metropolitan Housing Association and Peabody Trust).

4.9 General Practice

- The General Practice to develop a policy on domestic violence that includes a requirement that all staff have training on domestic violence in line with their responsibilities.

- That information on sources of help for those experiencing domestic violence and for perpetrators of domestic violence is visible and readily available within the Practice.
- The Panel would wish the General Practice to consider adopting the Royal College of General Practitioners' (RCGP) guidance on responding to domestic violence.

4.10 Haringey and Enfield Clinical Commissioning Groups

- The Panel would like clinical commissioning groups (CCGs) to be assured that primary care are adopting the RCGP guidance and considering the IRIS model to improve the early identification of domestic violence.

4.11 Tyrer Roxburgh Solicitors

- Tyrer Roxburgh Solicitors to ensure that all staff working with clients who are at risk from domestic violence, or who may be perpetrating abuse, have training on how to recognise risk, how to respond effectively (including referrals to MARAC) and to have information visibly available in its offices about local domestic violence services and services for perpetrators of abuse.
- Tyrer Roxburgh Solicitors to review whether sending a letter outlining the legal options for removing an ex-partner from the family home should continue as a stand-alone response, or whether this needs to be accompanied by actions that identify and respond to risk.

4.12 Haringey Domestic Violence Operational Group

- The Operational Group to consider the key role of family law solicitors in providing routes to safety for those experiencing domestic violence. The solicitor or paralegal may be the only professional who has any knowledge that someone may be at risk and they may need support to work safely and appropriately. The borough's specialist domestic violence services work closely with some of the family law solicitors in the area, to the benefit of clients of both services. The partnership between domestic violence services and solicitors is of value and there should be an exploration of providing a kite marking process that acknowledges the enhanced service provided by those solicitors that have staffed trained to recognise and respond to clients at risk from domestic violence.
- The Operational Group to consider a recommendation that Haringey domestic violence services will only recommend legal firms that have achieved the kite mark mentioned above.

4.13 Haringey Domestic Violence Strategic Group

- The Strategic Group should consider the development of an awareness raising programme to assist recognition, response and referral of those at risk from domestic violence to specialist services. This should focus on behaviour and situations of risk which is not limited to physical violence.

4.14 Haringey Children and Young People's Service

- Haringey Children and Young People's Service to find a way to recognise the valuable contribution that can be played by a family friend when they step into a crisis where children are suddenly bereaved. Following the deaths of Adult A and Adult B, a family friend played a very important role in meeting the needs of their children over a sustained period. While there were a number of agencies and professionals looking to the needs of Young People C and D, the needs of the family friend also need to be acknowledged and responded to.

Author of report:	**Neil Blacklock**
Designation and organisation:	**Development Director, Respect**
Date:	**22 February 2013**

Appendix One: Chronology of significant events and agency involvement

Date	Event
12.12.63	Adult B born in Ghana
26.01.66	Adult A born in Ghana
09.08.89	Adult B and Adult A marry in Ghana
1991	Adult A resident with Adult B in Tottenham
1992	Young Person C born in the UK
1996	Young Person D born in the UK
25.07.02	Adults A and B marry in civil ceremony
2003	The family move to address where the homicide took place
07.03.06	Adult B convicted of a drink driving office, sentenced to probation supervision and attendance in Drink Impaired Drivers Course
22.12.06	Adult B in court for breaching the conditions of his Community Order
2007	Adult A attended HAGA complying with the conditions of his Community Order
2007	Adults A and B remain in the same house but start to live separately
March 2011	Adult A awarded a degree in Psychology
September 2011	Young Person C started his degree course at University A
February 2012	Adult B's business fails and he declares bankruptcy
March 2012	Adult B's mother dies
11.04.12	Adult A starts divorce proceedings
17.04.12	Adult B agrees to move out of the family home and is not contesting the divorce
30.04.12	Adult B returns signed divorce papers to solicitor
20.05.12	Adults A and B argue late on at night
21.05.12 morning	Adult A drives Young Person D to school
21.05.12 lunchtime	Adult A calls her solicitor – tells him that Adult B had returned home the night before and left the gas cooker on and that she wants him to leave
21.05.12 between 16.30-17.30hrs	Young Person D returns home after Adult A fails to pick her up after school. She is unable to gain access to the family home and goes to stay with friends and returns later
21.05.12 - 21.27hrs	After being unable to contact Adult A or gain access to the home, the police are called who then force entry to the house and find the bodies of Adults A and B

Appendix Two: Terms of reference

HARINGEY DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE: CASE A

1. Introduction

Domestic Homicide Reviews (DHRs) are a vital source of information to inform national and local policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims.

As far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame. Subsequent learning should be disseminated to the local MARAC, any local Domestic Violence Forums or similar, the Local Safeguarding Children Board and commissioners of services. It should also be incorporated into local and regional training programmes.

2. Purpose of this review

The purpose of this DHR is to:

- 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 and to hold perpetrators to account
- 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
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

Scope of this review

i) To review events in the twelve month period up to the date of the deaths of Adult B (date of birth 12/12/1963) and Adult A (date of birth 26/01/1966) on 21 May 2012 unless it becomes apparent to the Independent Chair that the timescale in relation to some aspect of the review should be extended.
ii) To include events outside the twelve month period where these are relevant.
iii) To review the actions of the agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act (2004) who were involved with the A family and – at the initiative of the Chair and subject to their agreement – any other relevant agencies or individuals.
iv) To seek to involve the family in a sensitive and considered manner and include their potential contribution to the review in the way set out in Section 7 of the Home Office Multi-Agency Statutory Guidance for the Conduct of DHRs.
v) To produce an overview report which:
    - Summarises concisely the relevant chronology of events including the actions of all the involved agencies
    - Analyses and comments on the appropriateness of actions taken
    - Makes recommendations which, if implemented, will better safeguard families and children where domestic violence is a feature

- Takes into consideration the findings of Haringey Local Safeguarding Children Board (LSCB) Serious Case Reviews involving domestic violence, with a particular focus on the needs and experiences of children who witness domestic violence.

vi) To complete a final overview report by the end of November 2012, acknowledging that this will be dependent, to some extent, on the completion of agency individual management reviews to the standard and timescale required by the Independent Chair.

3. Circumstances of particular concern

The DHR will focus on the following areas of particular concern, with a particular focus on paragraph vi:

1. Was there was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with their recognised best professional practice.
2. Did any of the agencies or professionals involved consider that their concerns were not taken sufficiently seriously or not acted on appropriately by the other parties involved?
3. Whether the homicide indicates that there have been failings in one or more aspects of the local operation of formal domestic violence procedures or other procedures for safeguarding adults, including homicides where it is believed that there was no contact with any agency.
4. Where homicide appears to have implications/reputational issues for a range of agencies and professionals.
5. Does the homicide suggest that national or local procedures or protocols may need to change or are not adequately understood or followed?
6. Where the victim had no known contact with any agencies. For example, could more be done in the local area to raise awareness of services available to victims of domestic violence?

Membership of Haringey's Domestic Homicide Review Panel

Independent Chair (external appointment)
Haringey Council
Community Safety Partnership Strategic Manager
Assistant Director, Children & Young People's Service
Domestic and Gender Based Violence Co-ordinator
Deputy Director, Adult and Community Services
Head of Safeguarding Adults Service
Director of Public Health
Assistant Head of Legal Services
Senior Policy Officer, Policy and Equalities
Police
Critical Incident Advisory Team (CIAT), Metropolitan Police Service
Haringey Community Safety Unit, Metropolitan Police Service
Probation
Senior Probation Officer, London Probation Trust
Health
Designated Nurse Child Protection, NHS North Central London, Haringey
Voluntary and community sector
Manager, Independent Domestic Violence Advocates, Nia
Executive Director, Haringey Women's Forum and Chair, Haringey Domestic and Gender Based Violence Operational Group

4. Independent Chair of the Review Panel

In line with Home Office Guidance published in 2011, the Independent Chair of the Review Panel will be responsible for:

- Managing and coordinating the review process
- Commissioning individual management reviews
- Discussing with relevant criminal justice and/or other agencies (e.g. HM Coroner, Senior Investigating Officer (SIO), Independent Police Complaints Commission) at an early stage how the review process should take account of such proceedings
- Liaising with family and friends, working with the police Family Liaison Officer and the Children and Young People's Service Social Work Team
- Producing the final Overview Report based on Individual Management Reviews (IMRs) and any other evidence the Review Panel decides is relevant.

Additional support will be provided by the Review Panel within existing resources in relation to specialist domestic violence, project management and administration. The Review Panel will monitor Haringey's chairing arrangements; if it is felt these are not working effectively, the Panel will meet to determine an alternative way forward.

5. Equality and diversity

The Independent Chair and members of the Review Panel will bear in mind all equality and diversity issues at all times. These include: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. These may have a bearing on how the review is explained and conducted and the outcomes disseminated to local communities.

6. Timescales

Event	Date	Who
Advise Home Office of decision to establish a Domestic Homicide Review,	29 June 2012	Chair, Community Safety Partnership
Advise individual agencies to secure case records and begin to draw up a chronology of involvement with the victim, perpetrator and their families	Initial email: 2 July 2012 Further guidance 6 August 2012	Chair, Community Safety Partnership
Appoint independent chair	6 July 2012	Review Panel
Complete Overview Report	30 November 2012	Independent Chair

7. Involvement with friends, family members and other support networks

When meeting with friends, family members and others, the Review Panel will:

- Communicate through a designated advocate who has, where possible, an existing working relationship with the family i.e. a voluntary or community sector representative.
- Make a decision regarding the timing of contact with the family based on information from the advocate and taking account of other on-going processes i.e. post mortems, criminal investigations.
- Ensure initial contact is made in person and to deliver any relevant information leaflets.
- Ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.

- Explain clearly how the information disclosed will be used and whether this information will be published.
- Explain how their information has assisted the review and how it may help other domestic violence victims.
- Provide a completed version of the review to the family prior to submitting the report to the Home Office. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.
- Maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential consequences of publication i.e. media attention and renewed interest in the homicide.

The Review Panel may also wish to access other networks which victims and perpetrators may have disclosed to, for example, employers, health professionals, local professionals involved in domestic violence perpetrator programmes (DVPPs) or their local voluntary and community sector (VCS) agencies.

8. Individual Management Reviews (IMRs)

Agencies will:

- Secure all relevant case records as soon as notification of the DHR is received.
- Begin the IMR as soon as a decision is taken to proceed and once the terms of reference have been set, including a chronology of their involvement with the victim, perpetrator or their families, using the guidance and terms of reference provided by the Independent Chair of the DHR.
- Keep a written record of interviews undertaken in the preparation of the IMR which should be shared with the relevant interviewee.
- Remind staff that the review does not form part of a disciplinary investigation. The views of the SIO and subsequent CPS advice must be sought prior to interviewing witnesses involved any criminal proceedings.
- Ensure that professionals outside the IMR process (such as GPs) should contribute reports of their involvement with the victim(s) and/or perpetrator(s).
- Ensure that the officer conducting the IMR has not been directly involved with the victim, the perpetrator or either of their families and should not have been the immediate line manager of any staff involved in the IMR.

The IMR will enable agencies to:

- Look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made/
- Identify how those changes will be brought about.
- Identify examples of good practice within agencies.
- Indicate if disciplinary action should be taken under the agency's established procedures (although this is not part of the IMR and should be pursued separately by the agency).

The senior manager of the agency will:

- Quality assure their report, ensuring that any recommendations from both the IMR and, where appropriate, the Overview Report are acted on appropriately.
- Feedback and debrief staff involved in the review, following completion of the IMR, with a follow-up sessions once the Overview Report has been completed and prior to its publication.

9. Overview Report

The Chair of the DHR will:

- Bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests into the Overview Report.
- Make recommendations for future action which the Review Panel will translate into a SMART action plan.
- Ensure that the findings are regarded as 'Restricted', in line with the Government Protective Marking Scheme (GPMS) until the date of publication. Prior to this, information should be made available only to participating professionals and their line managers who have a pre-declared interest in the review. It may also be appropriate to share these findings with family members, as directed by the Independent Chair.
- Appoint lead individuals or agencies to take responsibility for engaging with family members and friends, and for responding to media interest about the review, in liaison with contributing agencies and professionals.
- Direct that all media enquiries are to be dealt with by Haringey Council's press office in line with Council's media and PR guidelines.

The Review Panel will:

- Keep personal details anonymous within the final report and Executive Summary.
- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report.
- Ensure that the Overview Report is of a high standard and is written in accordance with the Home Office Guidance for the Conduct of Domestic Homicide Reviews (April 2011).
- Translate the recommendations in the Overview Report into a specific, measurable, achievable, realistic and timely (SMART) Action Plan, agreed at senior level by each of the participating organisations.
- Ensure that the Action plan sets out who will do what, by when, with what intended outcome; the Panel will also set out monitoring and reviewing arrangements in the Action Plan.
- Provide a copy of the Overview Report, Executive Summary and Action Plan (known collectively as the 'supporting documents') to the Chair of Haringey's Community Safety Partnership (CSP).

Haringey's CSP will:

- Agree the content of the Overview Report and Executive Summary for publication, ensuring that it is fully anonymised apart from the names of the Review Panel Chair and members.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.
- Sign off the Overview Report and supporting documents.
- Provide a copy of the Overview Report and supporting documents to the Home Office Quality Assurance Group.
- After clearance from the Home Office Quality Assurance Group:
  - Publish the document.
  - Provide a copy of the Overview Report and supporting documents to the senior manager of each participating agency.
  - Upload an electronic copy of the Overview Report and Executive Summary to the CSP webpage.
  - Monitor the implementation of the Action Plan.
  - Formally conclude the review when the Action Plan has been implemented and include an audit process.

Appendix Three: Redaction framework for DHR

General principles

1. The DHR's aim is to ensure that a proper analysis of the issues relating to a homicide is obtained which enables lessons to be learned without blame being apportioned. The report is produced in accordance with Home Office guidelines.

2. Any redaction within the report should seek to properly balance rights to privacy and confidentiality in a way which does not affect the proper analysis of agencies' actions and what lessons should be learned.

3. Information already in the public domain should not be redacted retrospectively unless a specific barrier exists in law.

4. Where information is redacted this should be obvious to the reader. The majority of redactions are likely to be in relation to personal data and will in general require no specific explanation. Redactions other than for protection of personal data should be accompanied by a short explanation (at an appropriate place in the report) unless to do so would in itself place a person at risk of harm.

5. The identities of all professionals, family and associates shall be redacted in accordance with a standard scheme which reveals the professional status or family background, but not the name e.g HV1 for Health Visitor 1; GP1 for General Practitioner etc.

Safety issues

6. Both Executive Summary and Overview Report will be published in accordance with government guidelines. The nature of the information therefore entering the public domain may be such that children and adults may be placed at risk of harm.

7. If, in the opinion of the report author, facts which might be included in the report could place an individual at risk of harm then s/he shall redact it to remove such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Sensitive personal information, including health information

8. If, in the opinion of the report author, the inclusion of sensitive personal information about living individuals would infringe upon their legitimate expectations as to privacy or their rights to privacy under Article 8 The Human Rights Act 1998 or the Data Protection Act 1998, then s/he shall redact it to remove, edit or amend such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Audit and moderation

9. The Domestic Abuse Programme Manager shall maintain a list of any such specific redactions which shall be submitted to the DHR Panel for moderation on such frequency as is appropriate to the case.

Appendix Four: Glossary and abbreviations

Alcohol Treatment Programme. Community sentence that requires the offender to attend supervision with a probation officer and a requirement to attend sessions with alcohol treatment worker see http://www.london-probation.org.uk/PDF/Sentencers_Sentencer%20Bulletin_June2010.pdf

Community Order. The name given to a sentence where the offender spends the whole of their sentence in the community, rather than in prison, and attends supervision with a probation officer. See http://www.london-probation.org.uk/what_we_do/community_order.aspx

CSP. Haringey Community Safety Partnership

DAAT. Haringey Drug and Alcohol Action Team

DASH. Risk identification checklist, an abbreviation of Domestic Abuse Stalking and Harassment, developed by CAADA and Laura Richards. There is a police version which has 27 items and 24 item version. See http://www.dashriskchecklist.co.uk/ and www.caada.org.uk

DGBV. Domestic and gender based violence

DHR. Domestic Homicide Review, in line with Home Office guidance 2011

Drink Impaired Driver Programme. A fourteen session group programme to help people avoid drinking and driving see http://www.swmprobation.gov.uk/wp-content/uploads/2010/06/drink_impaired_drivers__dids_leaflet_-_june_2010.pdf

DVIP. Domestic Violence Intervention Project, a voluntary sector organisation providing a range of interventions for the people using violence and abusive behaviour in relationships. See http://www.dvip.org/

HAGA. Haringey Advisory Group on Alcohol

IDAPA Programme – Group Programme for offenders convicted of a domestic violence related offences – IDAPA is shortened version of the IDAP. See http://www.westyorksprobation.org.uk/content.php?pageid=218

IDVA. Independent domestic violence advocate

IRIS Project. A GP focussed training and referral programme on domestic violence. See http://www.irisdomesticviolence.org.uk/

IMR. Individual management review, in line with Home Office guidelines for multi-agency domestic homicide reviews 2011

JSNA. Joint strategic needs assessment

LPT. London Probation Trust

LSCB. Local Safeguarding Children Board

MARAC. Multi-Agency Risk Assessment Conference. A multi-agency setting where high risk domestic violence cases are reviewed and strategies developed to reduce risk. See http://www.caada.org.uk/marac/Information_about_MARACs.html

MPS. Metropolitan Police Service

Nia. Voluntary sector violence against women agency working in North London with a broad range of services. See http://www.niaendingviolence.org.uk/

NMUHT. North Middlesex University Hospital NHS Trust

PAA. Personal academic advisor

PSHE. Personal, social and health education curriculum in schools

Respect. National membership organisation that develop, deliver and support effective services for; perpetrators of domestic violence, young people who use violence and abuse at home and in relationships and men who are victims of domestic violence. See http://www.respect.uk.net/

RCGP. Royal College of General Practitioners

SDVC. Specialist Domestic Violence Court