STANDING together
against domestic violence

DOMESTIC HOMICIDE REVIEW

Executive Summary

The London Borough of Croydon
Case of Adult H

Joint Chairs Anthony Wills and Victoria Hill

April 2015

Introduction

1.1 This executive summary outlines the process and findings of a domestic homicide review undertaken by the London Borough of Croydon into the murder of Adult H. The identity of those involved has been anonymised for the purposes of confidentiality.

Facts

Adult H's death

2.1 On 20/12/2012, Child F had been feeling unwell. As a result she did not go to school and was left in the care of her father (Adult G, the perpetrator) whilst her mother (Adult H, the victim) went to work. Adult H and Adult G had actually separated at this time but they were in regular contact with each other. Adult G had a new girlfriend (Adult M), who received two text messages on that day from him. One said that he wished he had killed himself and the second message at 13.30hrs indicated that he wanted to attend Accident and Emergency and as he was feeling down. He said he was waiting for Adult H outside her workplace and wanted to spend time with his child prior to attending the hospital.

2.2 Adult G drove to Adult H's place of work (with Child F) to pick Adult H up from work, and they then returned to Adult H's address.

2.3 Later that day at 14:58 hrs, the Police received a call from a concerned neighbour who stated that they could hear the sounds of a disturbance at a neighbouring property. A female had been heard screaming and there was a banging noise coming from the address. The informant stated they knew the male and female and believed that the male had mental health issues. Police attended the address ten minutes later at 15:08 hrs and the flat was in darkness with no sounds of disturbance coming from within. The Police visited a neighbour (not the original caller) who stated that they had not heard any disturbance. The Police then left the scene.

2.4 Later at 15:23 hrs, the original informant's partner rang the Police. She asked the Police to re-attend the address as she was concerned that something had happened. The caller repeated that there had been screaming and then it had gone quiet. She stated that no one had left the address, the blinds were down and she was convinced that something had happened. She reiterated that she believed that the male at the address had mental health issues and that there was a young child at the address.

2.5 At 15:45 hrs, nearly one hour after the original call was received, Police re-attended the address and looked through the letterbox with a torch. The officers could see a trail of blood through the hallway and immediately tried to gain access to the flat. The officers managed to force entry to the property and found Adult H lying on the floor of the lounge. She had been fatally stabbed. The officers checked a bedroom and found Child F. She was removed from the flat and taken into Police protection. She had sustained a graze and bruise to her cheek. She said her father had grabbed her and pulled inside her mouth. Later she made comment that Adult G had picked up her mother from her workplace and they were arguing, which continued at home. Her father picked up a knife and stabbed Adult H.

2.6 Officers found Adult G alive in the main bedroom, lying face down with blood on his legs. He had with froth/vomit around his mouth. He was moaning and rocking back and forth. He told Police that his wife had stabbed him in the leg and so he had taken the knife and stabbed her. Adult G said he had taken some pills. He was arrested for murder at 16:00 hrs. He began to shake and became unresponsive. Adult G was put into the recovery position and oxygen was administered.

2.7 On examination by London Ambulance Service (LAS), Adult G was found to have a stab wound to the right side of his thigh above the knee. Intravenous access was successful and Diazepam was administered. Adult G was removed to the ambulance. It is documented that the doctor had concerns about a possible overdose. En route to the hospital Adult G was agitated. Following the LAS's initial examination he was conveyed to St Georges Hospital for further treatment. The ambulance left the scene at 16:46 hrs and arrived at the hospital at 17:32 hrs.

2.8 Whilst Police officers were at the scene, Adult G's Psychological Care Nurse arrived for a pre-arranged appointment to assess his wellbeing.

2.9 Adult H's life was pronounced extinct by the LAS at 16:05 hrs on 20/12/2012.

The relationship between Adult H and Adult G

2.10 Adult H and Adult G were in a long term relationship and were together for ten years (they met when Adult H was 13 years old and had been together since Adult G was 15 years old). They married in 2006 and that same year Adult H gave birth to their child (Child F). At the time of her death, Adult H was aged 25 years and Adult G was 28 years. Their daughter was 6 years old. Despite being separated at the time of her death, they had presented to mental health services as a couple.

2.11 During the relationship there were three incidents of domestic violence reported to Police: a matter of fraud in 2006 (which was not flagged as being a domestic), one to Sussex Police in 2007 and an incident on two days before Adult H's death) which was reported to the Metropolitan Police.

The perpetrator – Adult G

2.12 Following his conviction, Adult G was written to by the independent chair to enquire whether he wished to contribute to the review. No response to this letter was received.

2.13 Adult G had one caution and three convictions for four offences. At the time of Adult H's death, Adult G had three impending offences for fraud which have now been committed to court. He was on unconditional bail following his arrest for assault on Adult H two days before her death.

2.14 Adult G is of Turkish origin and worked as a personal trainer. He was also a body builder. Following his separation from Adult H in 2011, he started a new relationship (having met his new partner at a gym they worked at). Subsequent to Adult H's death, his new partner (Adult M) told the Police that Adult G's behaviour had become erratic during their relationship. She had formally reported him missing on two occasions. There was a suggestion that Adult G also used anabolic steroids and cocaine. He had previously been sectioned for an assessment of his mental health.

2.15 Although Adult G and his family frequently reported that he had a diagnosis of Bipolar Disorder, this was excluded by SLaM as such a diagnosis requires at least two episodes of hypomanic, manic, mild to severe depression, with or without psychotic symptoms. Manic episodes usually begin abruptly and last for between two weeks and four to five months with depressions lasting much longer[1]. Adult G did not report that his symptoms lasted more than a few hours or one or two days.

2.16 All mention of Adult G having Bipolar Disorder in this report should therefore be understood as ***"Adult G's claimed Bipolar Disorder".*** It has been deemed that it was most likely that he had features of both emotionally unstable and dissocial personality disorder.

2.17 Adult G received care and treatment from several CAGs within SLaM, these were:

[1] CG38 – Bipolar Disorder, National Institute for Health & Clinical Excellence revised April 2012

2.17.1 Psychological Medicine - provides Liaison Services at Croydon University Hospital, Croydon Home Treatment Services and Croydon Triage Ward.

2.17.2 Psychosis – provides section 136 Place of Safety facilities and Acute wards including Gresham 2 Ward.

2.17.3 Mood, Anxiety and Personality - provides assessments and treatment in the community from teams such as East Croydon MAP; as well as talking therapies and social care for self-help including Croydon Intensive Psychological Therapies Service (IAPTs).

Sentencing of Adult G

2.18 On 03/02/2014. Adult G pleaded guilty of the manslaughter of Adult H. Judge Nicholas Cooke QC said BS would have received a twenty year minimum sentence if it was a murder charge.

2.19 The court heard evidence from two forensic psychiatrists who agreed he was suffering from a drug-induced psychosis and a borderline personality disorder. The charge of assault occasioning actual bodily harm (ABH) relating to Child F was ordered to lie on the court file.

2.20 The judge in sentencing Adult G said: *"The circumstances of this offence were extremely grave. You stabbed a defenceless victim to death in a ferocious attack... I am satisfied that you are dangerous and will remain so for an unascertainable period. The combination of an untreatable personality disorder and a propensity to abuse drugs against the background of the explosion of violence dictates as much. I have therefore been driven to the conclusion I must pass a sentence of life imprisonment. It is a life sentence which means you will be released when it is decided it is safe to do so. I have utmost sympathy for the deceased's family."*

2.21 Adult G will have to serve at least ten years and eight months before being considered for parole.

2.22 The Judge made reference to domestic violence and that there were too many domestic violence murders occurring.

The Domestic Homicide Review Process

3.1 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Community Safety Partnership (CSP) in the London Borough of Croydon. The initial meeting was held in March 2013 and there have been four subsequent meetings of the DHR panel to consider the circumstances of this death.

3.2 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

3.3 The purpose of these reviews is to:

3.3.1 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.

3.3.2 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.

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

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

3.4 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Terms of Reference for the DHR

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

DHR methodology

3.6 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Adult H or Adult G. IMRs included chronologies for contact in the period agreed by the panel for the terms of reference.

3.7 The time period subject to the review was the 01/01/2005 to 20/12/2012. This time period was agreed to cover Adult H's pregnancy with Child F. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

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

Parallel reviews

3.9 The Independent Police Complaints Commission (IPCC) investigation into events that lead to Adult H's death has been completed. The investigation focused on:

3.9.1 Adult G being released on unconditional bail on 19/12/2012.

3.9.2 The response by the uniformed officers who originally attended Adult H's address on the 20/12/2012.

3.9.3 Several Police officers were to be subject of Unsatisfactory Performance Procedures. Of these Police officers, two are to attend Stage 3 Gross Incompetence Meetings; however, no date has yet been set.

3.10 Croydon Safeguarding Children's Board did not undertake a serious case review.

3.11 Now that the criminal case is concluded, a panel at NHS England will make a decision on whether to commission an independent investigation in the mental health care and treatment of Adult G.

Composition of the DHR panel

3.12 Agencies and services represented:

- Metropolitan Police – Croydon borough and Critical Incident Advisory Team
- Croydon Council – Public Realm and Safety
- Croydon Council – Social Care and Family Support
- Croydon Council – Public Health
- Croydon Council – Adult Social Services and Housing[2]
- Croydon Council – Safeguarding and Looked After Children Service

[2] Croydon Landlord Services provided an IMR and a chronology for the review.

- NHS England
- Croydon Clinical Commissioning Group (author of GP IMR)
- Croydon Health Services NHS Trust
- London Probation Trust
- South London & Maudsley NHS Foundation Trust
- Croydon Family Justice Centre
- London Ambulance Service NHS Trust
- Standing Together Against Domestic Violence (chair)

A full list of panel members is contained in Appendix 2.

3.13 Up until November 2013, the independent chair of the DHR was Anthony Wills. Anthony Wills was an ex-Borough Commander in the Metropolitan Police, and was previously the Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing effective, coordinated responses to domestic violence. Anthony Wills retired from Standing Together in November 2013 and also from his position as independent chair of this review.

3.14 Anthony Wills was supported in this review by Victoria Hill, an associate consultant for Standing Together. Victoria Hill has fifteen years' experience of working in the domestic violence sector and she supported Anthony Wills in his role of chair throughout this review, drafting the overview report and has attended the panel meetings.

3.15 Following Anthony Wills retirement, Victoria Hill has taken on the role of the independent chair for this review. Both Anthony Wills and Victoria Hill have had no connection to the London borough of Croydon or with any agency involved in this case.

3.16 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Overview of health services in the London Borough of Croydon

3.17 Adult G's contact with General Practice, Mental Health Services and the Hospital Trust is extraordinarily difficult to navigate and present to the reader in a concise way that outlines his journey through services and how the risks to Adult H and Child F were considered. The outline of both his and Adult H's contact with health services needs to be cross referenced together by the reader, as there were several occasions when they saw different health services on the same day.

3.18 The chronology details a complex pattern of contact that Adult G had with different GP practices. It is summarised below to assist the reader:

3.18.1 Adult G's first noted contact with GP Surgery in Greenwich was in November 1999. In June 2006 he registered at a different GP Surgery (in Blackheath). He was living in Blackheath at that time. In April 2009, Adult G returned to the GP Surgery in Greenwich, but six months later was seen at the GP Surgery in Blackheath (he had another consultation with them later in March on 2011). On 25/03/2011, Adult G saw a GP at both the GP Surgery in Greenwich and Blackheath (this is his last contact with the GP Surgery in Greenwich). In November 2012, he registered with a new GP Surgery (the same one as Adult H in Croydon).

3.18.2 Adult H's first contact with her original GP was in June 2005. In July 2009 she registered with the Green Surgery, which Adult H then later joined.

3.18.3 Adult G had contact with three GP practices and well as two mental health Trusts: South London and Maudsley (SLaM) NHS Foundation Trust and Oxleas NHS Trust.

3.19 Due to the complexities of the health services in this area and the fact that the individuals involved in this review have had contact with a variety of health providers, a brief overview of each organisation is provided below:

Croydon Health Service NHS Trust

3.20 Croydon Primary Care Trust (PCT) was established as a provider and commissioner of services in 2002. Croydon PCT became the commissioning PCT in August 2009. Croydon PCT Then became NHS South West London: Croydon Borough Team in 2011 and was responsible for commissioning services on behalf of the population of the local borough.

3.21 Croydon Community Health Service was the provider arm of Croydon PCT until 01/08/2010 when it amalgamated with the Croydon University Hospital (CUH) and became Croydon Health Service NHS Trust. As of 2012, Croydon Health Service is now divided into four clinical directorates:

- Adult Care Pathways
- Surgery
- Cancer and Core Functions
- Family Services.

3.22 Adult H, Adult G and Child F were known to one or more of the following departments within Croydon Health Service:

- Emergency Department Adult and Children
- Children's Universal Service: The Children's Universal Service is an integrated school nursing and health visiting service focusing on promoting the health and wellbeing of families and children aged 0-19 years of age
- Safeguarding Child and Young People's Liaison Service
- Maternity Services.

NHS England

3.23 The NHS England is an executive non-departmental public body. It works under its mandate from the government to improve the quality of NHS care and health outcomes, reduce health inequalities, empower patients and the public and promote innovation. Its key responsibilities include:

- Authorisation and oversight of Clinical Commissioning Groups (CCGs) and support for their on-going development
- Direct commissioning of primary care
- Specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships)
- Developing and sustaining effective partnerships across the health and care system.

South London & Maudsley NHS Foundation Trust (SLaM)

3.24 South London and Maudsley (SLaM) NHS Foundation Trust provides a full range of mental health services for people of all ages from over one hundred community sites in south London, including three psychiatric hospitals and specialist units based at other hospitals. It provides mental health and social care services in partnership with local authorities for people with mental health problems who live the communities of South London. SLaM also provides specialist services to people from across the UK and beyond. Each year, the Trust provides about five thousand people with hospital treatment and supports about thirty thousand people through its community services.

3.25 The services SLaM provides are organised into Clinical Academic Groups (CAGs) that offer the best care and treatment, based upon reliable research evidence. The CAGs are broadly

aligned to care pathways and are each led by a Service Director, a Clinical Director and an Academic lead.

Croydon Clinical Commissioning Group

3.26 Croydon Clinical Commissioning Group (CCG) is a membership organisation made up of all sixty-one GP practices in the London Borough of Croydon. The organisation was established in April 2011 as a shadow organisation and received authorisation from the NHS Commissioning Board (now NHS England) in March 2013. On 01/04/2013, Croydon CCG became legally responsible for commissioning healthcare services for the residents of Croydon.

Individual Management Reviews

4.1 Agencies were asked to give chronological accounts of their contact with Adult H prior to her death. Each agency's report covers the following:

- A chronology of interaction with the victim and/or their family
- What was done or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's point of view.

4.2 Nine of the twelve agencies and services that were involved in the panel responded as having contact with the individuals concerned. These agencies were:

- Metropolitan Police
- Croydon Council – Adult Social Services and Housing
- Croydon Council – Safeguarding and Looked After Children Service
- NHS England
- General Practice
- Croydon Health Services NHS Trust
- London Probation Trust
- South London & Maudsley NHS Foundation Trust
- Croydon Council Family Justice Centre
- London Ambulance NHS Trust.

Contact with family, friends and other people who knew Adult H and Adult G

5.1 The following is a description of the relationship between Adult H and Adult G based conversation(s) which took place with Adult H's father, mother and neighbour. Adult H's sister also spoke with one of the co chairs. It is their view of what took place within that relationship. The information contained in this section and the beliefs of the family will be further considered within the analysis section of this report.

5.2 Adult H's mother (Mother P) and her father (Father K) are no longer together. They were seen and communicated with separately by the co-chairs, and have been contacted regularly as part of the review. From November 2013, the chair has been in regular contact with Adult H's father and mother. She has spoken with them frequently and met with them both twice (to share the draft report). Victoria Hill also spoke with Adult H's sister and she was present at the meeting with her father to review the draft report.

5.3 It was not until the final stages of the DHR process that information was shared by Mother P with the independent chair that Adult H had a half brother. He was written to and provided with an opportunity to engage in the review. He did not respond to the invitation.

5.4 Adult H lived with her mother when she was pregnant with Child F. Adult G then moved in with them after he had been asked to leave his parents' house and had been sleeping in his car. They all lived with Adult H's mother (Mother Pf) or eighteen months before they moved to their own property. Whilst they lived together Adult H, Adult G and Child F spent most of their time in their room and Mother P rarely saw them (this was partly due to renovation work being undertaken on the ground floor of Mother P's house). She felt that Adult G's Bipolar Disorder started when he started to spend all his time in the one room in her house.

5.5 Mother P said that she had never witnessed any violence between her daughter and Adult G, and that her daughter never told her that there had been any. Adult H did not confide in her mother and kept matters very much to herself. Mother P stated that she once overheard an argument between Adult H and Adult G and she asked her daughter if everything was alright and she replied it was. On Christmas Eve December 2011, Adult H arrived at her mother's address in her pyjamas and said that she had had an argument with Adult G. She stayed the night with Child F and returned to Adult G the next morning.

5.6 Adult H would return to her mother's address to collect post and do washing but would not say much about her relationship with Adult G. After she moved out, Mother P would help with Child F. When Mother P visited her daughter at her flat, Adult G was not present. She said that she did not know much about Adult G. She described him as quiet and that he did not speak to her.

5.7 Mother P recalled an incident when Adult G pulled down a kitchen cabinet in anger and was put on an anger management course. She was aware that Adult G had threatened a nurse at the hospital as this was her neighbour.

5.8 Adult H spent most days with Adult G. She asked Mother P to look after Child F when she had to work and also Adult G on occasions. Mother P stated that Adult H had also contacted a social worker as she was concerned about Child F at this time.

5.9 On 8/12/2012, Mother received a text message from Adult H's phone (but not apparently made by her daughter) stating that Adult H was using cocaine and was asking for advice on how to help her. This appears to have been sent to multiple recipients.

5.10 Adult H's father (Father K) disclosed that his daughter did not tell him about the problems between herself and Adult G. Adult G would visit the family home to see Adult H. Adult H's father described Adult G as a quiet and withdrawn young man who did not speak to him much, and would only really interact with Adult H in Turkish.

5.11 Father K believes Adult G isolated his daughter and prevented Adult H from meeting up with her family, he explained that he did not see his grand-daughter until she was five years old.

5.12 Father K thought that Adult H was intending to leave Adult G before her death. He said that she had started to visit him more often, which he suspected Adult G did not know about. During these visits, Adult H did not discuss with her father any fears or concerns she had. Father K did ask how Adult G was, and Adult H would reply that he was busy with work. Father K did not think that Adult G went to work as Adult H was supporting the family financially. Father K said that Adult H loved Adult G and believed she could change him.

5.13 Father K said that his daughter's neighbours had said that Adult G had a bad attitude and that he did not like his neighbours. They described him to Father K as both controlling and unpleasant.

5.14 Father K stated that his daughter kept diaries and he described a domestic violence incident where Adult G threw a table at her. There is no record of Adult H telling the Police about this incident.

5.15 Mother P felt that Adult G demanded much of Adult H's attention, such as after his suicide attempt in April 2012.

5.16 Concerning what Father K believes could have been done differently to prevent Adult H's death, (following Adult H withdrawing her support for a prosecution), he believes that the Police should have spoken to neighbours to obtain further evidence. On the day of Adult H's death, the Police should have made more thorough investigations of the flat and entered it on the first visit, rather than leaving and returning later. He also states that Social Services should have been more involved with the family.

5.17 Mother P feels that the NHS did not fully examine Adult G's mental health and that she and Adult H did not think that the one-and-a-half week stay in Bethlem Royal Hospital was sufficient time to treat Adult G, and that Adult H was very concerned on his release. The hospital reassured Adult H that Adult G would be released with a coordinated care plan, but Mother P said this did not happen. When he became difficult to care for, they did not readmit him back to Bethlem Royal Hospital. Mother P also said that the Police should not have released Adult G without bail conditions.

5.18 A neighbour who was a friend of Adult H was also contacted as part of this review. The neighbour met Adult H in the summer or 2012. They lived in the same apartment block and their daughters regularly played together. Her eldest child went to school with Adult H's daughter (Child F). She described Adult H as very sociable with everyone in the block of flats where they lived.

5.19 The neighbour first met Adult G when they had an argument as she thought that Adult G had hit her car. She explained that she was quite shocked at his reaction as she was very angry and he did not respond, he did not try to argue or and defend himself, he just apologised. She said she did not tell Adult H about that incident. From that incident, she said that she and Adult G avoided each other. The neighbour explained that if she was with Adult H and she knew that Adult G was coming home or nearby, she would make excuses to leave so she did not have to see Adult G.

5.20 Once Adult G approached her at school (she noticed that he had a bandage on his arm) and asked if she wanted a lift home. She first declined his offer, but after she realised that Adult

H was in the car she reconsidered and accepted the offer. During the journey Adult G said he had “Bipolar Disorder” and that he was self-harming. He asked her if she would sit with him for a few hours every Monday morning until he found a carer.

5.21 She said that Adult H rarely ever bought up her relationship in conversation with her and never spoke of any issues between them. She said that one day Child F said that ‘papa had hit mamma’. She never saw them arguing but knew he used to control Adult H because of the way she would act. She said that there was no indication from what she observed of Adult G taking Adult H’s life.

5.22 Adult G would say he was ill and because of this Adult H had him admitted to Bethlem Royal Hospital but he kept discharging himself and coming home. On one occasion he had locked Adult H and Child F out of the house due to his paranoia.

5.23 In terms of what could have been done differently to have prevented Adult H’s death, the neighbour said that Bethlem Royal Hospital kept letting him out and that perhaps if he had remained he could have been treated and this would have helped.

5.24 Another friend of Adult H was contacted to contribute to the review, but declined to be involved.

5.25 When the draft report was shared with Adult H’s father and sister, her sister remarked that with hindsight could recollect instances where Adult H became overly concerned and anxious about Adult G’s reaction would be to certain things. She said there was once a time a few years before her death that they were out in Adult H’s car and she got a speeding fine. Her sister said that that Adult H became very concerned about what Adult G would do and remarked that it “would set him off”. This is another indicator of the coercive control that Adult G subjected Adult H to and that this is likely to have been over a period of years prior to her death.

5.26 At one of the meetings to share the draft report, Mother P asked why Children’s Social Care attended Adult H’s home two days after her death. Subsequent checks have been made to check this information and it has been confirmed that no visit to Adult H’s address took place.

5.27 Adult H’s sister also raised concerns that her sister’s body was initially incorrectly identified. This matter was addressed again by the chair with the Police Family Liaison Officer who

stated that extensive enquiries about this had been previously made and it was deemed to be an unfortunate mistake made at the scene.

5.28 Adult H's mother has raised concerns about the preservation of the crime scene and recounted several errors and discrepancies she had noted with the photographs taken. These particularly concern footprints and the position of a clothes laundry dryer which had been knocked over but in other photographs it is show to be upright.

Key findings arising from the review

6.1 There was not a significant history of reported domestic violence to the Police between Adult H and Adult G. We are aware that there were issues in their relationship dating back to what appears to be financial abuse in 2006 and the domestic violence related caution in 2007 by West Sussex Police. The matter in 2006 was not originally seen in the context of domestic violence. When Adult G was cautioned in 2007, Adult H disclosed to officers it was not the first time there had been problems between her and Adult G.

6.2 Adult G was a constant feature in Adult H's life from her teenage years. It is possible that violence and abuse was present in their relationship as young people. Given the change to the government's definition of domestic violence in March 2013 to include 16 and 17 year olds who experience domestic violence (or teenage relationship abuse), the partnership should look to address this issue with all young people.

6.3 Adult G's patient notes show that from a young age there was evidence of low mood with general medical care provided by a number of GP practices with periods of non - contact and the registration with a new GP Practice. This is continued throughout the time period subject to review.

6.4 When accessing Adult H's patient records, it was noted that she had been known with different names and not as Adult H. This may have impacted on the connections with what information was known by the GPs about the family as a whole. It is clear that Adult H did access her GP for help, although her contact is characterised by ongoing lack of follow up by the GP.

6.5 Given Adult G's use of steroids it is relevant to consider that a known side effect is aggression.

6.6 Adult H and Adult G had separated at the time of her death. Separation is a known risk factor in domestic violence and a high percentage of domestic homicides occur after the point of separation (or closely around that time). The fact that the couple had separated and the increased risk this posed to Adult H was not recognised or acted upon by agencies (although it is noted that this risk factor may have been masked as they presented as a couple to mental health services).

6.7 Adult G's diagnosed personality disorder is a thread throughout the review and dominated his contact and engagement with services and agencies. A picture emerges from the IMRs of Adult G continually seeking treatment and medication from different health services, depending on his current wishes and their response to his presentation. Adult G's claimed diagnosis of Bipolar Disorder seems to have become accepted as fact during his contact with his GP's and there is no evidence this was tracked back, reviewed and checked. This may be partly due to his use of different surgeries (often over the same period of time). This, combined with the nature of patient databases, inefficient information sharing processes all impacts on patient records, their review and continuity of care.

SLaM (including an explanation of Adult G's mental health diagnosis, assessment and the options for treatment)

6.8 Adult G was in contact with secondary mental health services in Croydon for just under eleven weeks. Adult G's contact with SLaM was short and there was insufficient reliable collateral information to make a substantive diagnosis. During that time, Adult G had twelve episodes of care provided by six separate SLaM teams.

6.9 Adult G presented with psychotic symptoms on occasion and transient psychotic symptoms which may occur in response to illicit drug use and in reaction to severe stress in emotionally unstable personality disorder. The capacity to consider a number of possible diagnoses is a normal part of psychiatric practice.

6.10 The requirements of mental health care are that the treating Psychiatrist is required to make a diagnosis for each patient during each episode of care. This is the case even when the patient has no severe mental health diagnosis.

6.11 Over the time that Adult G had contact with Mental Health Services, an evolving understanding of his mental health occurred: the diagnosis of bipolar disorder suggested by Adult G was discounted with confidence; there was increasing assurance that his presentation could be best understood as a personality disorder; there was some uncertainty if this reflected a single disorder (emotionally unstable) or whether comorbid[3] conditions (emotionally unstable and dissocial) was a more appropriate formulation.

6.12 Adult G's diagnosis at the time of the incident was emotionally unstable personality disorder[4]. This disorder is often characterised by instability in:

[3] Comorbid is the presence of one or more additional disorders.
[4] ICD-10 International Classification of Diseases, 10th revision, World Health Organization, 1992.

6.12.1 Emotions – inappropriate intense anger and intense episodic dysphoria, irritability, or anxiety usually lasting for a few hours and only rarely more than a few days

6.12.2 Self-image - marked and persistent unstable self-image or sense of self

6.12.3 Interpersonal relationships - a pattern of unstable, intense relationships characterised by alternating between extremes of idealisation and devaluation.

6.13 Emotionally unstable personality disorder is apparently often seen with comorbid conditions such as substance use, self harm - including recurrent suicidal behaviours, gestures, or threats, or self-mutilation[5].

6.14 Risk evaluation within mental health care involves both an assessment of the likelihood of risk and an assessment of what factors within the mental health of an individual may be modifiable in such a way as to reduce the likelihood of future risk. There is no treatment for personality disorder that can reduce risk predictably and rapidly. There is effective treatment for emotionally unstable personality disorder; although, this needs to be considered as being effective over a longer timescale (six months to one year) and requiring the active engagement of the patient in treatment. The situation for dissocial personality disorder is less clear and there is a body of evidence that this is very poorly responsive to treatment.

6.15 There is usually no definitive objective test to provide 100% assurance of any psychiatric diagnosis. A full diagnostic assessment can involve both repeated meetings with the individual or discussion with a close family member or informant. However, this does not mean that patients being treated within a service will initially have no diagnosis. An initial formulation often called a *"working diagnosis"* does guide treatment during initial treatment of a new patient. This includes repeated statements that Adult G may have both an emotionally unstable and dissocial personality disorder.

6.16 It is common for an individual to present with features of more than one personality disorder, and this can occur in up to 20% of patients with an emotionally unstable personality disorder. There is no evidence Adult G previously received a diagnosis of bipolar disorder prior to his contact in October 2012. His assessment within SLaM which included a five day inpatient admission provided a consistent period of assessment that did allow this diagnosis to be more confidently discounted.

[5] BORDERLINE PERSONALITY DISORDER: TREATMENT AND MANAGEMENT
National Clinical Practice Guideline Number 78, National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence published by The British Psychological Society and The Royal College of Psychiatrists.

6.17 An “adjustment disorder with dysphoric reaction” is recognised in the World Health Organisation International Classification of Mental and Behaviour Disorders; although, it does not have very specific symptoms. It is characterised as a change in behaviour that occurs in response to an external stressor although the outside stressor may often not be severe or life threatening.

6.18 The behaviour change settles once the outside stressor is removed. It is not a condition that requires specific treatment. The language used by the Consultant Psychiatrist who saw Adult G in Croydon University Hospital suggests a degree of uncertainty as to whether Adult G exactly met criteria for this condition. As explained above this was most appropriate diagnosis for Adult G at that time.

6.19 Dysphoria is a term used to describe intense and unpleasant subjective feelings of distress and unease. These feelings can occur in the full range of mental health conditions. They do occur in serious mental illnesses such as depression and bipolar disorder. They also occur in other conditions not considered a severe mental illness such as an adjustment disorder.

6.20 Overall this term reflects an opinion that Adult G presented with quite significant symptoms and distress. These symptoms were however not indicative that he had a significant mental illness or that acute psychiatric treatment was required. The nature of adjustment disorders is that these feelings resolve once the outside stressor is removed.

6.21 It is concerning that the SLaM care coordinator did not meet the expected standards of timely and effective information sharing in relation to communicating with the Triage Ward; arranging a home visit following adult G’s discharge; responding to the concerns raised by the Approved Mental Health Professional (AMHP) following his mental health assessment (MHA) at the police station two days before Adult H’s death.

6.22 There was evidence of information sharing between the teams within SLaM teams. Although it was timely and detailed it was unidirectional. This resulted in a missed opportunity for the community team to build on the excellent information gathering that had taken place on Triage Ward.

6.23 At no point did Adult H directly contact the police herself concerning domestic violence between her and Adult G. She sought help in respect to Adult G’s and his mental health issues, and seemed to do this constantly throughout in November and December 2012. It would appear that she wanted him to get help and have him reassessed; this could be seen

as the mechanism she used to help her minimise and cope with the abuse she was experiencing.

6.24 Adult H's disclosures to Triage Ward staff about her concerns that, she was scared of Adult G and him being angry for calling the police; that he had isolated her by taking taken her keys and prevented her from seeing other people) were all missed and minimised by staff. These concerns were not considered acted upon as Adult H became more reassuring to the ward team and minimised her earlier disclosures.

6.25 Adult G had multiple presentations to mental health services during November and December 2012. The impact on Adult H and their child was only briefly considered. There was a verbal handover from the emergency department doctor where the safeguarding concerns were shared with the on call psychiatric team.

6.26 From 24/10/2012 to 07/11/2012 Adult G was an inpatient on an adult orthopaedic ward and was displaying increasingly concerning behaviour. There is documentary evidence to show that he was presenting as aggressive, angry, paranoid and abusive towards ward staff. At one point, Adult H was seen as a calming influence on him, but full consideration does not appear to have been given by the orthopaedic or psychiatric team to the impact his behaviour and ill mental health was having and could have on Adult H and Child F.

6.27 Adult H was present at the assessment on 07/11/2012, where Adult G's possible admission to Bethlem Royal Hospital was discussed. She was spoken to but not separately from Adult G. The assessment was well documented in Adult G's notes but there is no recorded evidence of the risks of domestic violence being specifically explored with Adult H, nor is there recorded evidence of her how her opinion was gained concerning the decision to discharge Adult G home.

6.28 Despite Adult H disclosing her fears about Adult G's violence, SLaM staff seemed to have been unclear about how to respond to domestic violence. SLaM's guidance on domestic violence is limited. There is a small section in the Domestic Violence and Partner Abuse Policy – 2005 (section 4.2 Adult clients who disclose as perpetrators). The policy gives no guidance on how to acquire information and clarification in circumstances where a service user may be abusing their partner. The review date for the policy was 2008 but this is outstanding. Documents relating to Domestic Violence are available on the Trust Safeguarding and Protecting Children webpage but this is not clearly signposted.

6.29 Although SLaM is part of the Croydon Multi Agency Risk Assessment Conference [6] knowledge of the DASH risk assessment tool and referral processes is limited.

Croydon Health Services

6.30 The family's contact with Croydon Health Services has highlighted a lack of a shared understanding between services of the overall concerns in relation to Adult G, Adult H and Child F. There were many missed opportunities to appropriately assess the safeguarding concerns, risks and needs of the family.

6.31 Given Adult G's presenting concerns, staff should have considered and explored the possibility of domestic violence and, to a lesser degree (as this was progressed a little), safeguarding children concerns. The provision of care by both the Emergency Department and the adult ward highlights that there was an issue of who should take the lead for managing Adult G's care. The very nature of emergency departments mean there is a turn-over of patients and staff throughout the day and this can affect the continuity of care and follow up of concerns.

6.32 The Domestic Violence Care Pathway (Croydon Health Services August 2011), states that when a patient arrives in a department with suspected domestic violence or relational abuse this needs to be explored. Although Adult G was the patient, (arriving in the department with mental health concerns), Adult G disclosed worries about his behaviour and so the potential risk of domestic violence should have been explored. The risk of domestic violence was not recognised and other risks that Adult G presented were seen in isolation and were not followed up.

6.33 An example of how risk was managed is found in the chronology where it states that on 07/11/2012 Adult H was advised to take away Adult G's car keys to stop him from driving and to call the police if he refused. This incident is an example of how statutory services did not recognise the risks posed to Adult H and expected her to manage Adult G's behaviour. This was an unusual, inappropriate and unsafe request which may have placed Adult H at greater risk of harm.

6.34 The risks that Adult G displayed whilst he was admitted, such as threatening hospital staff, were not considered from the perspective of how they manifested in his behaviour at home

[6] Multi-Agency Risk Assessment Conferences (MARACs) are regular local meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the IDVA, a risk focused, co-ordinated safety plan can be drawn up to support the victim.

and towards Adult H and Child F. The concerns about his behaviour were narrowly considered within the setting of the hospital only. The member of staff whom he apparently became fixated upon, reported her concerns to the police. These concerns were not adequately investigated by the Police and the hospital should have better addressed these concerns (in terms of safeguarding concerns and work place health and safety).

6.35 It is apparent that the Emergency Department safeguarding prompts are not being used by staff. This is particularly concerning given that they were introduced following a Serious Case Review in 2011.

6.36 Disclosures made by Adult H were not fully represented in the risk assessments. The mental health care coordinator did not make a timely home visit in order to assess any child safeguarding or presence of domestic violence issues. Risk screens and assessments were completed and updated while adult G was on Triage but whilst they acknowledge that Adult H was concerned about Adult G when she called the Police, the assessments emphasise that she was a protective factor.

6.37 The discharge summary conflicted with what was recorded about the risks Adult G posed. His behaviour on 28/10/2012 was considered as extremely violent and aggressive on the ward. In the same period of care it was agreed he could be discharged home when he said he would not harm anyone. His behaviour was seen in respect to poly-substance misuse and not poor mental health which dominated the treatment and risk assessment conducted. The risks which were identified were overlooked and not addressed.

6.38 Even if the assessment was correct to conclude that the risks Adult G posed were contained due to his admission to hospital, a robust mechanism of review should have been put in place to ensure a formal assessment of the risks happened at the point of discharge. Children's Social Care should have been included in the information sharing at that point.

London Probation Trust

6.39 Probation was unaware of significant information about Adult G's previous violent behaviour (prior to his period of probation supervision in 2007/2008) and concerns about his mental health. The risk assessment by probation and period of supervision was therefore conducted without understanding the full picture of Adult G's offending history. There was not an accurate understanding of the risks he posed, and how he should be managed whilst subject to supervision.

6.40 The management of Adult G whilst subject to a community order was not rigorous or informed by all known information about him. There appears to have been limited depth in the process of engaging with him. He was registered as a Tier 3 offender which would indicate medium level intensity involvement was required. The IMR stated that the records detailing the individual appointment contacts the offender manager had with Adult G are short and could have been more detailed. The concerns about the texts messages he sent threatening his employer were not followed up and did not trigger a review of his risk assessment.

6.41 It would appear that several key elements that would have informed and influenced his supervision were not identified or addressed. The IMR contained several incidents where the probation supervision was not conducted in accordance with probation policy:

6.41.1 Adult G's order was made on 21/08/2007 but he was not offered his first appointment with his Probation Officer until 07/09/2007. He was unable to keep this appointment and it was rearranged to 10/09/22007.

6.41.2 Adult G's final two appointments on 07/07/08 and 11/08/2008 were not recorded.

6.41.3 An OASys assessment was not completed within the required timescales of fifteen working days from when the order was made.

6.41.4 A termination assessment at the end of the Order was not completed.

6.41.5 Adult G's offence of GBH in 2003 (he self-reported that this offence involved him throwing a jar of pickles at a work colleague) when he received a Community Punishment Order, did not prompt the Probation Officer to complete a full OASys.

6.41.6 Records do not indicate that the London Probation Trust process for checking if a child is known to Children's Services was followed.

6.41.7 Probation records indicate that that the Probation Officer had no knowledge of the allegation in 2002 of Adult G stabbing an 11 year old boy in the face (this was a robbery which he was never arrested for). Nor does it appear that the Probation Officer was aware of the domestic violence incident in 2007 when Adult G received a caution for assaulting his partner (Adult H) in a car.

6.41.8 Probation were unaware of Adult G's mental health issues.

6.41.9 The lack of intelligence sharing is a concerning factor for the reasons outlined above. London Probation has, since the time when this case was managed, significantly improved its processes around National Standard timeliness and risk management.

6.42 Given the Police call out for domestic violence and the GBH offence, a full OASys risk assessment should have been conducted on adult G. An intelligence check was not conducted during Adult G's period of supervision. The registration as a potentially dangerous offender should have triggered this check which would have resulted in Police intelligence being shared with probation which would have informed their risk assessment (and management of Adult G). The overall lack of intelligence sharing in this case is concerning.

6.43 Adult G's registration as a Potentially Dangerous Offender was carried over from a previous case management system and there is no information as to why he was recorded as such. It is important that any such flags have the rationale clearly recorded, so that risk posed to others can be clearly understood, monitored and addressed. Adult G did not meet the criteria for Multi Agency Public Protection Arrangements.

6.44 Records did not indicate whether a home visit was conducted in this case. Such a visit may have provided information on how the family were functioning and an insight into his relationship with Adult H.

6.45 London Probation has shared its safeguarding children policy and procedure with the review and has given assurances that since the time when Adult G was managed, it has significantly changed and improved its processes around its timelines and management processes of person subject to supervision.

Metropolitan Police

6.46 The domestic incident between Adult H and her mother in 2007 did not generate a Police Merlin report despite Child F being mentioned during the argument. A Police Merlin report should have been completed and shared with Croydon Children's Services. Adult H's caution for this may (and Police no further actions) have influenced her future help seeking attempts and any contact with the Police.

6.47 Although a referral to the Family Justice Centre (FJC) was noted on the Police systems for the incident in 2006, there is no evidence of this with the FJC. It would appear that rather than this being a referral it was a signposting contact. It is understood that at this time referrals to the FJC were completed in a somewhat ad hoc and informal manner. It is therefore thought more likely to have been a general signposting contact by the officers than a proactive referral being made. Although the FJC now receive details of Police domestic incidents on a daily basis, there is no systematic process in place of how referrals are progressed in the Borough. The Borough needs to be clear about the difference between

signposting and a direct referral to specialist services, and what this means in terms of professional responsibilities and actions.

6.48 It is of note that between 2008 – 2011, no incidents of domestic violence were reported to the Police.

6.49 When Adult G was later reported by his girlfriend (his new partner – Girlfriend M), as missing there was no formal information sharing protocol or record of vulnerable adults coming to notice. Better systems are needed to ensure information on vulnerable adults is shared with adult social care and health. It is positive that since April 2013, systems have been enhanced and the Police Merlin system was upgraded to facilitate the recording of vulnerable adults (aged 18+), who are vulnerable because of their mental health, age, illness or disability, and there is a risk of harm to that person or another.

6.50 The threats Adult G made to a member of nursing staff at Croydon University Hospital (CUH) were not investigated by the Police. They were recorded as an intelligence report. This was at a time when his mental health had deteriorated and the risk he presented to himself and others was not considered. An investigation should have followed, as there was sufficient information to record an allegation under the Harassment Act or Public Order Act.

6.51 There is no explanation provided on the custody record confirming the decision to place Adult G in a rest period after his Mental Health Assessment. It is unclear whether the question of interviewing at that time was considered by Police, but dismissed or whether it could not be progressed due to the lack of availability of an Appropriate Adult (AA). The custody officer should have provided an entry on the record confirming this and/or documented efforts made to secure an AA. There was no rationale provided on either the custody record or the crime report as to why Adult G was given unconditional bail on the day before Adult H's death following the allegation of assault on her. The Police should have granted conditional bail (this is standard Police practice), in order to provide protection to both Adult H and Child F. Bail conditions may have prevented Adult G from returning to Adult H's address the following day.

6.52 It would appear that the Book 124D risk assessment conducted by the Police front line uniformed officers on the day before Adult H's death did not fully explore her concerns and they were not recorded. There were no specific details of her concerns, particularly how the incidents had escalated and what concerns she had around his use of alcohol, drugs and his mental health. The assessment level of standard would undoubtedly have changed if all the facts and intelligence were known. Training on risk assessment for front line officers is

essential and where this has been provided and standards of reporting remain poor additional training is necessary.

6.53 Police checks were conducted only using the CRIS system. A five year check would not have shown any history of domestic violence between Adult H and Adult G. Had intelligence checks been conducted (in accordance with the Police Standard Operating Procedures for Domestic Violence using the Integrated Information Platform), then a comprehensive picture would have been established showing Adult G had been reported missing twice and had suffered significant mental health issues on at least three occasions within the previous nine months resulting in him being hospitalised. The risk assessment was conducted without the full information available and the incident was viewed in isolation. A review of all information would have likely indicated that the level of risk posed to Adult H by Adult G was higher than "standard".

6.54 After Adult G had been bailed, the risk assessment should have been reviewed and a discussion should have taken place with Adult H about safety planning and referrals to specialist domestic violence services. Despite the potentially incorrect risk assessment, it is considered to be unlikely this would have affected the decision to bail Adult G.

6.55 The provision for AAs was an issue as the system did not allow one to be accessed in the time available. This appears to be a pan London issue and commissioning arrangements vary borough to borough. The provision and capacity of the Emergency Duty System (point of contact) also needs to be reviewed and improved.

6.56 This review has repeatedly shown that Adult H was rarely informative about the circumstances of her life (as will often happen in cases of domestic violence where victims are suffering many aspects of coercive control and abuse). This emphasises the need for police to put great effort into securing other witnesses to offences wherever possible. Enquiries the next day, when attempting to establish evidence for a prosecution, may have supported a substantive charge against Adult G.

Croydon Council – Safeguarding and Looked After Children Service

6.57 Children's Social Care took little significant safeguarding action. There is no evidence of any discussion with the professionals making the referrals, despite clear reference in the referral from the Accident and Emergency doctor requesting an assessment of Child F's safety within the family home. In relation to the checks completed by the Police on 16/10/2012, the IMR author's opinion is that these were inadequate and inaccurate. This is because the risk

factors relating to "Tendency Towards Violence', 'Domestic Violence and 'Abuse' are all listed as 'Unknown' and this would have had an impact on Children's Social Care's perception of risk.

6.58 The letter that Children's Social Care sent to Adult H was a minimum response and was not timely (it was dated twenty days after the incident). The letter offered little in the way of a supportive response from statutory services, stating "Croydon Social Services have received notification regarding concerns in relation to Adult G's mental health" and references " that you have a young child in the home and her physical and emotional safety should always be a priority". This could be viewed as unsupportive and seen by Adult H as her being held wholly responsible for safeguarding their child. It is also important to note that Adult G was invisible in this response in relation both to his behavior and parental responsibility to safeguard Child F.

6.59 The overall response from Children's Social Care's duty assessment team was not as rigorous as it should have been, in part due to the nature of information received from other agencies. It is significant that in the financial year 2012/13 Croydon Children's Social Care received in excess of eleven thousand Police Merlin reports. This is an extraordinarily high number and there was an acknowledgement that a number of such contacts were corporately missed. It is unsurprising that Children's Social Care have struggled to cope and respond to this volume of notifications.

6.60 In January 2012, a new 'workflow process' was put in place to ensure the timely and secure transfer of information from the corporate center to Children's Social Care. In addition the department's initial '*point of receipt'* for Police Merlin reports was moved into the Screening Team' to ensure there is no delay in Children's Social Care reviewing the contents of these reports and loading them onto individual client records.

6.61 In November & December 2012, significant weaknesses were identified in the internal processes for transferring *'contacts to the council'* into Children's Social Care. This included the way in which Police Merlin reports were passed to the 'Screening & Intake Teams' (Children's Social Care's front door).

6.62 Despite this new process being in place, the contact on 05/10/2012 from the hospital did not result in significant action being taken by Children's Social Care. The assessment and decision making should have been more robust. Given the issues of parental mental health, substance misuse, previous domestic violence, the missing persons reports, a Section 47 child protection enquiry would have been appropriate and should have been conducted.

6.63 This should also be considered within the partnership's journey towards establishing Croydon's Multi Agency Safeguarding Hub (MASH). (The Public Protection Desk and Children's Social Care's Screening Team were co-located in July 2013).

LAS NHS Trust

6.64 The calls on 05/10/2012 were not assessed as a high priority. The process of categorising calls to the LAS is complex. The safeguarding concerns that the LAS noted were shared with the hospital although no distinct referral from the LAS was logged on Children's Social Care's system. The call on 05/12/2012 to the LAS was cancelled after a delay of an hour as the Police decided to take Adult G themselves to a place of safety. Despite the frequency of calls to Adult G, he was not classified as a frequent caller by the LAS (defined as twenty calls received a month for a period of six months). It is a concerning gap in practice that the safeguarding children concerns were not transmitted to the local authority.

General

6.65 There was a significant and concerning delay in securing a mental health assessment for Adult G when in Police custody. It was requested much earlier in the day, and following a telephone call at 16:53 hours it transpired that no one could attend before 21:00 hours. The assessment was eventually conducted at 12:45 – 01:00 hours the following day.

6.66 Adult G's recovery in his presenting behavior (during this time period), would confirm the view that his behavior was due to his poly drug use. He had a clear recovery and the psychiatric expertise certainly would have been able to identify the presence of any mental health issues. This factor must be viewed in conjunction with his claimed mental health problems.

6.67 It should be noted that when Adult G was in custody, there was only one AMHP on duty, and the person who originally received the referral was completing an assessment in Accident and Emergency at the time so was unable to respond to the custody suite immediately. The referral generated in normal office hours was therefore passed over to the duty team to progress in this instance. The capacity of the AMHP system is limited and should be examined for effectiveness in circumstances similar to this.

6.68 SLaM and Croydon Community Health Services (and potentially the GP) all have access to the MARAC and could have referred Adult H had they obtained sufficient information to justify such a referral. Both services are members of the MARAC and a risk assessment

could have been completed. Had someone spoken appropriately and sensitively to Adult H and heard her concerns about Adult G's behaviour and the concerns about his mental health, a referral to the MARAC may have been seen as appropriate.

6.69 Despite having a borough domestic violence strategy, more work is needed to implement the aims of the strategy into operational practice. For example, staff within Croydon Health Services are expected to use the 'CAADA-DASH Risk Identification Checklist[7]. They are advised in training that when using this form and the number of 'ticks' on this checklist is fourteen or more, the case would normally meet the MARAC referral criteria. This is in compliance with Croydon Domestic Abuse and Sexual Violence Strategy 2012-2015[8], whereby all agencies are being asked to sign up to use of the CAADA risk assessment and case management framework. There is no documentary evidence to suggest that the CAADA – DASH Risk Assessment Checklist was used with or in relation to this family, even though two child protection referrals were submitted to Croydon Council Safeguarding and Looked After Children Service on 05/10/2012 and 23/10/2012.

[7] http://www.caada.org.uk/marac/RIC_with_guidance.pdf
[8] Croydon Domestic Abuse and Sexual Violence Strategy 2012-2015. 2012. Croydon and Children Families Partnership.

Diversity

7.1 The protected characteristics as outlined in the Equality Act 2010 have been considered in relation to this case. Those of possible relevance are:

7.1.1 **Age:** The couple started a relationship when they were young adults. Awareness of intimate partner relationships was limited at that time (as are specialist support services) which may have meant that Adult H did not recognise the dynamic of domestic violence or from where to get support from (the definition of domestic violence was changed in March 2013 to include 16 and 17 year olds).

7.1.2 **Disability:** Adult G's apparent enduring mental health issues is a dominate theme in this review. The issue of his mental health overshadowed the dynamic of domestic violence. It was commented that adult H was keen for him to get help and this was the focus of all interventions.

7.1.3 **Marriage and civil partnership:** Incomplete pictures of Adult G's relationships emerge in the IMRs as there was contact with both Adult H, and his new girlfriend was also mentioned (by health services). His relationships and living arrangements were never explored to an extent that has now been proven necessary. Adult H and Adult G appear to have presented as a couple to mental health services,

7.1.4 **Pregnancy and maternity:** During her pregnancy with Child F, Adult H was apparently not asked about her relationship or any history of domestic violence.

7.1.5 **Race:**

a. Adult G was of Turkish origin. We know from the victim's father that Adult G would only speak to Adult H in Turkish. This may have been a tactic used to isolate and control Adult H. The review has identified no services that formally recognised the complexity of this family's mixed cultural heritage or specifically Child F's racial identity.

b. There is no evidence that any targeted services were delivered to any member of this family to assist them in managing the impact of racism or to help them develop an understanding the complexity of Child F's identity.

7.1.6 **Sex:** Despite the limitations of the intervention from Children Social Care, there is evidence of a focus of them holding Adult H responsible for safeguarding Child F (from Adult G). This gender-based expectation focused on the mother meant Adult G was not challenged or held accountable for his behaviour. No attempt was made by Children's Social Care to engage with Adult G or create an opportunity to talk to him about how he could change his behaviour and understand the impact of his actions on his child.

Conclusions

8.1 Many statutory sector agencies had considerable contact with those involved in this homicide. This review has revealed a number of agencies failing to recognise the potential for domestic violence, adult and children safeguarding concerns and the connection of mental health with these issues. Not only is there individual agency failure, but there was no coordinated operational response to these issues. At the very least, a coordinated community response to domestic violence means agencies liaise with each other and share information. Ideally such an approach would also lead to joint policies and practice that would help ensure that similar cases do not go unidentified.

8.2 This case has highlighted many concerns of a strategic partnership that is addressing domestic violence. The partnership is malfunctioning and work is needed by all agencies to improve its outcomes and effectiveness. Health organisations especially play a huge part in the response and must be a core part of any future action.

8.3 The FJC is attempting to drive through change to the response to domestic violence and these developments are discussed below. The FJC, whilst playing an important role in these issues, cannot alone be defined as “the” response to domestic violence locally. What will also be required is strategic involvement and commitment to make sure strategies and plans result in improved action across every agency.

Developments in the response to domestic violence in Croydon

8.4 Since late 2012, there have been a number of positive and innovative developments to Croydon’s coordinated response to domestic violence. These are very much welcomed. The FJC has seen footfall increased by 300%, and is now seeing on average twelve clients per day.

8.5 The developments and the work completed by the FJC are listed below:

8.5.1 The FJC has had significant financial investment in it and it has transferred directorates from Community Safety to the Children, Families and Learners. There is a new Governance Structure and the Anti-Violence Group and Domestic Abuse and Sexual Violence group have been merged and the group will be chaired by the Chief Executive of Croydon Council.

8.5.2 DV declaration written for all Directors and Chief Executives CE’s to sign up to.

8.5.3 There is now a coordinated action plan in place to prevent and tackle domestic and sexual violence and services and tacking perpetrators which is broader than signposting victims to the FJC.

8.5.4 Re-established its relationship with the Voluntary and Community Sector.

8.5.5 The domestic abuse and sexual violence strategy has been re-written (as well as the MARAC protocols), which has secured senior management engagement in the MARAC. Multi agency MARAC training has been developed. The performance of the MARAC has improved with better attendance and increased referral rates by 400% (sustained over six months and increasing, averaging 20 per fortnight).

8.5.6 The partnership with Victim Support to manage the CRIS list has been reviewed and is now working effectively.

8.5.7 Developed a multi-agency approach at the FJC, which includes representation from probation and mental health.

8.5.8 Increased the number of IDVA's by two and training for all remaining FJC staff.

8.5.9 Currently recruiting a specific young person domestic abuse and sexual violence advocate.

8.5.10 Secured agreement for a joint strategic needs assessment on domestic violence.

8.5.11 Agreed a single assessment process with housing for individuals presenting as homeless due to domestic violence.

8.5.12 A domestic violence data and information sharing protocol is now in place.

8.5.13 Co-wrote the tender with Supporting People for the three local refuges and for the floating support service.

8.5.14 Developed surgeries for practitioners to help support their understanding of domestic and sexual violence and improve practice.

8.5.15 Agreed referral routes and pathways, protocol now written

8.5.16 Commissioned prevention work in a cluster of schools and there is a view of expanding this work.

8.5.17 The Police (CSU) will be based in the FJC one day per week and an IDVA will be based at the Police station one day per week.

8.5.18 Legal remedies will be shared Police to look at civil protection action taken to help consider all options not just criminal justice responses to domestic violence.

Preventability

9.1 The review has identified a number of incidents where the response by statutory services was limited to the extent of insufficiency. This led to a failure to safeguard Adult H and Child F.

9.2 When considering the issue of preventability the panel has examined the impact of:

- The Police's decision to release adult G on unconditional bail (prior to the incident that resulted in Adult H's death)
- The 999 Police response to the incident (which resulted in Adult H's death)
- The invisibility of the issue of domestic violence by professionals the individuals in this review came into contact with)
- The lack of recognition and identification of the risks Adult G posed to Adult H and Child F
- The assessment and treatment of Adult G's mental health concerns.

9.3 Adult G showed that he posed a significant risk to himself and others in respect of his aggressive behaviour, personality disorder, substance misuse and multiple self-harm attempts in a number of settings and on various occasions. The focus appeared to have been on the medical and psychiatric needs of Adult G. The risks he posed to Adult H (and also to Child F) were missed or not considered as sufficiently important or worrying.

9.4 The information about this family was mostly viewed in isolation by the different services with whom they came into contact with. There is little evidence of understanding of the Toxic Trio or the "Think Family" approach to safeguarding by professionals and this then being reflected in their practice. This was a family dominated by the violence and mental health of one individual and the whole family situation was never sufficiently considered.

9.5 Agencies focused on Adult G's behaviour which could be very challenging. This resulted in the needs and risks he posed to Adult H and Child F being overlooked. When the relationship was discussed, the dynamic of domestic violence was not appropriately or fully explored. Practice was not informed by domestic violence policies and the local strategy.

9.6 There were various differences of opinion by panel members on the subject of preventability. The panel has struggled with the definition of preventability and there were diverse views on the chain of causation of Adult H's death. As a panel consensus on the issue of

preventability could not be reached it is the view of the independent chair of the review that Adult H's death could have been prevented.

9.7 Had the agencies involved with Adult G, Adult H and Child F worked more effectively and as part of a functioning coordinated community response to domestic violence, they would have been better able to identify and manage the risks Adult G posed to Adult H and Child F, and Adult H may not have died.

9.8 There were several key incidents when protection and support could have been afforded to Adult H and these opportunities were missed. It is regrettable that Adult H and Child F did not receive a level of support that could have prevented this death occurring.

Recommendations

10.1 The recommendations of this review are specific and detailed to support Croydon Community Safety Partnership and individual agencies understand the issues identified which need improvement. The recommendations will help hold agencies accountable for action they now need to take now and into the future. The recommendations are wide ranging and attempt to address direct themes identified in the review as well as associated issues that have an impact on the response to domestic violence by statutory services.

10.2 The review identified that engagement with public health and the clinical commissioning group in the Community Safety Partnership has been limited. If the recommendations of this review are to be implemented, Public Health, the Acute Hospital Trust (especially Accident and Emergency) and Croydon Clinical Commissioning Group must engage fully with the coordinated community response to domestic violence, ideally through the existing structures (e.g. the CSP and the Croydon Strategic Domestic Violence Strategic Group and partnership).

10.3 Internal actions for agencies have been identified in their respective IMRs and have already been promulgated to allow learning to occur alongside swift change to organisational activity.

10.4 The recommendations of this review will be combined with the recommendations of another domestic homicide review being conducted at this time.

10.5 All recommendations will be overseen by the Croydon Community Safety Partnership, and will be delivered by the Croydon Domestic Violence Strategic Group. The recommendations also have been translated into an action plan (Appendix 3).

10.6 The review has found little evidence of internal agency policies and procedures on the issue of domestic violence. This is a significant gap within the response to domestic violence and must be addressed by all agencies mentioned in the review (except the Metropolitan Police). In light of what we have discovered regarding the use of the A&E prompts, (introduced as a result of an earlier serious case review and not being used), it will be extremely important that the partnership response to this review is able to engage and influence the Acute Hospital Trust, amongst others.

10.7 A domestic violence referral pathway would help support professionals respond appropriately to concerns of domestic violence, and will help preventing victim's falling between gaps in services. A referral pathway will also help support a coordinated community

response to domestic violence, where staff are clear about and understand their roles and responsibilities in regard to domestic violence.

10.8 Specific recommendations are shown below.

Croydon Community Safety Partnership:

Recommendation 1

Conduct a rigorous borough-wide review (through the Croydon Domestic Violence Strategic Group) of the response to domestic violence. This review must address the gap between the strategy and delivery of the strategic aims in the operational practice of partner agencies.

Recommendation 2

In conjunction with other strategic boards, produce a domestic violence protocol, policy and care pathway. This should include domestic violence enquiry and provision for safeguarding children, adults at risk and vulnerable young people.

Recommendation 3

Disseminate learning from the two domestic homicide reviews widely across the partnership. This should be in the form of a written briefing to all staff and dissemination sessions and incorporating findings into any domestic violence training that is commissioned and delivered locally.

Recommendation 4

Commission a borough multi-agency domestic violence training programme, which, bearing in mind the findings of this review, should specifically address themes of diversity. This should be done with the support of other strategic boards and take up of training should be audited and monitored by each agency through the Croydon Domestic Violence Strategic Group. It is recommended that the training covers awareness and dynamics of domestic violence, specific skills training on enquiry and completion of MARAC risk assessment, safeguarding responsibilities and referrals pathways.

Recommendation 5

Examine ways to raise awareness amongst young people of the issue of relationship violence and publicise what support is available.

Recommendation 6

Consideration must be given (alongside the LSCB and SAB) to include adults within the Croydon MASH process.

Recommendation 7

Address the issue of having a formal commissioned system in place to provide Appropriate Adult services out of hours.

Metropolitan Police (all London boroughs):

Recommendation 8

Through training, ensure that all custody sergeants when granting bail without conditions provide a full rationale around their decision on the subject's custody record.

Recommendation 9

Prisoners should be interviewed at the earliest opportunity, and all decisions must be documented in the custody record around not interviewing / rest periods and showing all efforts to contact an Appropriate Adult.

Recommendation 10

All staff responding to DV incidents to receive mandatory training in the use of the DASH 2009 risk identification, assessment and management tool in order to effectively assess risk.

Recommendation 11

Implement changes to the current DV guidance to instruct that intelligence enquiries be conducted on suspects and victims MPS wide utilising the MPS systems (Integrated Information Platform, CRIMINT, CRIS, Merlin) and nationally using Police National database.

Recommendation 12

Ensure Police Merlin reports are completed accurately and are timely expedited to Children's Social Care.

Recommendation 13

To address the volume of sharing of information through the Merlin system so that Merlin reports are more focused, specific and relate to the assessment of risk.

London Probation Trust:

Recommendation 14

Ensure that information and intelligence about risk is always sought between key agencies.

Recommendation 15

Audit that a rationale for any 'flags' on agencies' case management systems is clearly recorded

Recommendation 16

Audit adherence and implementation of policy of conducting Police intelligence checks.

SLaM:

Recommendation 17

Design a strategy to implement the NICE Guidance (PH 50) on Domestic Violence and Abuse[9], ensuring through audit that practice is change and improved.

Recommendation 18

Improve staff awareness of issues relating to violence and abuse, (primarily against women, as service users and the partners, carers or members of the family of service users) through a dedicated training programme separate from, but based on the Safeguarding Children Strategy. The work to raise awareness must be underpinned by evidence and framed in a way that resonates with different staff groups in SLaM as recommended in 'Responding to Violence against Women and Children – the Role of the NHS''.

Recommendation 19

Update the Trust Policy on Domestic Violence and Partner Abuse (2008) to reflect current best practice and findings from the two domestic homicide reviews conducted in Croydon.

Recommendation 20

Review the policy and practices around seven day follow-up email to ensure they meet the requirements of the organisation and comply with national guidance. In the meantime it is recommended that the Assistant Director Patient Safety drafts and distributes a Blue Light Bulletin that clearly states the standard expected for seven day follow up

Croydon Safeguarding Adults Board:

[9] http://www.nice.org.uk/guidance/PH50

Recommendation 21

Examine commissioning and delivery of training to support staff in understanding the dynamic of domestic violence in relation to the safeguarding of adults and the role of carers and partners, the risks and needs of those involved

Croydon Council Adult Services:

Recommendation 22

Examine commissioning and delivery arrangements for the AMHP Service.

Croydon Council Family Justice Centre:

Recommendation 23

Rewrite the multi-agency borough referral pathway agreement to include action taken by agencies and the outcomes of referrals.

London Ambulance Service NHS Trust:

Recommendation 24

Remind crew staff of the safeguarding policy and procedure with specific reference for confirming receipt of all faxed safeguarding referrals and responsibilities for safeguarding children and adults at risk.

Recommendation 25

Review internal systems of receiving and transmitting safeguarding concerns from crews to the relevant local authority safeguarding teams.

Croydon Council Public Health:

Recommendation 26

The Joint Strategic Needs Assessment on domestic violence should reference the findings of the two domestic homicide reviews

NHS England, Croydon Clinical Commissioning Group and Croydon Council Public Health:

Recommendation 27

Work together to help identify funding to commission a pilot a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.

Croydon Clinical Commissioning Group and Croydon Council Public Health:

Recommendation 28

Ensure appropriate health engagement in Croydon's coordinated community response to domestic violence which includes appropriate health representation at the Community Strategic Partnership and Croydon Domestic violence and Sexual Violence Strategy Board

NHS England

Recommendation 29

Identifying and responding to domestic abuse and the safeguarding of children and adults is discussed with General Practitioners (from the GP practices concerned specifically in this review) during appraisal and revalidation.

Recommendation 30

To write to all Croydon General Practices advising them of the need to ensure that their mandatory safeguarding training (adults and children) for which they are responsible, includes domestic violence information to an appropriate level.

Recommendation 31

Ensure when appointed that the Lead GP for safeguarding has domestic violence included in their job description.

Croydon Clinical Commissioning Group

Recommendation 32

Consider whether the existing tools for depression screening should include psychological/social aspects on the dynamic of mental health and domestic violence.

Croydon Health Services NHS Trust:

Recommendation 33

Create, disseminate and then regularly review an organisational domestic violence policy and care pathway. This should include:

- Specific reference to the use of the A&E prompts for the emergency department
- Routine enquiry policy for health visiting and school nursing services
- An organisational stance on providing "private time" at the ante natal booking appointment, and then throughout all ante natal care appointments to enable midwives to ask about sensitive issues such as domestic violence.

Recommendation 34

Embed the use of the A&E safeguarding prompts in practice, and seek to include the key questions in the prompts in the new electronic record keeping system (Cerner) to be used by services within CUH from 30 September 2013 onwards.

Recommendation 35

Review and improve systems of sharing safeguarding concerns between the emergency department and other departments with CUH, (including the ward staff).

Recommendation 36

Work with the Community Safety Partnership to ensure a workforce training programme on domestic violence is delivered (this may be part of the training led by the CSP or separately commissioned).

Recommendation 37

Develop and distribute a universal resource on the range of help and support available to new parents (this should include a number of issues such as housing, parenting, benefits as well as information on help for victims and perpetrators of domestic violence) to support routine enquiry for domestic violence during ante natal and post natal care.

Recommendation 38

Reconfirm domestic violence enquiry practices within maternity services and ensure that staff are appropriately trained to ask about domestic violence and respond to a concern or a disclosure from a pregnant woman. This should include approaches for enquiry of pregnant teenagers and also for women who have suffered a miscarriage.

Recommendation 39

Conduct a system wide review of the processes within A&E so that staff are aware of their role and responsibilities in relation to responding to domestic violence and any safeguarding concerns. This should include:

- Mandatory training programme for all A&E staff on domestic violence
- Provision of information on local domestic violence support services and how to refer to them (including the MARAC)
- Ensuring the safeguarding prompts are being used
- Staff understanding the Domestic Violence pathway
- Agreeing A&E's staff roles and responsibilities in relation to domestic violence risk assessment and referral to services.

Recommendation 40

Examine the organisational policy and procedures for the recording of any threats to staff. This should include a refresher for staff and managers and provides management support and a process to ensure that any allegations of crime are reported to Police.

Croydon Safeguarding Children's Board:

Recommendation 41

Audit safeguarding children's training to ensure that domestic violence is appropriately addressed.

Recommendation 42

Review the Board's policy on safeguarding children where there is a parent with ill mental health, substance misuse or a learning disability to also include domestic violence.

Recommendation 43

Highlight and explain widely the 'think family' approach so that practitioners, professionals and clinicians understand the concept and their roles and responsibilities regarding safeguarding children.

Recommendation 44

Provide staff with information on the Toxic Trio to inform their safeguarding practice.

Croydon Council – Safeguarding and Looked After Children Service:

Recommendation 45

Adopt a new secure email system that provides the authority with a clear audit trail in terms of the time and date it receives Police Merlin Reports.

Recommendation 46

Consideration to be given to expanding the role and remit of Croydon's MASH to include vulnerable adults and adult service providers.

Recommendation 47

The MASH process is developed to ensure robust social care oversight of all 'contacts' that are not progressed to an assessment of the child's needs by a 'lead professional' within the partnership.

Croydon Council Commissioned Drug Services:

Recommendation 48

Drug services to explore the dynamic of domestic violence when working with individuals who use anabolic steroids.

GP practices concerned in this review:

Recommendation 49

Review their policy and procedures for identifying and responding to domestic violence and ensure all staff receive appropriate training to support contemporary practice for healthcare practitioners.

Key

Adult G	Perpetrator
Adult H	Victim
CAG	Clinical Academic Groups
Child F	Daughter of Victim and Perpetrator
CSC	Children Social Care
CSP	Community Safety Partnership
CSU	Community Safety Unit
CUH	Croydon University Hospital (formally Mayday Healthcare) NHS Trust
DAO	Duty Assessment Officer
DHR	Domestic Homicide Review
DV/A	Domestic violence and abuse
EBS	Emergency Bed Service
EOC	Emergency Operations Centre
Father K	Victim's father
FJC	Family Justice Centre
Girlfriend M	Adult G's new girlfriend
GPs	General Practitioners
HTT	Home Treatment Team
IMR	Individual Management Review
IPCC	Independent Police Complaints Commission
IRIS	Identification and Referral to Improve Safety (GP practice scheme)
LAS	London Ambulance Service NHS Trust
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
Mother P	
MPS	Metropolitan Police Service
SLaM	South London & Maudsley NHS Foundation Trust