DOMESTIC HOMICIDE REVIEW

The London Borough of Croydon

Case of Adult H

Joint Chairs Anthony Wills and Victoria Hill

April 2015

Contents

Introduction

Details of the incident

1.1 On 20/12/2012, Police were called to a disturbance at the address of Adult H. Having gained entry to the flat, officers found Adult H in the lounge. She had been fatally stabbed. Her husband, (Adult G) was found alive in the bedroom of the flat. Their six year old daughter, (Child F) was found with a minor injury in her bedroom. Adult G was arrested for murder of Adult H and was taken to Croydon Police Station.

1.2 Adult G was deemed fit for detention and fit for interview with an Appropriate Adult (AA) present. He was interviewed with the presence of a Solicitor and Social Worker. He made no comment throughout.

1.3 On 21/12/2012, the post mortem found that Adult H had died from multiple stab wounds. On 28/12/2012, Adult G was charged with Adult H's murder and assault occasioning Actual Bodily Harm (ABH) on Child F. Adult G was remanded in custody. He had been transferred back to prison following assessment at a medium secure unit.

1.4 On 03/02/2014, Adult G admitted manslaughter on the grounds of diminished responsibility and the charge of ABH against Child F was ordered to lie on file. Adult G was sentenced to serving a term of imprisonment of ten years, eight months before he will be considered for parole.

The review

1.5 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.

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

1.7 The purpose of these reviews is to:

1.7.1 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

1.7.2 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

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

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

1.8 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

1.9 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

1.10 All individuals mentioned in this review have been given anonymised names.

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

1.12 The time period subject to the review was 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.

1.13 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. This report is the product of that process.

Parallel reviews

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

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

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

1.14.3 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.

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

1.16 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

1.17 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 Housing1
- Croydon Council – Safeguarding and Looked After Children Service
- 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.

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

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

1.19 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.

1.20 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.

Overview of health services in the London Borough of Croydon

1.21 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. Adult G had contact with different GP practices. It is summarised below to assist the reader:

1.22 Adult G's first noted contact with GP Surgery in Greenwich was on 09/11/1999. On 05/06/2006 he registered at a different GP Surgery (in Blackheath). He was living in Blackheath at that time. On 30/04/2009, Adult G returned to the GP Surgery in Greenwich, but 6 months later was on the 30/10/2009 was seen at the GP Surgery in Blackheath (he had another consultation with them on 18/03/2011). 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). On 19/11/2012, he registered with a new GP Surgery (the same one as Adult H in Croydon).

1.23 Adult H's first contact with her original GP was on 07/06/2005. On 21/07/2009 she registered with the Green Surgery, which Adult H then later joined.

1.24 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.

1.25 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:

1.26 **Croydon Health Service NHS Trust**

1.26.1 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.

1.26.2 Croydon Community Health Service was the provider arm of Croydon Primary Care Trust 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:

a. Adult Care Pathways

b. Surgery

c. Cancer and Core Functions

d. Family Services.

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

a. Emergency Department Adult and Children

b. 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

c. Safeguarding Child and Young People's Liaison Service

d. Maternity Services.

1.27 **NHS England**

1.27.1 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:

a. Authorisation and oversight of Clinical Commissioning Groups (CCGs) and support for their on-going development

b. Direct commissioning of primary care

c. Specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships)

d. Developing and sustaining effective partnerships across the health and care system.

1.28 **South London & Maudsley NHS Foundation Trust (SLaM)**

1.28.1 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.

1.28.2 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.

1.29 **Croydon Clinical Commissioning Group**

1.29.1 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.

The 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 Adult G (father/perpetrator) whilst Adult H (mother/victim) went to work. Adult G and Adult H had at this point actually separated but they were in regular contact with each other. Adult G had a new girlfriend (Girlfriend M) who received two text messages on that day from Adult G. One said that he wished he had killed himself and the second message at 13.30hours indicated that he wanted to attend Accident and Emergency as he was feeling down. He said he was waiting for Adult H outside her work and wanted to spend time with Child F prior to attending the hospital.

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

2.3 At 14:58 hours on 20/12/2012, the Police received a call from a concerned neighbour who stated he could hear the sounds of a disturbance at a neighbouring property. A female had been heard screaming and that there was bang noises coming from the address. The informant stated he knew the male and female and believed that the male had mental health issues. Police attended the address ten minutes later at 15:08 hours 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 hours, 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 hours, 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 (Adult G) had grabbed her and pulled inside her mouth. Later she made comment that Adult G had picked up Adult H 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 white froth/vomit around his mouth. Adult G 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. He said he had taken some pills. He was arrested for murder at 16:00 hours. 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, Adult G was conveyed to St Georges Hospital for further treatment. The ambulance left the scene at 16:46 hours and arrived at the hospital at 17:32 hours.

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 hours 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 Child F. At the time of her death, Adult H was aged 25 years and Adult G was 28 years. Their daughter Child F was 6 years old. Despite being separated at the time of Adult H's 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 18/12/2012 (two days before death Adult H's) 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 has one caution and three convictions for four offences. At the time of Adult H's death, he 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 on 18/12/2012.

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, Adult G started a new relationship (with M) having met his new partner at a gym where they both worked. Subsequent to Adult H's death, his new partner (Girlfriend 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[2]. 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 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:

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

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 Adult G 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 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 defenseless 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 H 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.

Contact with agencies and services

Metropolitan Police (including West Sussex Police matter)

3.1 Adult H and Adult G first came to notice of the Police as a couple in 2002. There was no significant history of reported domestic violence between them. There were three incidents of domestic violence between Adult H and Adult G reported to Police (in 2006, 2007 and 2012).

3.2 Despite being outside of the time period subject to this review, the Police noted that in 2002 Adult G was convicted of assault (Grievous Bodily Harm). Whilst on a lunch break at work, Adult G had an argument with a work colleague. In the presence of other colleagues he picked up a glass bottle and hit the male over the head. The victim suffered a fractured eye socket. Adult G was convicted and sentenced to one hundred hours Community Punishment Order. In the same year he assaulted his younger brother, who did not wish to take any action against Adult G.

3.3 In 2002, the couple were victims of an unprovoked attack by a large group. A counter allegation was made to the Police that Adult G had assaulted one of the group. There was insufficient evidence to progress the investigation.

3.4 In 2006, Adult H alleged Adult G had obtained credit in her name and incurred a significant amount of debt without her knowledge. He used her bank account, which she had given him legitimate access to for the purpose of paying bills, to apply for credit cards without her permission and by fraudulently using her details. Adult H was pregnant at the time. No further investigation was taken.

3.5 On 01/10/2006, (a week after Child F was born), Adult H and Adult G were living with Adult H's mother (Mother P). Adult H and her mother had an argument about the care of the baby (Child F). The Police were called and gave advice around alternative housing and seeking support from the GP about any concerns of postnatal depression. A Book 124D DV report, which contains a risk assessment, was completed. This is a risk assessment undertaken by the Police who attend domestic violence incidents to help understand the risk the victim faces and calibrate their response accordingly. The risk was assessed in full within the Book 124D and considered as standard. Adult H was signposted by the officers to Croydon

Domestic Violence Advocacy Service (CDVAS) and the Family Justice Centre. A Police Merlin Report[3] was created for Child F and shared with Social Services on 10/10/2006.

3.6 There was another domestic incident between Adult H and her mother on 11/11/2007. There was an allegation that Adult H had slapped her mother and pushed her head against the wall. Adult H was arrested for assault. A Book 124D and risk assessment was completed. This was recorded as 'standard' risk on the report. Adult H's mother provided a statement saying she did not want to take any action, and was signposted to the Family Justice Centre. Adult H was cautioned for assault.

3.7 March 2012 was the first occasion when Adult G was reported as a missing person by his new girlfriend, (Girlfriend M). She had last seen him before she left for a trip abroad. When she returned, he had left their flat without belongings. She highlighted to the Police that Adult G claimed he had Bipolar Disorder and although he was not on medication, he had weekly meetings around his mental health at a clinic in Greenwich[4]. The Police made enquiries with his mother who stated that Adult G had previously gone missing but this had not been formally reported. The Police IMR stated that Adult G "had apparently been found by his sister in a car with a knife".

3.8 The initial risk assessment by the Police on the missing persons report was shown as 'medium' risk due to his mental health concerns. He could not be traced and he had called in sick to work. He was eventually spoken to by the Police over the phone and he confirmed he was fine and returned home. He told officers that he had a GP's appointment on the same day.

3.9 On 14/05/2012, there is a second missing person report for Adult G by his new girlfriend (Girlfriend M). She reported that he had left their address on 12/05/2012 and not returned. There were concerns due to his apparent mental health issues. Due to the previous missing person report where he returned safely, Adult G was assessed by the Police as a 'low' risk missing person on this occasion. Enquiries were made with his family who confirmed that they had not had recent contact with him. Prior to the Police contacting Adult H, Adult G had returned home safe and well, but he refused to state where he had been.

[3] A Police Merlin report is created in all instances when a child or young person who comes to the attention of a Police officer where it is believed there are concerns about the child's well-being or safety and one or more of the Every Child Matters outcomes are not met, must be recorded onto a MERLIN PAC form, as soon as reasonably practicable and within that tour of duty. The child does not need to be present, only knowledge that a child exists.

3.10 Adult G apparently attempted suicide through a drug overdose on 05/10/2012 at Adult H's address. The Police were called to the above address by the LAS who had received a call from Adult G's GP stating he had consumed a large amount of cocaine in a suicide attempt. The GP stated that Adult G had made several suicide attempts during the week. Adult G had been looking after Child F, but she was found safe and well. He was taken to the Croydon University Hospital for a Mental Health Assessment. A Police Merlin report was created for Child F that highlighted the concern that Child F should not have unsupervised contact with Adult G until the full extent of his mental health issues were known and assessed. The Police Merlin was shared with Children's Social Care on 16/10/2012 and in addition a phone call was made to Children's Social Care to notify them on the same day.

3.11 During his treatment at Croydon University Hospital, Adult G threatened a member of nursing staff. On 06/11/2012, a nurse from the hospital attended Croydon Police Station and reported her concerns that a patient on a ward had displayed threatening behaviour towards her. Adult G had said to her, "I know where you live." The nurse said that he had previously been her neighbour. The incident was recorded as an intelligence report. It should have been recorded as a crime and it is unclear as to why this course of action was not taken by the officer. This intelligence report was supervised and closed on 06/11/2012. No further action was taken.

3.12 On 28/11/2012, the Police were called to Adult H's address by the LAS following Adult G taking a drug overdose and locking himself in the bathroom. He was struggling for breath and believed to be violent. Prior to arrival at the address, the Police were cancelled by the LAS. The LAS stated that he was being cooperative and agreed to attend hospital for a mental health assessment.

3.13 A few days later on 05/12/2012, there was a call from LAS to the Police from Adult H's address. The LAS stated that they had received a call from a female (believed to be Adult H) stating Adult G was having a psychotic episode at the address. He was hallucinating, suicidal and smashing property in the flat. The LAS were unable to provide an ambulance or attend, so they asked for Police for assistance to attend. When the Police officers attended, Adult G was outside of the address and was restrained. Officers assessed that Adult G needed urgent help and they could not wait any longer for an ambulance. He was taken by Police under sec 136 Mental Health Act to Croydon University Hospital. At the time the Bethlem Royal Hospital was full. Police assisted in transporting Adult G to Lambeth Hospital.

3.14 There was an incident of domestic violence between the couple on 18/12/2012. The Police were called to Adult H's address by Adult G who claimed that Adult H was taking drugs and preventing her and Child F from leaving the address. When the Police arrived, Adult G was not there. Adult H informed officers that he had punched her jaw and pulled her hair. She had no visible injury. She declined to make a statement and said she had not called the Police. Adult H asked for Adult G to be seen by mental health experts. Adult G was located nearby and he was arrested for common assault. He denied the assault and said that Adult H just wanted him sectioned. A Police Merlin report was created and shared with Children's Social Care on19/12/2012. The initial DASH Risk Assessment was completed and deemed to be standard.

3.15 During a further conversation with Adult H's mother, she revealed that she had been informed that there were witnesses to this assault on Adult H by Adult G. The CRIS entry shows that Adult G made the original call to the Police and that Adult H stated there were no other witnesses, apart from her daughter. Police made enquiries with neighbours but without further information being obtained.

3.16 Adult G arrived in custody at 09.35 hours on 18/12/2012, and was seen on several occasions by a Custody Nurse Practitioner. Adult G suggested that he was "Bipolar" and he was initially assessed as fit for interview with the presence of an appropriate adult (AA). The Police Community Safety Unit (CSU) Investigating Officer arranged for an AA to attend. Adult G's condition deteriorated whilst he was in custody and he appeared to hallucinate: he claimed he was seeing things that did not appear to be there. As a result, Police requested a Mental Health Assessment (MHA). Attempts were made to secure a representative from the Mental Health Team to attend:

3.16.1 At 16.53 hours an entry was made on the custody record to say that the Mental Health Team could not attend until 21.00hours

3.16.2 At 22.34 hours, the Mental Health Team said they had been diverted elsewhere.

3.17 A MHA took place between 00.05 and 01.00 hours on 19/12/2012. The Approved Mental Health Professional (AMHP) and two independent doctors, (section 12 approved psychiatrists) considered Adult G was not suitable for section under the Mental Health Act and no further contact was necessary from the Mental Health Team. They confirmed that he required an AA for interview.

3.18 The custody detention log shows no record as to whether enquiries were made to secure an AA following the MHA. Furthermore, there was no formal request to the Emergency

Duty Team during the evening of 18/12/2012 and the morning of 19/12/2012 (it has been confirmed that the Social Care AA service does not operate between 00.00 – 09.00 hours). The custody record provides no rationale behind the decision to place Adult G in a rest period. Whether the Custody Officer considered interviewing Adult G at this stage is not clear. Given that the custody time limit was rapidly expiring, had Adult G and his solicitor been agreeable and an AA been readily available, then Adult G could have been interviewed in these circumstances. However, Adult G was left to sleep and any attempts to acquire the services of an AA do not appear to have been made until after 07:00 hours. This significantly reduced any chance of Adult G being interviewed that morning.

3.19 At 08.30 hours on 19/12/2013, an entry was made on the custody record by the Custody Sergeant stating that efforts had been made to arrange two separate AAs but they were either unavailable at that time or not answering the phone. The twenty-four hour custody time limit was due to expire at 09.53 hours on 19/12/2013. There was insufficient time left to secure an AA to interview Adult G without exceeding the twenty-four hour detention limit. The offence was not indictable; therefore, an extension could not be authorised by a Superintendent. Adult H had not provided a statement and there was insufficient evidence for this matter to pass the 'Threshold Test' for the Crown Prosecution Service to consider charging Adult G.

3.20 The custody risk assessment detailed Adult G's self-harm and mention of Bipolar Disorder. The pre-release risk assessment recorded him to be 'a risk' due to the above factors but detailed that he had been assessed by the Mental Health Team and deemed not suitable for sectioning and no further engagement was required. On both the custody record and the crime report it was noted that there was no previous history of domestic violence. The crime report does not show any supervisory review of the uniformed Police Officer's risk assessment.

3.21 The Police Officers completed a domestic violence Book 124D risk assessment. It stated that Adult H showed she had a perception of risk in relation to Adult G's behaviour, that there had been an escalation and abuse of alcohol/drugs and mental health concerns with her partner. The level of risk was assessed as 'standard.'

3.22 At 08.46 hours, Adult G was given unconditional bail to return to the Police station on 05/01/2013. Adult H was informed of this decision. No record was made on the crime report as to what alternative safety measures or options were offered to her or whether the original risk assessment had been reviewed.

3.23 **West Sussex Police matter – incident on 04/08/2007**

3.23.1 On 04/08/2007, in West Sussex members of public called Police after Adult G had threatened and assaulted Adult H. She had been forced to leave the car and remove Child F whilst in traffic. The family had been in the car together when Adult G's mood significantly changed. After abusing Adult H he then unfastened her seat belt and Child F's baby seat, whilst still driving along. Adult H lent over to the rear of the car in an attempt to re-fasten Child F's seat. Adult G then struck her on the leg. As the car slowed in traffic Adult H got out with Child F (where members of public came to her assistance and called for Police). The Police arrived and stopped Adult G a short way down the road. He was arrested for common assault and taken to the Police station. He was interviewed and made admissions; he was then bailed. Adult H did not want to support any further action, but suggested during the risk assessment process that this was not the first time that she had been victim of abuse by him. Adult G was cautioned for common assault.

Health services

3.24 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 were considered. The outline of both his and Adult H's contact with health services need to be cross referenced together by the reader as there were several occasions when they saw different health services on the same day.

South London & Maudsley NHS Foundation Trust (SLaM)

3.25 Adult G was the very first person to be admitted to the new triage unit and it is noted that he received a "gold standard" service. He had two admissions, one for a brief period of respite care common for personality disorders and an extensive review in triage.

3.26 The first contact Adult G had with SLaM services was on 05/10/2012 when he was taken to Croydon University Hospital following a reported overdose in the context of recent self-harming behaviour. He was assessed by a Psychiatric Liaison Nurse who found no evidence that he was mentally unwell. He was offered an assessment by a psychiatrist but he declined. Adult G was unwilling to stay for further assessment and was given information on where he could get help should he need it in future.

3.27 The address he gave was the Croydon flat he shared with Adult H and his child. A referral was made to Children's Social Care and a Child in Need form was sent to them by Accident and Emergency on 06/11/2012.

3.28 Adult G presented again to Croydon University Hospital, Emergency Department on 23/10/12 at 15:09 hours with Adult H and his mother and father. He reported taking an overdose of cocaine, steroids and white spirit and that he had injected himself with white spirit and fly-spray. Adult G also reported trying to gas himself using a cooker.

3.29 Adult G was medically cleared before being assessed by a psychiatrist from the Mental Health Liaison Team. The psychiatrist undertook an assessment of Adult G risks as follows:

3.29.1 Risk to self - low/moderate

3.29.2 Risk to others - low, not aware of any previous history of harm to others but risk to daughter and wife would need to be reviewed

3.29.3 Risk of self-neglect – low

3.29.4 Risk of non-compliance - high, refusing admission and has history of not complying with medication or non-engagement with services.

3.30 Adult G refused informal admission and was therefore assessed by two doctors and an Approved Mental Health Professional [AMHP] for admission under Section 2 of the Mental Health Act. They concluded that he did not require formal compulsory admission.

3.31 Some confusion arose at this time about Adult G's home address as he appeared to have an address in Wandsworth as well as the address he shared with Adult H and Child F in Croydon. There was evidence of some liaison with Mental Health Services in Wandsworth, but Adult G was discharged to his Croydon address with follow-up to be provided by the Croydon Home Treatment Team (HTT).

3.32 Safeguarding issues were discussed and excluded by the Mental Health Liaison Team on 23/10/2012.

3.33 On 24/10/2012, Adult G was visited by HTT workers at his home in Croydon. On examination of the wound on his arm caused by the injection of white spirits, his hand was very swollen, almost white in colour and he said he was unable to move his fingers. The lower arm was also very swollen and looked red and discoloured in places. Adult G was shivery and his forehead felt hot to the touch. He was advised to return to Croydon University Hospital as soon as possible and Adult H agreed to drive him there.

3.34 Adult G was admitted to a surgical ward at Croydon University Hospital and discharged by Croydon HTT. A Child Needs Risk Screen[5], which assesses potential risks to a dependent child, was completed on 24/10/2012 by the HTT. This was then updated by them on 31/10/2012.

3.35 Adult G remained an inpatient in Croydon University Hospital until his discharge on 08/11/2012. Concerns about his mental state were followed up by the Mental Health Liaison Team at the hospital. During his lengthy admission, Adult G was seen for evaluation by a Consultant Psychiatrist whose impression of Adult G diagnosis was "adjustment disorder with dysphoric reaction".[6]

3.36 Two days before his discharge from hospital, Adult G had become quite aroused, aggressive and threatening to staff on hearing that there were plans to discharge him. He was initially assessed by a junior psychiatrist who was concerned about the threats Adult G was making and asked for a further assessment for admission to a mental health ward under Section 2 of the Mental Health Act [MHA].

3.37 The first doctor to assess him for a medical recommendation felt that "There are […] risks of violence towards others, but I am not convinced these are driven by mental illness" as a consequence the doctor did not make the recommendation for detention under The Mental Health Act and Adult G was to told that "…should his behaviour again become unmanageable, […] the team would call the Police."

3.38 After his discharge from the hospital on 08/11/2012 – 23/11/2012, Adult G was visited at home by members of the Croydon HTT. He was assessed daily by nurses and was seen twice by a consultant psychiatrist.

3.39 The earlier referral to Children's Social Care was followed up on 15/11/2012 at the request of the HTT. It was documented that Children's Social Care had received the referral and "no further action was needed at this time".

3.40 There were further updates to the Child Risk Screen recorded: on 12/11/2012 by the HTT. They also discussed the risks to Child F whilst Adult G was under his care on 13/11/2012. They sought a referral to Children's Social Care and discussed this with Adult G and Adult H on 14/11/2012.

[5] This assessment aims to ensure that the needs and safeguarding of dependent children (or others) that the service user may come into contact with, are considered.
[6] For an explanation of "adjustment disorder with dysphoric reaction" refer to section titled: Explanation of the context of Adult Gs mental diagnosis, assessment and the options for treatment.

3.41 Adult G was discharged from the care of the HTT back to his GP on 23/11/2012. He was reviewed shortly before discharge by the HTT Consultant Psychiatrist, who found "no evidence of mental illness – no affective, psychotic or neurotic symptoms." Evidence of mixed personality traits of antisocial and emotionally unstable types with harmful use of cocaine and steroids was found. It is noted that Adult G was not happy to be discharged at that time.

3.42 On 28/11/2012, Adult G presented to Croydon University Hospital Emergency Department having been brought in by LAS at 15:55 hours reporting that he had taken an overdose. He was medically cleared before being assessed by a duty psychiatrist with the Mental Health Liaison Team. The doctor's impression was that Adult G was experiencing depressive symptoms in response to his upcoming court appearance. He sought advice from a senior colleague who considered that there was an indication of personality traits and therefore a short respite admission was indicated.

3.43 There was further discussion of the risks Adult G might present to Child F. Both Adult G and Adult H reported no concerns for Child F's safety at home. It is unclear how these discussions were conducted and what specifically was asked. The Child Needs Risk Screen was reviewed during this contact but was not materially changed.

3.44 Adult G was admitted to an acute mental health ward at Bethlem Royal Hospital on 29/11/2012 and he was discharged the following day as planned. On discharge his diagnosis was documented as "mixed traits of Dissocial and Emotionally unstable personality disorder". Adult G was referred for a brief period of care co-ordination by the East Croydon Assessment and Treatment Community Mental Health Team – also known as East Croydon MAP.

3.45 It is understood that after discharge, a care coordinator was allocated to Adult G by East Croydon MAP but had some difficulty contacting him to carry out the required seven day follow-up.

3.46 On 05/12/2012 at 09.32 hours, Adult G arrived at Croydon University Hospital Emergency Department accompanied by the Police and it was reported that they had detained him under s136 of the MHA outside his address in Croydon. They had tried to transport him to the Croydon 136 Suite at Bethlem Royal Hospital but it was occupied. As an Emergency Department is not a designated "place of safety", Adult G was later transferred to the s136 Suite at Lambeth Hospital.

3.47 On assessment at the Lambeth Hospital, Adult G was found to be cooperative and stable. The psychiatrist who reviewed him considered discharge but then spoke with Adult H.

3.48 Adult H made it apparent to the doctor that Adult G had not stated the full facts of his ailments so the doctor decided to assess him for detention under Section 2 MHA so that Adult G's mental state could be fully assessed as an inpatient as he may "have transient psychotic symptoms sometimes seen in patients with Personality Disorders".

3.49 Adult G was detained under Section 2 for assessment and then transferred to Bethlem Royal Hospital on 06/12/2012. He was the first patient to be admitted to the newly opened Croydon Triage Ward. On admission, the routine drug screen was positive for cocaine.

3.50 A comprehensive assessment was conducted during the five day admission to the Triage Ward, which considered Adult G's personal, forensic and family history including his relationships. It is noted that much of the information on which the assessment was based was provided by Adult G however corroboration was gained from Adult H when she visited the ward.

3.51 There is a report that Adult H visited the ward and reported that she was scared of Adult G because he was angry with her. This appears to have been in relation to the incident on 05/12/2012 when she called the Police in response to his agitated behaviour and they had detained him under s136, which ultimately led to his detention and admission to hospital for assessment.

3.52 Initially Adult G presented as guarded on the ward but gradually opened up and denied symptoms of paranoia or psychosis. He engaged with nursing staff, and although his cooperation on the ward was reported to be conditional, Adult G was calm and concordant with medication but remained unforthcoming about his impending court case.

3.53 During the discharge planning process, there was discussion of the risks to and needs of Child F. Adult G and Adult H disclosed more information to the clinical team including that Adult H did not feel happy about leaving Child F alone with Adult G and would leave Child F with neighbours when she went to work.

3.54 Possible risks associated with the relationship between Adult G and Adult H were discussed in the MDT ward round and it was documented that "Adult H has been subjected to mental and some physical abuse by Adult G". After making these initial disclosures, it is stated that Adult H became more reassuring to the ward team and therefore the disclosures were minimised. Risk screens and assessments were completed and updated while Adult

G was on Triage. While they acknowledge that Adult H was concerned about Adult G when she called the Police, the assessments emphasise that Adult H was a protective factor, the disclosures made by Adult H were not fully represented in risk assessments.

3.55 Adult G was discharged from section 2 on 11/12/2012 and apparently returned home to Adult H and his child. His care coordinator at East Croydon MAP was aware that he had been discharged and spoke to him by phone (on the 12/12/2012). Adult G attended a duty appointment, he was advised to go to Accident and Emergency about his arm. At 10:20 Adult G telephoned the ward to report that he had not been seen for his discharge follow up as arranged. On referring to EPJs entries, the nurse taking the call explained that the telephone conversation he had with his care coordinator on the 12/12/2012 was noted as his 7 day discharge follow up.

3.56 A call is received on 15/12/2012 (stated as Adult G's sister) to ask if he has been admitted to hospital. On the 17/12/2012 the care coordinator rang Adult G several times to change the time of the home visit later in the day (from 14:00 to 15:30 hours). Adult H returned the call to say that they were going out and would not be at home for a later visit. He did not attend his appointment with SLaM on the 18/12/2012.

3.57 Following the domestic incident on 18/12/2012, at the Police station, Adult G's mental state was assessed in the early hours of the morning of 19/12/2012 by an AMHP and two independent doctors: one of which was a senior psychiatrist. The professionals who assessed Adult G had access to his records prior to their visit and it was confirmed that they read and discussed his notes and history prior to assessment. All of the professionals saw Adult G face-to-face. All three professionals agreed that he did not meet the criteria for admission or detention (sectioning). The AMHP who assessed Adult G contacted Adult H to discuss any concerns with her, to gain some collateral information and discuss with her where Adult G should go once released. During this conversation, Adult H clearly stated that she wished Adult G to come back to the home address.

3.58 After concluding the assessment, the AMHP emailed the care coordinator at East Croydon MAP so he could pick up safeguarding concerns the following day. On 19/12/2012, a letter was sent to Adult G from the IAPT service highlighting concerns about his responses to the completed questionnaire they had received showing thoughts of self-harm and intent to end his life. The questionnaire had been received on 11/12/2012 and reviewed by the Team on 19/12/2012 with a referral made to MAP Team East (Mood Anxiety and Personality Team) on the same day.

3.59 On the afternoon of 20/12/2012, a care coordinator attended Adult H address as planned for a home visit, he was met by Police who informed him that the patient had killed his wife.

General Practice

3.60 Although prior to the time period subject to this review, Adult G's GP records show a history of depression and suicidal thoughts back in 2002, there is no formal diagnosis in Adult G's records of Bipolar Disorder. There was no record whether he was referred for counselling.

3.61 At the beginning of 2005, Adult G was seen as he had an unexplained swollen hand and heart burn/chest pain in July 2005. He was given advice by the GP practice regarding stress management.

3.62 In June 2005, Adult H registered with the GP Blue Surgery. She registered using her maiden name. No concerns are documented on registration. One month after Child F's birth, Adult H was admitted to St. George's Hospital for a scan. The GP contacted Adult H by telephone the same day with her diagnosis, but there is no evidence of follow-up to this event within her records by GP practice.

3.63 Between 2006 – 2008, Adult G was registered with GP Surgery in Blackheath, initially on 05/06/2006 with no concerns at registration. From the end of June 2006 until the end of August 2008, Adult G was seen on a number occasions regarding problems at work with his manager, work related stress, complaining of sleeping problems and back/joint pains. There is an admission to Accident and Emergency on 30/09/2007 with no evidence for the reason for admission or any follow-up regarding this event.

3.64 In April 2007, Adult H was seen at GP Blue Surgery. She was depressed and stated that she had felt low for the last four months. She was not considered suicidal or of having any thoughts of harming Child F. She stated that she had no support. The GP asked her to think about taking antidepressants and counselling. No depression screening was evident.

3.65 Adult H was seen again on 03/05/2007 and expressed a wish to have antidepressants and counselling. Citalopram 20mg was prescribed and she was referred to psychological therapies. A depression questionnaire score of 19/24 is recorded though no evidence of the questionnaire was in her patient notes. She was next seen on 07/06/2007, but there is no discussion about depression. A week later Adult H rang the practice requesting her GP write to the council as she was staying with her mother and wished to move. On 23/07/2007, Adult H saw her GP. She was still depressed and had started to experience panic attacks. There was no evidence of depression screening, nor any enquiry for the

reasons for the stress and panic attacks. However, following her appointment, that same day she received a call from the Priory who conducted a telephone assessment with her about her depression.

3.66 The GP records are unclear, which highlights problematic recording. Adult H was seen by the same GP but for different health issues; however, there was no follow up or review of the depression previously mentioned.

3.67 On 01/08/2007, Adult H was sent a letter following her telephone assessment, signposting to 1:1 counselling services for young people. On 09/08/2007, a letter was received by the GP from the psychology department at the Priory confirming the referral. There is no evidence of follow-up with Adult H until a month later (11/09/2007) when she was seen by the GP still depressed, experiencing panic attacks and stress from her living arrangements with no kitchen facilities. She expressed a wish to have her own home and no longer live with her mother. Citalopram was increased to 30mg for a week with a further appointment made for 12/10/2007, where she is still experiencing a depressed mood and wishing to have contraceptive pill. There was no evidence of depression screening during this period.

3.68 At the end of August 2008, Adult H was seen for travel vaccinations and there was no mention of discussion regarding depression, her past history of panic attacks or her living accommodation.

3.69 In July 2009, Adult H registered with a new GP surgery in Croydon. There was no mention of discussion regarding a past history of depression at this stage. She was seen on a number of occasions after registering with the practice by GPs and Practice Nurses for issues deemed by the panel to be irrelevant to the nature of this review.

3.70 From the beginning of 2009, Adult G sought advice regarding family planning and investigations continued to be conducted by the GP practice until August 2009. During 2009, Adult G had appointments at a number of GP practices regarding stress and bullying at his work. He requested sick certificates and claimed continuing problems with back pain. He also requested help with family planning and received a referral to Mayday Urology Department. In November 2009 he left a telephone message for the GP, but there is no documentation of the reason or any follow-up.

3.71 At the beginning of 2010, Adult G contacted the GP Surgery (in Blackheath) by telephone regarding a urology outpatient appointment as he had not received an appointment. The GP practice informed him that the letter had been sent to his Croydon address. He informed the practice that he had moved back to Blackheath and wished to stay with the

GP Surgery. The practice informed him that he needed to re-register with a Croydon GP (to be referred back to Croydon University Hospital.

3.72 Adult G was seen on 18/03/2011 at the Blackheath GP Surgery saying he felt unwell and expressed suicidal thoughts with a query noted as whether he had taken an overdose of tablets. It is documented that he had poor sleeping, early waking and urges to kill someone from his previous job. He felt angry and felt like destroying things like his sofa but did not know why he had done it. He informed the GP that he 'jarred' someone when he was 17 years of age, had difficulty staying in one job for long and that his family had a strong history of schizophrenia. The GP made a referral to the Assessment and Shared Care Team for urgent assessment and possible admission.

3.73 At the end of March 2011, Adult G was seen at the GP Surgery (in Greenwich) and also at the GP Surgery in Blackheath on the same day. He was screened for depression at by the Croydon GP Surgery with no action or follow-up. At the Blackheath GP Surgery Adult G was screened for depression with a score 21/24 (considered to be a high score), documented that he felt low, poor appetite or binge eating with no suicidal thoughts. He requested a sick certificate as he was due for a disciplinary hearing at work the next day. The GP prescribed Citalopram 20mg and advised him to attend the work hearing and contact the anger management team he had been referred to. The GP advised Adult G that if he felt suicidal to contact the Samaritans or go to Accident and Emergency. There was no discussion regarding referral earlier in the month to the Assessment and Shared Care Team or repeat referral to the same, with the view to review in a month or earlier. There was no further follow-up, as this was the last consultation at the Blackheath GP Surgery.

3.74 Adult G was referred by his GP to Oxleas NHS Trust, and was assessed by their Intake and Liaison Team on 18/03/2011. He was not taken on for treatment and the assessor did made contact with the referring GP suggesting that Adult G should be prescribed a low dose anti-depressant. They signposted Adult G to a local third sector resource for anger management and he was also given contact details for the out-of-hours urgent advice line.

3.75 On 11/04/2011, Adult G was seen at GP Surgery in Greenwich regarding on-going depression and screened for depression with a score of 23/24 (deemed high) and referred by fax to Ferryview Shared Care Team. This was concluded in July 2011 with the GP Practice receiving a letter to confirm non - attendance at the appointment at Ferryview. There was no evidence of follow-up from the GP in relation to this non-attendance.

3.76 That same day (11/04/2011), the Greenwich Intake and Liaison Team (Oxleas NHS Trust) were contacted by another GP (from the same GP practice) as Adult G had been brought

to see him by his mother. She was complaining about the diagnosis of mild depression made at the assessment in March. She also stated that her son had not obtained the anti-depressants prescribed to him by the GP as he had no money. The mother felt that he was suffering with some form of schizophrenia and described a number of presenting problems. Following discussion with the GP, the Intake and Liaison Team advised him to refer Adult G for a psychiatric review.

3.77 Adult G then did not attend his appointment on 06/07/2011. The Oxleas NHS Trust Intake and Liaison Team contacted Adult G's mother who told them that he no longer lived with her and "comes and goes as he pleases". She reported that he did not attend that day because he had another appointment. She had no contact number for him. The team agreed to send him a letter with details on how to contact the service again should he need to. It was then agreed with his GP to discharge him on that basis and his case was closed on 22/07/2011.

3.78 On 09/02/2012, Adult G's GP Surgery in Greenwich received a telephone call from him (no record of reason or follow-up noted. In April 2012, there was a third party discussion with Adult G's mother that his new girlfriend (Girlfriend M), had reported him missing to the Police (he had not been seen at this GP practice since April 2011).

3.79 Adult H saw her GP (her second GP practice in Croydon which Adult G later joined) on 12/10/2012 with abnormal weight loss of two stone. She stated she had a lack of appetite, was coping with caring for a child of six years of age and two jobs on a teaching training course and working in a supermarket. She discussed with her GP that her partner had mental health problems, that he can be aggressive often, smashing chairs or mirrors, but had never hit her. She disclosed she had little support. There is no evidence of depression screening or discussion regarding her vulnerability (or Child F) or referral to Children's Services.

3.80 In October 2012, Adult G was admitted to Croydon University Hospital after apparently injecting fly spray, white spirit and cocaine into his right arm requiring orthopaedic surgery. During his hospital stay, Adult G was seen by the Psychiatric Liaison Team regarding self-harm and mental wellbeing with the view for admission to the Bethlem Royal Hospital. A decision was made for him to be discharged to the Croydon Home Treatment Team. Within the discharge summary there is no mention of concerns or consideration regarding the impact or vulnerability of Adult H or Child F. The discharge summary was sent to his GP; although, there is no evidence of registration with this GP Practice resulting in no follow-up. A copy of a letter to Adult G regarding a Croydon Immediate Access to Psychological

Therapies (IAPT) referral is sent to Adult H's GP Surgery: as Adult G was not registered with the GP Practice at this time, the referral resulted in no follow-up at this stage or when he registered with the practice on 19/11/2012.

3.81 A history of depression was recorded on Adult G's registration at Adult H's GP Surgery. There was no evidence of a confirmation of his mental health diagnosis, or discussion regarding his recent hospital admission, mental health input or impact on home life and support networks. When he was seen on22/11/2012 by the GP, there is evidence of the discussion of mental health support and an intention by the GP to make contact with the Home Treatment Team. There is no record of the GP contacting the Home Treatment Team or considering any impact on the family unit or vulnerability of Adult H and Child F.

3.82 Adult H was last seen at her GP Surgery on 08/11/2012 when it was noted she was called twice for the consultation and eventually found with her partner and was seen regarding problems with vomiting. Adult G was also present during the consultation. The GP documented that Adult G told him he had Bipolar Disorder. It is unclear in the records whether Adult G or Adult H said this to the GP. The GP suggested that Adult G register with the same GP practice (which he appears to have done on 19/11/2012). Adult G was observed to be polite but restless and disruptive during consultation. There was no discussion about their relationship, depression or stress or the impact on their young daughter of Adult G's enduring mental health. There was an appointment on 22/11/2012, but Adult H did not attend (this was the first time she had ever failed to attend). A follow-up and an appointment made for the 21/12/2012 (the day after her death).

3.83 On 28/11/2012 at 15:35 hours, Adult G was admitted to Accident and Emergency following a 999 call due to an overdose of Ibuprofen tablets. He was assessed by the Psychiatric Liaison Team as suicidal with intent to kill himself and transferred to Gresham 2 Ward from Accident and Emergency. Adult G was due for a court case attendance on 29/11/2012 (which he subsequently did not appear for) and was deemed well enough to attend the court case and to return to his home environment with the support of the Community Mental Health Team (CMHT) for seven days and to contact the SUN Project (Service User Network for people with personality disorders).

3.84 The suicidal attempt was diagnosed as an impulsive act as there was no evidence of depressive disorder or suicidal thoughts. In the discharge summary on 29/11/2012, the assessment of risk noted that Adult G was worried about his safety at home and that his relationship with his daughter was 'fine'. He denied ever having thoughts of wanting to harm his daughter and Adult H confirmed she had no concerns for Child F's safety. There

was no evidence or consideration of referral to Children Services or contact with the GP Practice following discharge.

3.85 On 05/12/2012, Adult G's admittance to Croydon University Hospital Accident and Emergency is evidenced by a discharge letter to the GP practice received on 12/12/2012. It noted an overdose and poisoning with a subsequent transfer to Lambeth Hospital and a letter from Croydon University Hospital Vascular Team was received the same day highlighting that he was being cared for by his wife and friend (not named) twenty-four hours a day. Further correspondence was received from SLaM on 18/12/2012 informing that Adult G had not attended an outpatient's appointment. There is no evidence of follow-up from the GP practice about the combination of these events.

3.86 On 19/12/2012, a letter was sent to Adult G from the IAPT service. There is no evidence of the patient or GP being contacted other than by letter with the GP practice receiving the letters on 24/12/2012. service highlighting concerns about his responses to the completed questionnaire they had received showing thoughts of self-harm and intent to end his life. The questionnaire had been received on 11/12/2012 and reviewed by the Team on 19/12/2012 with a referral made to MAP Team East (Mood Anxiety and Personality Team) on the same day.

Croydon Council – Family Justice Centre

3.87 Adult H was referred to the Family Justice Centre (FJC) in 2006 by the Police following the domestic incident with her mother where they argued about child care. The FJC included the Domestic Violence Advocacy Service and neither had a record of this contact.

3.88 It has been confirmed that the Domestic Violence Advocacy Service is still in operation and is a key service within the Family Justice Centre. There are now different systems in place (from 2006 and 2007) where a list of details of all domestic incidents is shared with them from the Police every day so that proactive contact can be made with victims. The FJC are reviewing their policies and procedures in relation to referral practices.

Croydon Council Support – Adult Social Services and Housing

3.89 Adult H was not a tenant of Croydon Landlord Services. She privately rented her accommodation where she held an assured short hold tenancy with the leaseholder, who had purchased the property on a lease from Croydon Council in 2006.

3.90 Adult H approached Croydon Council as a homeless applicant following issues of domestic violence between herself and her mother and stayed at a hotel between 30/06/2006 to 17/07/2006 with Adult G. Records showed that she had been living alone at the address with Child F since 19/12/2007.

Croydon Health Services NHS Trust

3.91 The couple and their child (Child F) were known to the Emergency Department (Adult and Children), Children's Universal Service (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) and the Safeguarding Child and Young People's Liaison Service.

3.92 In 2011 following a recommendation made in a Serious Case Review, a prompts system was implemented within the Emergency Department. The prompt is a stamp that was to be added to the Emergency Department paper record for all adults who attend the Emergency Department at Croydon University Hospital. The purpose of the prompts was to assist staff in identifying the following:

- Adult / young person has any dependants (children/ unborn children)
- Dependants are subject to a child protection plan
- Adult or young person presents as a vulnerable person
- Adult or young person is looked after by a local authority
- Evidence of domestic violence/abuse
- Evidence of drug and alcohol misuse
- Evidence of a learning disability
- Adult or young person presents with any mental health problems.

3.93 There is no documentary evidence to suggest that this prompt was used with any contact with Adult G.

3.94 During the families contact with Health Services there were opportunities for identification and assessment of domestic violence. For example, the Antenatal Booking Clinic appointment in March 2006 and the subsequent antenatal contacts the maternity services had with Adult H. At each antenatal appointment a woman's risks should be reviewed and an individualised management plan must be documented in the pregnancy notes. The pregnancy care record used at that time included a section on domestic violence, substance use and ill mental health. This has been embedded into policy within CHS since

2012[7]. There were no obstetric and midwifery records within Adult H's confidential file. It has therefore not been possible to identify if the midwife asked Adult H about current or previous history of domestic violence when she was seen at the antenatal booking clinic or for subsequent antenatal contacts.

3.95 On 03/10/2006, the Health Visitor completed a new birth visit. Adult G was not present at this visit, but Adult H did identify that she had a partner. There was no documentary evidence to suggest that Adult H's experience of domestic violence or her relationship with Adult G was explored by the Health Visitor.

3.96 It is noteworthy that on 01/05/2007, Adult H did not want to change her health visiting appointment to a home visit after she said she was not confident with the staff in the clinic. This potential indicator of issues in the home was not explored.

3.97 On 19/06/2009, Adult H was seen at the emergency department at Croydon University Hospital with moderate abdominal pain, mild headache, nausea and tiredness. The notes state that she was possibly approximately five weeks pregnant at the time. Research shows that 30% of domestic violence begins or escalates during pregnancy[8].
There is no other evidence or records of this pregnancy and there is no documentary evidence to suggest that Adult H was asked about the possibility of domestic violence.

3.98 There was also a notable list of attendance and contact by Adult G with Health Services in the months leading up to Adult H's death.

3.99 Adult G came to the Emergency Department at Croydon University Hospital on 23/10/2012, 28/11/2012 and 05/12/2012 with mental health concerns (on 05/10/2012 and 05/12/2012 Adult G attended the Emergency Department with the Police). He attended the emergency department on seven separate occasions during a two month period from 05/10/2012 to 05/12/2012.

3.100 Child protection referrals to Croydon Children's Social Care were completed by doctors in the Emergency Department on 05/10/2012 and 23/10/2012. There is evidence that referrals were successfully faxed through, but there is no record of follow-up or that the referral had been received or acted on by Children's Social Care.

3.101 On 05/10/2012, Adult G attended the Emergency Department following multiple suicide attempts. He had taken an overdose of Diazepam and stated that he had attempted suicide

[7] Clinical Risk Assessment (Antenatal). Health Services 1, June 2012.
[8] Gynneth Lewis and James Drife, Why Mothers Die 2000-2002 - Report on confidential enquiries into maternal deaths in the United Kingdom (CEMACH, 2005).

by self-strangulation and ingestion of cocaine. He disclosed to the emergency doctor he had been low in mood for several weeks and in the last week had tried on multiple occasions to kill himself. He presented as increasingly aggressive and hostile, refused to wait to see the on call psychiatric team and wanted to leave the Emergency Department. The Emergency Department duty doctor had completed a child protection referral in light of concerns about the safety of Child F. Adult G was subsequently seen by a social worker within the on call psychiatric team, who assessed him as "having capacity" as his mental health issues were as a result of drug and substance use. He was then discharged home without needing to see the psychiatric team.

3.102 On 23/10/2012, Adult G attended the Emergency Department at Croydon University Hospital. He disclosed to the duty doctor that he had been trying to kill himself for the last three weeks, and that he had tried to kill himself by ingesting cocaine, white spirits and steroids. He had injected white spirits into his left forearm and inhaled gas from the cooker at home. He stated that he had planned the suicide attempts and intended to try it again.

3.103 Adult G also stated that he had been diagnosed with Bipolar Disorder at Oxleas NHS Trust hospital in Greenwich[9].

3.104 Adult G's care was shared by the Emergency Department Team and the on call psychiatric team. As stated in the IMR, the Emergency Department doctor became aware of Adult G having a child through overhearing Adult H and Adult G talking about her. He completed a child protection referral because he was concerned about the risk to Child F. It is recorded that Adult H and Adult G's mother were seen by the on call psychiatric team and they expressed concerns about his mental health. Adult H also disclosed to the on call psychiatric team that Adult G believed she was having an affair. There was no evidence of the awareness of the risks this posed to Adult H.

3.105 A child protection referral was then completed in relation to Adult G's suicide attempt and aggressiveness. This was appropriate but the risks posed were not clearly defined within the referral. No relevant and additional information had been included about Adult G's self-reported Bipolar Disorder, his multiple suicide attempts, the fact that a child protection referral had been completed two weeks ago or the reasons for this.

3.106 On 24/10/2012, Adult G returned to the Emergency Department because his left arm was now swollen and painful. The paper record completed by the Orthopaedic Senior House Officer specifically states in the initial assessment on Adult G: *"domestic disharmony" (with*

[9] It has been subsequently confirmed by Oxleas NHS Trust that Adult G did have appointments with their services following referrals made by his GP but that Bipolar Disorder was never diagnosed.

his wife). He was also recorded as displaying increasingly aggressive and concerning behaviour but there no documentary evidence to suggest that the doctor attempted to respond to these issues and purely focused on providing medical treatment.

3.107 In the period from 24/10/2012 to 07/11/2012, Adult G was an inpatient on an adult orthopaedic ward and he was displaying increasingly concerning behaviour. He was presenting as aggressive, angry, paranoid and abusive towards ward staff as set out below:

3.107.1 25/10/2012 Adult G was presenting as irritable, disruptive to fellow patients and difficult to manage

3.107.2 27/10/2012 Adult G was presenting as anxious and having aggressive responses

3.107.3 28/10/2012 Adult G became extremely aggressive towards staff on the ward- shouting, swearing and threatening violence. Security had to be called.

3.107.4 30/10/2012 Adult G disclosed the following to the psychiatric liaison team:

a. A history of self-harm, provoked or triggered by minor or trivial changes in his circumstances (such as an argument with his wife)
b. He occasionally used alcohol and illicit drugs when his mind is disturbed or he has unpleasant moods.

3.107.5 06/11/2012 Adult G had become aggressive, angry, paranoid and abusive towards ward staff. He was described by medical staff as potentially dangerous to the point that staff required the presence of security staff on the ward. The psychiatric liaison team recorded that:

a. He had become physically disturbed after an argument with the tea trolley man
b. He had become fixated on a member of staff (who was an ex next door neighbour) and threatened to kill/murder her (this nurse then went and reported these threats to the Police 06/11/2012)
c. He threatened the security staff with a knife if they went near him
d. He felt ‘paranoid’.

3.108 At one point Adult H was seen as a calming influence on Adult G. There is no documentary evidence of the risks of domestic violence being explored with Adult H, or her opinion being sought regarding the decision to discharge Adult G home on 07/11/2012, instead of being admitted to Bethlem Royal Hospital. An admission to Bethlem was expected by the ward

and medical staff. Nursing staff were advised Adult G was to be sectioned if he did not voluntarily agree to the admission.

3.109 On 28/11/2012, Adult G came to the Emergency Department following attempted suicide by overdose of ibuprofen tablets. Adult H disclosed to the triage nurse that she was concerned about his behaviour but this was not explored.

London Probation Trust

3.110 Adult G was sentenced to a twelve months Suspended Sentence Supervision Order on 21/08/2007 with a requirement to attend a Thinking Skills Programme. He completed the order in August 2008. The offence was stealing by an employee. At the time he stated that his motivation for committing this offence was as a result of being bullied at work and he took the money out of spite.

3.111 Adult G complied with his order, completed the Thinking Skills Programme and reported to his offender manager as directed. He attended all appointments, there were no reported problems and he engaged well with the group work.

3.112 Adult G's offender manager did not undertake enquiries with the Police to establish if there were any other Police call outs. There was no suggestion of domestic violence or any serious mental health concerns being identified. No home visit was conducted during his period of supervision.

3.113 The only concern detailed during the supervision period was an allegation that Adult G had sent his manager two threatening texts on the night he had committed the theft offence from his employer. Adult G said that he was very stressed at the time of sending the text messages and the manager had been party to the bullying he had experienced at work. No charges were brought against him regarding this matter.

3.114 Adult G was registered as a Tier 3 offender which would indicate medium level intensity involvement was required. He was registered on London Probation's case management system as a potentially dangerous offender, albeit the rationale for this is unclear because it was migrated from an old IT system.

3.115 The probation record did not have any evidence of Adult G's mental health issues. The only mention is in relation to his disclosure that he was being bullied at work and felt under stress as a result of this, and this was recorded as having been a factor in why he committed the theft from his employer.

3.116 The Police previous convictions indicate that in 2007 Adult G was on Police bail to Sussex Police. As this matter was pending, it did not appear on the system checks conducted by the Metropolitan Police as it was out of their area. It is unclear from the file if Adult G'S history was ever later rechecked by Probation with the Metropolitan Police.

3.117 Adult G did not fall within the criteria of a referral to a Multi Agency Public Protection Arrangements.

3.118 Adult H was not known to the Probation Service.

Croydon Council – Safeguarding and Looked After Children Service

3.119 The family's first contact with Children Social Care was in 2006. This was a 'fax' from the Police (assumed to be a Police Merlin report). The only recording in the computer record is that this related to "Family/Relationship Problem". A copy of this Police Merlin report could not be found as it was the 'pre 2009 archive'. There is no evidence that Children's Social Care took any action at that point.

3.120 From cross referencing the other agency IMRs and the integrated chronology, this fax would have been as a result of the domestic incident between Adult H and her mother on 01/10/2006. It should be noted that Child F at this point was two weeks and two days old.

3.121 There is no subsequent contact with Children's Social Care over the next six years.

3.122 The Accident and Emergency referral to Children's Social Care about the risk Child F was being exposed to by Adult G (dated 05/10/12 at 19:52 hours) references the "concern of harm to self" (Adult G) but specifically states: "there is no history of violence towards child or partner". The referral document goes on to say that the expected outcome is that Children's Social Care will ". . . assess [the] safety of child as father intermittently lives with them".

3.123 On 06/10/2012, a referral was received from Croydon University Hospital's Accident and Emergency Department and the LAS in relation to an event on 05/10/2012. Adult G had "... presented at Accident and Emergency following a period of low mood and multiple suicide attempts." The LAS had been contacted by Child F's mother (Adult H) and his current "partner" (new girlfriend M).

3.124 The referral was closed on 09/10/2012 and a letter was sent to Adult H on 25/10/2012 advising her whom to contact if she required additional support. However, on 25/10/2012 a new contact is loaded to Child F's record by Children's Social Care at 17:39 hours following

the receipt of a Police Merlin in relation to the events on 05/10/2012. The Police Merlin report is dated 06/10/2012 and states that the Police attended the family home, having been called by the LAS.

3.125 The report made reference to a "...Bipolar Disorder where he (Adult G) can become aggressive and depressed" and the report also explores "… concerns that Adult G could have a violent outburst". The report states that they had observed "...signs that Adult G had punched walls and doors" within the property.

3.126 The report also explores discussions with Adult H on 05/10/2012 surrounding events on 04/10/2012. According to these discussions, Adult H had left Child F with Adult G. During that evening whilst caring for his daughter, Adult G stated he had taken "cocaine to see if it would kill him".

3.127 According to the Police report, Adult H was advised by Police Officers not to allow Adult G to have "… unsupervised contact with Child F until he is deemed fit and stable by a mental health worker."

3.128 The Police Merlin Report's risk assessment on Adult G listed the following risk factors:

- Substance/Alcohol Abuse
- Mental Health Issues
- Repeat Merlin.

3.129 Risk factors relating to "Tendency Towards Violence', 'Domestic Violence and 'Abuse' are all incorrectly listed as 'Unknown'.

3.130 On 25/10/2012, a contact is created within Child F's record and there is a review of the earlier Police Merlin Report. The duty senior links this referral to the earlier information, the record comments; "... this is the same incident [as] the one reported on 06/10/2012".

3.131 The following tasks are set and 'allocated' to be completed by a Duty and Assessment Officer (DAO):

- Contact Mental Health services, establish who is working with father
- Contact Mother on the number known, if unsuccessful contact the school to see if they have alternative contact number
- Clarify with mother if she has received our letter and establish what the contact arrangements are with father

- Establish who is the father's GP.

3.132 On 30/10/2012, the above tasks had not been progressed and there is a case record completed by the Duty Senior reminding the DAO to 'undertake tasks'. The record then details on 31/10/2012 several attempts made by the DAO to contact mother; the records state "... the phone ring[s] but no one is picking up, there is no answer phone ..." The records also make reference to the fact that Child F's school is closed because it is 'half term'. The records also detail multiple calls to the Home Treatment Team (HTT), and subsequent clarity from HTT in relation to who is responsible for Adult G from a psychiatric perspective.

3.133 Children's Social Care was informed that Adult G was in hospital and that he will be assessed by the Mental Health Team close to discharge, but that a date was not yet known for this. On 01/11/2012, this was reviewed and the case was closed with no further action to be taken on the basis that Adult G would be having a mental health assessment prior to any discharge. By the time this was followed-up, Adult G had left and returned again to the hospital.

3.134 There was an error in the dating of the Police Merlin Report. It was dated 06/10/2012; however, within the report itself there was reference to checks completed by the Public Protection Desk on 16/10/2012. This report could not have been completed or sent to Children's Social Care until at least eleven days after the incident and was not recorded as received by Children's Social Care until 25/10/2012. This is twenty days after the incident.

3.135 The report incorrectly stated that: "There are no other reports on Merlin regarding this subject". This is incorrect as a Police Merlin Report was created in relation to a domestic incident and received by Children's Social Care on 04/10/2006.

3.136 This Police Merlin Report did not include details of the two occasions when Adult G was reported 'as missing' and two occasions when he was arrested for theft. It also did not make reference to his history of violence. The Police Merlin Report did however reference concerns in relation to Adult H stating she was accused of committing ABH on her mother (Mother P).

3.137 According to the IMR, the tasks to contact mother and the professional network should have been undertaken by a qualified Social Worker not a Duty and Assessment Officer.

3.138 A Police Merlin Report was created on 19/12/2012 for the incident on 18/12/2012; however, Children's Social Care was unaware of this until after the events of 20/12/2012 (it was

recorded as received by Children's Social Care on 21/12/2012 following the Police Merlin Report being 'emailed to Group Assessment Managers in error by Pembroke Social Work Team'). Although this is noted as a delay, the panel is of the view that this would not have delayed action being taken as even if there was no delay, the information would not have been received before Adult H's death.

London Ambulance Service NHS Trust

3.139 On 05/10/2012, Adult G's sister made a total of five separate 999 calls to the Emergency Operations Centre (EOC) to attend Adult H's address (12:33 hours, 13:30 hours, 14:17 hours, 14:42 hours and 15:01 hours). It was reported that a 27 year old male (Adult G) had suicidal ideations. The caller stated that Adult G was her brother and that she was not with him but that she had received text messages from a friend who was with Adult G at Adult H's address.

3.140 It is noted on the call log that Adult G's friend was not taking things seriously. The friend was leaving his 6 year old daughter in Adult G's care whilst Adult G was using cocaine. A Child Safeguarding Concern was documented as being completed. This document was not received by the Trust's Emergency Bed Service (EBS) and therefore was not forwarded to the local authority as per the Trust's policies and procedures.

3.141 It was reported that Adult G had attempted suicide a few times and did not want assistance (on 01/10/2012 he had tried to hang himself but a friend had found him but did not call for help as Adult G did not want him to). It was also reported that Adult G had a cut on his head. Two vehicles were dispatched at 12:33 hours and 14:34 hours. These were both cancelled for a higher priority call. Further calls were received at 13:30 hours, 14:17 hours, 14:42 hours and 15:01 hours requesting the estimated time of arrival of an ambulance. Limited resourcing combined with increased demand for ambulances resulted in a delay in the ambulance being dispatched. A request for Police assistance was made at 14:31 hours by LAS control room staff on behalf of the crew attending the call. The 999 call log documented "significant danger to themselves or others, Adult G who has made numerous attempts of suicide in the past, now becoming agitated and violent"

3.142 An ambulance was dispatched at 14:39 hours arriving at address at 14:57 hours. On arrival the ambulance staff documented that Adult G wanted to take his own life. Adult G had attempted suicide on several occasions over past few weeks by overdose of sleeping tablets, cocaine and attempted hanging. Adult G was not on any prescribed medication. Adult G was of no fixed abode living between his ex-wife (Adult H), current girlfriend M and

his parents' homes. Adult G was found sitting in his daughter's bedroom wedged against the door refusing to come out, after approximately ten minutes Adult G agreed to sit in the lounge area and talk to the ambulance staff.

3.143 Adult G refused to allow any observations to be undertaken. He explained that he had taken several lines of cocaine to try and kill himself. Adult G agreed he needed help; however, he was not prepared to be taken to hospital.

3.144 A Fast Response Unit and the Police service were requested to assist. A Fast Response Unit was dispatched at 16:12 hours, arriving at 17:03 hours.

3.145 On arrival of the Fast responder to the address, an Assessment of Capacity Tool was completed and Adult G was assessed as not having capacity in respect of consenting to treatment or conveyance to hospital. However, after some persuasion, Adult G did agree to go to hospital and was transferred to the ambulance with a Police escort.

3.146 Following the crew's examination, Adult G was conveyed to Croydon University Hospital. The ambulance left the scene at 17:14 hours and arrived at the hospital at 17:30 hours.

3.147 En route to hospital, Adult G became progressively agitated advising that whilst in the flat he had thoughts of stabbing all of the staff on scene and locking himself in the bathroom. He stated that he felt it would have been a bloodbath. Adult G continued to behave irrationally, opening cupboards on the ambulance and touching disposable items.

3.148 The call on 05/10/2012 received a C2 response level (which the LAS deem as appropriate). The response time of thirty minutes was not achieved as demand was above expected levels throughout the day (4,757 999 calls were received). The LAS Demand Management Plan B (DMP) was in place from 12:25 hours onwards. The LAS stated that performance for C2 calls through the day was at 78.05%, (considered low). A Child Safeguarding Concern was documented as being completed; however, this was not received by the Trust's Emergency Bed Service (EBS) and therefore was not forwarded to Children's Social Care. The LAS crew have confirmed a referral was faxed to the EBS but were unable to recall receiving a confirmation receipt and did not call the EBS to confirm receipt. An adult referral was not made. This was not in accordance with LAS policies and procedures.

3.149 On 28/11/2012, a 999 call was received in EOC from 111 at 14:26 hours to attend Adult H's address. It was reported that a 28 year old male (Adult G) was struggling for breath, refusing to go to a mental health appointment due that day and had locked himself in the bathroom. He was said to have attempted to kill himself that morning with an overdose of

tablets. It was further reported that Adult G had a history of panic and anxiety attacks and injecting himself with white spirit.

3.150 A Fast Response Unit and an ambulance were dispatched at 14:32 hours and 14:34 hours, arriving at 14:39 hours and 14:42 hours respectively. On arrival Adult G was not locked in the bathroom and had not taken an overdose. The ambulance staff have documented that Adult G felt suicidal but had not taken an overdose, drunk alcohol or had taken drugs. LAS staff were told that Adult G suffered from depression, anxiety and panic episodes and that he was being seen at East Croydon Mood and Personality Team. Adult G felt very depressed and anxious at that time and felt he needed more help but was not getting it. Adult G initially refused to travel to hospital but on further discussion agreed to go. Adult G felt that he would harm himself and that he was not in control of his mind. Adult G stated that he wanted help as he was afraid of what he will do.

3.151 Following the crew's initial examination on the ambulance, Adult G was conveyed to Croydon University Hospital.

3.152 On 05/12/2012, a 999 call was received in EOC at 08:17 hours to attend Adult H's address. It was reported that a 28 year old male (Adult G) has Bipolar Disorder, is suicidal, hallucinating and smashing things. The caller stated Adult G was her husband. The Quality Assurance report documents the caller informed the call taker that Adult G had told her he would stab her if she called for an ambulance.

3.153 The 999 call log entries are documented as follows:

3.153.1 08:20 hours – He is violent, he has a weapon

3.153.2 08:23 hours – Patient threatened to stab caller (Adult H) if ambulance was called, patient will become agitated by Police, patient has locked caller out of the house

3.153.3 08:26 hours – Sent to MPS, psychotic illness, significant risk of danger to themselves or others, 28 year old male, Bipolar, hallucinating, suicidal, smashing things, violent, no ambulance to assign at present

3.153.4 08:29 hours– From MPS, please confirm full address, also where has the information come from that they are smashing the place up? Is it going on now?

3.153.5 08:30 hours – Sent to MPS, patient has threatened to stab caller and has thrown them out of property, male has a weapon

3.153.6 09:11hours – General broadcast radioed for available ambulance vehicles to attend

3.153.7 09:11hours – Sent to MPS, apologies still no ambulance to assign at present

3.153.8 09:11hours – Police are transporting now

3.153.9 09:19 hours– Sent to MPS, cancellation received.

3.154 These calls received a C2 response level (a response time of thirty minutes). This was not achieved as demand was above expected levels throughout the day (4,921 999 calls being received).

3.155 It was confirmed that there had been no anti-social behaviour or noise nuisance reports from Adult H's address previously.

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

4.1 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 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.

4.2 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.

4.3 It was not until the final stages of the DHR process that information was shared 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.

4.4 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 Mother P for 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 PP's house). Mother P felt that Adult G's Bipolar Disorder started when he started to spend all his time in the one room in her house.

4.5 Mother P said that she had never witnessed any violence between her daughter and Adult G, and that Adult H never told her that there had been any. Adult H did not confide in her mother and kept matters very much to herself. She 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.

4.6 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 Adult H 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.

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

4.8 Adult H spent most days with Adult G. She asked her mum 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.

4.9 On 8/12/2012, Mother P received a text message from Adult H's phone (but not apparently made by her) 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.

4.10 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. Father K 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.

4.11 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.

4.12 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.

4.13 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.

4.14 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.

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

4.16 Concerning what Father K believed 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.

4.17 Mother P felt 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 he 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.

4.18 A neighbour and 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 and her eldest child went to school with Adult H's daughter. The neighbour described Adult H as very sociable with everyone in the block of flats where they lived.

4.19 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. The neighbour 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.

4.20 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 at 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.

4.21 The neighbour said that Adult H rarely ever bought up her relationship in conversation with her and never spoke of any issues between them. XY 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.

4.22 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.

4.23 In terms of what could have been done differently to prevent 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.

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

4.25 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. 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.

4.26 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.

4.27 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.

4.28 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.

Analysis

5.1 Although there is not a significant history of reported domestic violence to the Police between Adult G and Adult H, 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.

5.2 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.

5.3 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.

5.4 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.

5.5 Given Adult G use of steroids, it is relevant to consider that a known side effect is aggression.

5.6 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.

5.7 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

5.8 SLaM - Explanation of Adult G's mental health diagnosis, assessment and the options for treatment

5.8.1 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.

5.8.2 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.

5.8.3 The requirements of mental health care is 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.

5.8.4 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[10] conditions (emotionally unstable and dissocial) was a more appropriate formulation.

[10] Comorbid is the presence of one or more additional disorders.

5.8.5 Adult G's diagnosis at the time of the incident was emotionally unstable personality disorder[11]. This disorder is often characterised by instability in:

a. 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

b. Self-image - marked and persistent unstable self-image or sense of self

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

5.8.6 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[12].

5.8.7 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.

5.8.8 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.

[11] ICD-10 International Classification of Diseases, 10th revision, World Health Organization, 1992.
[12] 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.

5.8.9 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.

5.8.10 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.

5.8.11 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.

5.8.12 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.

5.8.13 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.

5.9 SLaM's care to Adult G and Adult H

5.9.1 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 AMHP following Adult G's MHA assessment and the Police station on 18/12/2012.

5.9.2 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 the Triage Ward.

5.9.3 Adult H did not contact the Police concerning issues of domestic violence with Adult G. She did however seek help in respect to Adult G and his mental health issues, and seemed to do this constantly throughout November and December 2012. It would appear that Adult H wanted Adult G to get help and have him reassessed; this could be seen as the mechanism Adult H used to help her minimise and cope with the abuse she was experiencing.

5.9.4 Adult H's disclosures to the Triage Ward staff about her concerns (that she was scared of Adult G and him being angry for calling the Police and that Adult G had isolated her by taking her keys and preventing her from seeing other people) were all missed and minimised by staff. These concerns were not considered nor acted upon as Adult H became more reassuring to the Ward Team and minimised her earlier disclosures.

5.9.5 Adult G had multiple presentations to Mental Health Services during November and December 2012. The impact on Adult H and Child F 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.

5.9.6 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 as to the impact his behaviour and ill mental health was having and could have on Adult H and Child F.

5.9.7 Adult H was present at the assessment on 07/11/2012 where Adult G's possible admission to Bethlem Royal Hospital was discussed. Adult H 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 how her opinion was gained concerning the decision to discharge Adult G home.

5.9.8 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.

5.9.9 Although SLaM is part of the Croydon Multi-Agency Risk Assessment Conference[13], knowledge of the DASH Risk Assessment Tool and referral processes is limited.

Croydon Health Services

5.10 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.

5.11 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.

5.12 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 H disclosed worries about his behaviour and so the potential risk of domestic violence should have been explored. The risk of domestic

[13] 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.

violence was not recognised and other risks that Adult G presented were seen in isolation and were not followed-up.

5.13 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 inappropriate and unsafe request, which would have placed Adult H at greater risk of harm.

5.14 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 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 who 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 and work place health and safety.

5.15 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 SCR in 2011.

5.16 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 Adult H was a protective factor.

5.17 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 use and not poor mental health which dominated the treatment and risk assessment conducted. The risks which were identified were overlooked and not addressed.

5.18 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

5.19 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.

5.20 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. Adult G 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.

5.21 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:

5.21.1 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.

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

5.21.3 An OASys Risk Assessment was not completed within the required timescales of fifteen working days from when the order was made.

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

5.21.5 Adult G's offence of GBH in 2003 (Adult G 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.

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

5.21.7 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 Adult G 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.

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

5.21.9 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.

5.22 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.

5.23 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.

5.24 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.

5.25 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

5.26 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 matter (and the Police no further auctioning incidents between Adult H and Adult G) may have influenced thoughts about future help seeking and involving the Police later on in her relationship with Adult G.

5.27 Although a referral to the 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.

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

5.29 When Adult G was later reported by his girlfriend (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.

5.30 The threats Adult G made to a member of nursing staff at Croydon University Hospital were not investigated by the Police. They were recorded as an intelligence report. This was at a time when Adult G's 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.

5.31 There is no explanation provided on the custody record confirming the decision to place Adult G in a rest period after his MHA. 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 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 19/12/2012 following the allegation of assault on Adult H.

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.

5.32 It would appear that the Book 124D risk assessment conducted by the Police front line uniformed officers on 19/12/2012 of the domestic violence between Adult G and Adult H 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 Adult G's 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.

5.33 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".

5.34 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.

5.35 The provision for appropriate adults (AA) 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.

5.36 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

5.37 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.

5.38 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 Child F. It is also important to note that Adult G was invisible in this response in relation both to his behaviour and parental responsibility to safeguard Child F.

5.39 The overall response from Children's Social Care 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.

5.40 In January 2012, a new 'workflow process' was put in place to ensure the timely and secure transfer of information from the corporate centre 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.

5.41 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).

5.42 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 use, previous domestic violence, the missing persons reports, a Section 47 Child Protection Enquiry would have been appropriate and should have been conducted.

5.43 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

5.44 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

5.45 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.

5.46 Adult G's recovery in his presenting behaviour, during this time period, would confirm the view that his behaviour 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.

5.47 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.

5.48 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 violent behaviour and the concerns about his mental health, a referral to the MARAC may have been seen as appropriate.

5.49 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[14]. 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[15], 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.

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

Themes identified in this review

Information Sharing

6.1 Amongst health services the sharing of information was limited and slow.

6.2 At the end of 2012, there are frequent admissions of Adult G to Accident and Emergency with limited follow-up by the GP, which may have been hampered by delays in information reaching the GP practice. There would appear to have been an over-reliance on information being communicated by letter to both patient and GP practice resulting in limited follow-up with the patient.

6.3 In the last few months before Adult G's last Accident and Emergency attendance, there appears to be a lack of linkage between his partner (Adult H) being registered at the same GP practice and her own presenting mental health issues (in relation to her depression). This lack of a connection of the family's issues may have been compounded by Adult H being registered at the practice with different last names. There was little consideration regarding the vulnerability and the risk's posed to Child F and Adult H.

6.4 There is no documentary evidence to show that concerns were robustly shared between the teams and departments within Croydon Health Services and with Croydon Council's Safeguarding and Looked After Children Service. There was a reliance on letter writing which did not support effective and timely inter and multi-agency work. Systems were not up-to-date or interrogated to gather as much available known information on the family to inform risk assessments and appropriate safeguarding responses.

6.5 Referrals to Children's Social Care were made but often contained limited information and were not followed-up with sufficient rigour.

6.6 It is acknowledged that there is an exceptionally high number of Police Merlin Reports received by Croydon Children's Social Care, and whilst the planned introduction of a MASH is welcomed, it must not be considered as the complete answer to the issues around improved information sharing to support the safeguarding response, especially in relation to adults.

Role of universal services

6.7 Health Visiting, Maternity Services and the GP all had contact with the family; however, there was never any documented enquiry about the relationship (or the prospect of domestic violence). Considering the frequency of contact and presenting issues discussed in consultations, there were many missed opportunities to discuss domestic violence.

Early intervention and family support

6.8 The domestic incident in 2006 between Adult H and her mother predates the implementation of the Common Assessment Framework (CAF). Early help should have been offered to Adult H following her first disclosures to her GP about the depression and stress she was feeling. Health Visiting were unaware of any issues which highlights a gap in the information sharing from the GP.

6.9 When Children's Social Care decided no further action was necessary on 09/10/2012 (although considered an adequate response), a step down to a CAF could have followed to provide support to the family.

Toxic Trio[16]

6.10 In their review of Serious Case Reviews, Ofsted[17] noted that the most common issues identified within those reviews were domestic violence, parental mental ill-health and drug and alcohol use. All of these factors were present in this case, yet there was no acknowledgement of this or a recognition of the risks posed to Adult H or Child F. Given the overwhelming presence of these factors in previous Serious Case Reviews, it is alarming that professionals did not link these and respond appropriately. There was a wide spread lack of awareness of the impact they have on safeguarding which need to be addressed by all agencies.

Risk assessment

6.11 Apart from the Police process, there was no specific risk assessment conducted regarding domestic violence. Critical points such as Adult G's discharge planning should have triggered a risk assessment. The needs and safeguarding considerations of Adult H and

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181651/DFE-RR040.pdf
[17] p.10

Child F do not appear to have been given sufficient consideration. There was evidence to show that his behaviour was a concern and that this could pose a risk to them both.

Understanding and awareness of the dynamics of DV and its impact

6.12 The issues facing Adult H were not considered and she was never really seen in her own right or how the risks identified concerning Adult G impacted on her. The issues with Adult G were purely seen as mental health related and then this shifted to be an issue solely about his poly-substance use. Domestic violence was never identified or explored.

6.13 For example, following the incident on 05/10/2012, the Police Merlin Report observed signs of violence in the house (punched doors and walls). Adult H was in the property and there were two different sets of professionals in the household (the Police and the crew from LAS). Also Adult G was threatening staff and the HTT latterly assessed that it was not safe to conduct a home visit with Adult G alone. It seems remarkable that given the concerns about Adult G's behaviour this did not necessarily extend to Adult H and Child F's vulnerabilities within the home environment being considered. Safeguarding concerns in respect to Child F were raised but the potential risks to her were overlooked.

Role and function of the Family Justice Centre

6.14 There was one signposting contact made to the FJC in 2006 which did not materialise in the system. It would seem that this was a signposting contact rather than a proactive referral by the Police. Later in contact with services (particularly in 2012), the FJC was never considered – partly as the dynamic of domestic violence was not identified.

Mental health

6.15 During Adult G'S contact in November and December 2012 with SLaM, it was felt most likely he may have features of both an emotionally unstable and dissocial personality disorder.

6.16 He would on occasion present with psychotic symptoms. Transient psychotic symptoms may occur in response to illicit drug use and also in reaction to severe stress in emotionally unstable personality disorder. However, it was felt reasonable to admit Adult G to hospital to assess these symptoms more fully (this capacity to consider a number of possible diagnoses is a normal part of psychiatric practice). It did lead to Adult G having a brief admission in hospital under Section 2 of the Mental Health Act in which the diagnosis of Bipolar Disorder could be discounted more confidently.

Role of health services

6.17 The Health Services mentioned in this review had significant, frequent and on-going contact with Adult G and Adult H. Throughout the review of the Health IMRs, there is a recurring issue of lack of follow-up and little documentary evidence in notes about what actions were taken. More could have been done to action and progress referrals and coordinate care and support for the entire family.

Culture of questioning

6.18 There was little evidence of appropriate domestic violence enquiry. On the occasions where Adult H was asked about her relationship, it is unknown how these discussions were conducted and what tools were used to support assessments and decision making (such as the decision to discharge Adult G to Adult H's home).

The role of fathers

6.19 Despite a number of incidents where Child F was in Adult G's care when he self-harmed, the impact of his poor mental health on Child F was not addressed. The incident where Adult H was advised to take away Adult G's car keys to prevent him from driving and the letter she received from Croydon Council Safeguarding and Looked After Children Service are examples where she is being held wholly responsible for safeguarding Child F. Adult G was invisible in the safeguarding response to Child F from statutory services.

The "Think Family" approach

6.20 There was no evidence of a "Think Family" approach[18] to safeguarding in this case. The child protection concerns identified by Accident and Emergency were overlooked in the assessment, partly as Adult G was not living at Adult H's address. Adult G had different GPs and went back and forth between practices which did not help in joining up the attendances and understanding his family life.

6.21 Adult H was registered with the GP with different names. Adult G's use of two different GP practices is likely to have hindered continuity of his care and the following-up of referrals (particularly regarding his mental health). Clinician's would improve their safeguarding response if they were to note patient's social history and view consultations within this context so that they better assess and treat their patients.

[18]http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/Think-Family.pdf

6.22 All professionals who are involved with families need to be aware and understand the "Think Family" safeguarding agenda (2012) so that they are able to make holistic assessments, necessary referrals and coordinate support for the entire family's needs.

Policies and processes

6.23 There is little evidence of awareness of partnership policies. Despite having a borough domestic violence strategy, this is not reflected in operational practice. For example, Croydon Health Service's Domestic Violence Care Pathway has not been ratified or widely circulated. The Borough would benefit from having a domestic violence care pathway agreed to support professionals to respond to domestic violence.

Accident and Emergency safeguarding prompts

6.24 The lack of use of the Accident and Emergency safeguarding prompts is an example where strategic policy has not filtered down and been implemented into practice. There is evidence that these prompts are not being used currently. The prompts were introduced as a result of a serious case review. An audit found that staff were not using them as required. This issue must be urgently reviewed in light of the SCR recommendations and findings from this review.

Safeguarding vulnerable adults/adults at risk

6.25 Adult G was vulnerable due to his mental disorder and his concerning behaviour resulting in self-harm. He also displayed violent and threatening behaviour to members of staff whilst admitted. He presented risks to others due to his behaviour and also to himself. On the day before Adult H's death, Adult G did not meet the criteria to be sectioned so there were limited options from a mental health perspective of what could be done to protect him and safeguard others.

6.26 It is important that the MASH model addresses these gaps in the process for vulnerable adults. There needs to be a better grasp of the links between domestic violence and how this impacts on safeguarding adults concerns.

Diversity

7.1 The protected characteristics as outlined in the Equality Act 2010 have been considered in relation to this case:

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 were specialist support services) which may have meant that Adult H did not recognise the dynamic of domestic violence or from where to get support (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 **Gender reassignment:** Not applicable.

7.1.4 **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 M was mentioned (by health services). Adult G's relationships and living arrangements were never explored to an extent that has now been proven necessary.

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

7.1.6 **Race:**

a. Adult G was of Turkish origin. We know from KK 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.

7.1.7 **Religion or belief:** No relevant issues identified.

7.1.8 **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 Child F.

7.1.9 **Sexual orientation:** Heterosexual (no relevant issues were identified).

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 was 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 tracking 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 twenty 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 Recruited 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 with 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:

9.2.1 The Police's decision to release Adult G on unconditional bail (prior to the incident resulting in Adult H's death).

9.2.2 The 999 Police response to the incident on 20/12/2014 where Adult H died.

9.2.3 The invisibility of the issue of domestic violence by professionals the individuals in this review came into contact with.

9.2.4 The lack of recognition and identification of the risks Adult G posed to Adult H and Child F.

9.2.5 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 use 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 or 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 chairs 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 CSP and individual agencies understand the issues identified which need improvement. The recommendations will help hold agencies accountable for actions they 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 CCG in the CSP 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 CSP, 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 Accident and Emergency 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.

10.8.1 **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.

10.8.2 **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.

10.8.3 **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.

10.8.4 **SLaM:**

Recommendation 17

Design a strategy to implement the NICE Guidance (PH 50) on Domestic Violence and Abuse[19], 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 7 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

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

distributes a Blue Light Bulletin that clearly states the standard expected for 7 day follow up.

10.8.5 **Croydon Safeguarding Adults Board:**

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.

10.8.6 **Croydon Council Adult Services:**

Recommendation 22

Examine commissioning and delivery arrangements for the AMHP Service.

10.8.7 **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.

10.8.8 **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.

10.8.9 **Croydon Council Public Health:**

Recommendation 26

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

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

Recommendation 27

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

10.8.11 **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.

10.8.12 **NHS England**

Recommendation 29

Identifying and responding to domestic violence 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 30

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

10.8.13 **Croydon Clinical Commissioning Group**

Recommendation 31

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

10.8.14 **Croydon Health Services NHS Trust:**

Recommendation 32

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

a. Specific reference to the use of the Accident and Emergency prompts for the Emergency Department.

b. Routine enquiry policy for health visiting and school nursing services.

c. 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 33

Embed the use of the Accident and Emergency 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 34

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

Recommendation 35

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 36

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 37

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 38

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

a. Mandatory training programme for all Accident and Emergency staff on domestic violence.

b. Provision of information on local domestic violence support services and how to refer to them (including the MARAC).

c. Ensuring the safeguarding prompts are being used.

d. Staff understanding the Domestic Violence pathway.

e. Agreeing Accident and Emergency's staff roles and responsibilities in relation to domestic violence risk assessment and referral to services.

Recommendation 39

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.

10.8.15 **Croydon Safeguarding Children's Board:**

Recommendation 40

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

Recommendation 41

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 42

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 43

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

10.8.16 **Croydon Council – Safeguarding and Looked After Children Service:**

Recommendation 44

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 45

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

Recommendation 46

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.

10.8.17 **Croydon Council Commissioned Drug Services:**

Recommendation 47

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

10.8.18 **GP practices concerned in this review:**

Recommendation 48

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

ABH	Actual Bodily Harm
Adult G	Perpetrator
Adult H	Victim
CAG	Clinical Academic Groups
Child F	Daughter of Victim and Perpetrator
CSC	Children's 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
Girlfriend M	Adult G's new girlfriend
GPs	General Practitioners
Father K	Victim's father
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
MPS	Metropolitan Police Service
Mother P	Victim's mother
SLaM	South London & Maudsley NHS Foundation Trust

Appendix 1

Domestic Homicide Review Terms of Reference for Adult H

This Domestic Homicide Review is being completed to consider agency involvement with Adult H, and her partner, Adult G, following her murder on 20th December 2012. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

1) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published.

2) To explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies.

3) To review the involvement of each individual agency, statutory and non-statutory, with Adult H and Adult G during the relevant period of time: **January 1st 2005 – December 20th 2012.**

4) To summarise agency involvement prior to **January 2005.**

5) The contributing agencies to be as follows:
   a) Metropolitan Police
   b) Croydon Council
   c) London Probation
   d) Croydon Health Services NHS Trust
   e) Croydon Clinical Commissioning Group
   f) South London & Maudsley NHS Foundation Trust

6) For each contributing agency to provide a chronology of their involvement with the Adult H and Adult G during the relevant time period.

7) For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

8) For each contributing agency to provide an Individual Management Review:

   a) Identifying the facts of their involvement with Adult H, Child F and Adult G, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

   b) To consider issues of activity in other boroughs and review impact in this specific case.

9) In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following seven points:

   a) Analyse the communication, procedures and discussions, which took place between agencies.
   b) Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
   c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
   d) Analyse agency responses to any identification of domestic abuse issues.
   e) Analyse organisations access to specialist domestic abuse agencies.
   f) Analyse the training available to the agencies involved on domestic abuse issues.
   g) Analyse the links between the victim and the perpetrator's mental health and the incident.

   And therefore:

      i) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
      ii) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

iii) To improve inter-agency working and better safeguard adults experiencing domestic abuse.

10) Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Adult H, Child F or Adult G in contact with their agency.

11) To sensitively involve the family of Adult H in the review, if it is appropriate to do so in the context of ongoing criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process.

12) To coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

13) To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

14) To establish a clear action plan for individual agency implementation as a consequence of any recommendations. The action plan should meet SMART criteria.

15) To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

16) To provide an executive summary.

17) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Safer Croydon Partnership Board.

Appendix 2

Panel members and agencies represented

Agency	Panel Member
Standing Together	Anthony Wills
Standing Together	Victoria Hill
NHS	Shanti Medonca
NHS	Lorraine Thomson
CIAT MPS	Helen Flannigan
CIAT MPS	Paul Gardner
NHS	Sue Smith
NHS	Marie Davis
NHS	Rachel Blaney
Probation	Lissa Moore
MPS	Rachel Bennett
MPS	Simon Messinger
Croydon Council	Andy Opie
Croydon Council	Anthony Brooks
Croydon Council	Edwina Morris
Croydon Council	Paula Doherty
Croydon Council	John Scott
Croydon Council	Gareth Flemyng

Appendix 3

Action Plan

All recommendations will be overseen by Croydon Community Safety Partnership and will be delivered by:

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Croydon Community Safety Partnership					
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.	Review responses to DV by all partners, identify and map gaps	Domestic Violence Strategy Group.	Mapping exercise on current resources and responses.	Q3 2014/15	Prevention work informed by mapping exercise
In conjunction with other strategic boards, produce a domestic violence protocol, policy and care pathway. This should include domestic violence enquiry and provision for	Develop DV protocol, policy and care pathway across the partnership and for each organisation including enquiry	Domestic Violence Strategy Group.	Mapping exercise on current resources and responses. Agreement by Partners on DV protocol. Implementation of DV protocol;	Q4 2014/15	Better understanding of victims' experiences and issues.

safeguarding children, adults at risk and vulnerable young people.	and provision for safeguarding children and vulnerable young people.				
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.	Ensure all partners have received copies of DHRs and are signed up to the action plan	Domestic Violence Strategy Group.	Sign off of both DHRs by the Home Office	September 2014	Partnership Action Plan and Joint Strategic Needs Assessment reflect findings from the domestic homicide reviews for AB and HG.
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	A range of training programmes will be implemented to cover the problem areas identified where DV arises.	Domestic Violence Strategy Group.	First cohort of trainees graduate from each training programme. Second cohorts engage in training.	Training programmes will be a continuous process	Earlier identification resulting in more MARAC referrals & more early help. Information on the toxic trio embedded within training across adults and children's services. Drug services to explore the dynamic of domestic violence when working with individuals with substance misuse issues. People who misuse drugs

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.					or alcohol, have mental health problems and are affected by DASV are referred to relevant health, social care and specialist DASV services.
Examine ways to raise awareness amongst young people of the issue of relationship violence and publicise what support is available.	Young people's DASV addressed by providing support and services for children and young people experiencing DASV in intimate relationships.		YPVA in post since January 2014, working across gangs, serious youth violence, sexual exploitation and care leavers to inform practice. YPVA holding an active caseload.	Commenced in January 2014 and continues	Young people able to voice concerns about intimate violence confidentially and have advocate working on their behalf.
Consideration must be given (alongside the LSCB and SAB) to include adults within the Croydon MASH process.	Design model that includes adults in MASH.	MASH Adult Services	Assess capacity of MASH to integrate this into current work and assess likely outcomes for doing so.		

Address the issue of having a formal commissioned system in place to provide Appropriate Adult services out of hours	Lessons learnt from the DHR incorporated into Level 3 safeguarding children training. During training staff are directed to the safeguarding children policies and procedures folder on CHS intranet. Practitioners to talk through how to identify, explore and respond to DASV. Half day sessions on DASV to be delivered to all level 3 staff, as part of their safeguarding children foundation training.		All associated tools, guidelines, procedures and contact details loaded onto the CHS intranet. Domestic violence. Definition of DV and where to access information and advice is included in all levels of safeguarding children training. All staff providing safeguarding advice to CHS staff aware of the need to advocate the use of the CAADA questionnaire, when exploring / responding to DASV. Case studies included in all levels of training include at least 50% of cases where domestic violence is prevalent.		CHS Domestic Violence Policy will continue to raise awareness of DASV. Reduction in numbers of children suffering from DASV.
Metropolitan Police (All Boroughs)					
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.	Bail conditions to be rigorously enforced. Charged perpetrators provided with a letter and conditions enforced.	Croydon Police		Continuing process	Accountability established and rationale behind decision open to scrutiny should perpetrator reoffend.

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.	All custody sergeants made aware of these procedures.				Audit trail is established giving the reasons for not interviewing, provision of rest periods and of efforts to contact an appropriate adult through recoding these and other pertinent actions in the custody record.
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.					
Ensure police Merlin reports are completed accurately and are timely expedited to Children's Social Care. 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.	Training to be implemented to ensure that Merlins are correctly and accurately completed	Croydon Police	All officers required to complete Merlins receive training. Programme set up so that as staff are replaced, new staff also receive training.		Childrens' Social Care have a fuller picture of those at risk and can implement suitable observation or intervention.

London Probation Service					
Ensure that information and intelligence about risk is always sought between key agencies.	Protocols are instituted and reviewed to ensure that they are working.	Probation Service			Clear protocols and methods for information sharing.
Audit that a rationale for any 'flags' on agencies' case management systems is clearly recorded.	Ensure that audit results are disseminated to ensure everyone is clear on the meaning of the flags.	Probation Service			
Audit the adherence to and implementation of policy of conducting police intelligence checks.	Relevant information held by police on suspects will be passed to probation and elp mitigate risks to suspect's partners.	Probation Service			
South London and Maudsley					
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	Liaise with appropriate agencies (Council Social Services, Women's Refuges etc) to design and then implement training programme to		Training programme designed and approved. Key workers identified and trained. Other appropriate workers identified and trained. Training programme set up to ensure new employees will also attend	Training to commence in Q1 2015 / 16	Training programme for existing staff to be completed by end of Q3 2014 / 15. Regular training programme to be set up to cover intake of new staff.

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''	raise staff awareness of issues relating to domestic violence.		training courses.		
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	Review policy and see where it needs to be amended in the light of this DHR and the one for Janice.	SLaM	Review policy Identify gaps where current practice does not cover recommended practice found in the DHRs.		Review to commence when this DHR has received Home Office QA panel approval.
Review the policy and practices around 7 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	Test policy to see if it is working and if not identify reasons why not and implement revised policy and monitor outcomes for a three month period	SLaM	Identify existing policy and practice Identify good practice from elsewhere Test existing policy and practice against good practice Analyse outcomes Amend Croydon policy to		

Assistant Director Patient Safety drafts and distributes a Blue Light Bulletin that clearly states the standard expected for 7 day follow up.			make it watertight		
Croydon Council Safeguarding Adults Board					
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	Review support staff training on understanding DV in relationships between those at risk from carers and partners. If inadequate redraw the training and implement retraining.	Adult Services	Create template of ideal training programme. Conduct review of existing training Assess how well current practice meets the template If inadequate redesign training Ensure all relevant staff are trained or retrained		
Croydon Council Adult Service					
Examine commissioning and delivery arrangements for the AMHP Service.	Identify any gaps in services and consider implications for commissioning intentions	Adult Services	Identify AMPHs in the Croydon area, create directory and ensure it is distributed to frontline staff in adult services		Q4 2013 / 14. All staff will be able to identify and call out AMPH when necessary
Croydon Council Family Justice Centre					
Rewrite the multi-agency borough referral pathway agreement to include action taken by agencies					

and the outcomes of referrals.					
London Ambulance Service NHS Trust					
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.					
Review internal systems of receiving and transmitting safeguarding concerns from crews to the relevant local authority safeguarding teams.					
Croydon Council Public Health					
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					
Work together to help identify funding to commission a pilot a borough wide system to	New system piloted for responding to DV victims	NHS England	Pilot system implemented	Q4 2014/15	Victims of DV enjoy better understanding and appropriate care within NHS

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					
Ensure appropriate health engagement in Croydon's coordinated community response to domestic violence which includes appropriate health representation at the Croydon Community Safety Partnership and the Croydon Domestic Violence and Sexual Violence Strategy Board.					
NHS England					
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.	Letter, with agreed content, to be written to all GP practices advising that DV information must be included in safeguarding training and ask for confirmation	NHS England Croydon CCG	Draft letter. Approve letter Send letter Await responses Follow up on non-responders Once all those lacking DV info in training are identified inform them of need to train staff.		
Ensure when appointed that the Lead GP for	JD appropriately revised	NHS England	Lead GP is fully aware of DV responsibilities.	Q4 2014/15	Lead GP encourages development of DV

safeguarding has domestic violence included in their job description.					awareness among other GPs
Croydon Clinical Commissioning Group					
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					
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	New practice and procedure developed and implemented. A half day session on domestic violence is delivered to all level 3 staff, as part of their safeguarding children foundation training. All of our safeguarding children training (including the domestic violence	Croydon Health Services (CHS) and South London and Maudsley NHS Trust (SLAM)	Better outcomes from A&E admissions		1. The lessons to be learnt from the 2 Domestic Homicide reviews completed by CHS has been incorporated into Level 3 safeguarding children training. 2. All associated tools, guidelines, procedures and contact details (in relation to identifying, exploring and responding to DASV) have been loaded onto the CHS intranet in a policies and procedures folder called "Domestic Violence".

ante natal booking appointment, and then throughout all ante natal care appointments to enable midwives to ask about sensitive issues such as domestic violence.	presentation for level 3) is scrutinised annually by the CSCB sub group learning and development. All of presentations are to be reviewed at a minimum of annually; to ensure data is accurate, references are updated and new resources are included. The Named Nurses adult and children have drafted a CHS Domestic Violence Policy and will continue to raise awareness of DASV.				3. During all levels of training all staff are directed to the safeguarding children policies and procedures folder on CHS intranet. 4. Domestic violence, the definition and where to access information and advice is included in all levels of safeguarding children training. 5. Included in the electronic packs sent to staff prior to training is the handout on Domestic Violence, CAADA questionnaire, FJC and MARAC. 6. All staff providing ad hoc safeguarding advice to staff within CHS are aware of the need to advocate the use of the CAADA questionnaire, when exploring / responding to DASV. 7. The use of the CAADA

					questionnaire and referrals to MARAC is a significant section of our domestic violence safeguarding children training for level 3 staff. 8. Case studies included in all levels of training include at least 50% of cases where domestic violence is prevalent. This allows for practitioners to talk through how to identify, explore and respond to DASV.
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.	Provision of an outreach worker within CUH	Croydon Health Services			
Review and improve systems of sharing safeguarding concerns between the emergency department and other	System wide review of the processes within A&E in relation to responding to		Completion of mandatory training programmes for all A&E staff on domestic violence		Staff will be aware of their role and responsibilities in relation to responding to domestic violence and any

departments with CUH, (including the ward staff).	domestic violence. Provision of information on local domestic violence support services and how to refer to them (including the MARAC).		Use of safeguarding prompts becomes a matter of habit		safeguarding concerns. Staff understand the Domestic Violence pathway.
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).					
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	Provide an ante and post natal care service that is trained in recognising risks of DV	Croydon Health Services (Midwifery and Health visitors)	Midwives and Health Visitors receive DV risk recognition training	Q1 2014 / 15	1. All women offered the opportunity to discuss concerns with their Midwife and Health Visitor. 2. Domestic violence discussion is a routine part of the initial assessment undertaken by the HV service.

violence) to support routine enquiry for domestic violence during ante natal and post natal care.					3. There is a clear guideline in place for all midwives; giving instruction about screening for domestic violence and where / how this is recorded on maternity records. 4. The family health needs assessment tool used by the health visiting service has been recently updated to include the need to explore domestic violence.
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.					
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	Processes reviewed. Shortcomings identified. Practice revised. Training in new practices.	Croydon CCG Croydon Health Services	Admissions to A&E where there are DCV risks are identified and appropriate action implemented, engaging partners from across Croydon.	Q1 2014 / 15	Improved systems of sharing safeguarding concerns between the emergency departments and other departments within CUH, including the ward staff An environment for disclosing DASV created. Trained staff ask people about DASV. Specialist advice, advocacy and support as part of comprehensive referral pathway.

responsibilities in relation to domestic violence risk assessment and referral to services.					
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.	Identify existing policies and procedures in Croydon and identify best practice elsewhere and compare. Amend the Croydon policy where necessary	Croydon Health Services (CHS) and South London and Maudsley NHS Trust (SLAM)	Croydon policies identified and collated Best practice identified Analyse Croydon policy and identify shortcomings Revise Croydon policy Issue new Croydon policy		Q1 2014 / 15 All staff will be aware of threat policy and be able to report it to and obtain support from management.
Croydon Safeguarding Children's Board					
Audit safeguarding children's training to ensure that domestic violence is appropriately addressed.	Review and if necessary remodel safeguarding children training.	Safeguarding Children's Board / FJC / DASV Board	Existing training identified and forensically examined for DV related content.		
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.	Review and amend policies where required	Safeguarding Children's Board & SLaM	Identify existing policies. Set up review board. Identify gaps and ensure training modules are reformed to meet needs of children.		
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.					
Provide staff with information on the Toxic Trio to inform their safeguarding practice.					
Croydon Council Safeguarding and Looked After Children Service					
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.	Adopt secure e-mail system that meets auditing requirements		Identification of IT specialist in e-mail Review system options Run rigorous tests Identify system. Adopt new system		
Consideration to be given to expanding the role and remit of Croydon's MASH to include vulnerable adults and adult service providers.	Agree new tasks to be undertaken and assess capacity to take on new work	MASH / Safeguarding Adults Board	Examine and test capacity of MASH to adopt extra workload. Identify funding for extra staff if necessary.		
The MASH process is developed to ensure robust social care oversight of all Contacts'	MASH processes analysed and pathway identified that will highlight	MASH / Children's Services	Process analysis completed New procedure designed and implemented		

that are not progressed to an assessment of the child's needs by a 'lead professional' within the partnership.	those contacts who have not been allocated a lead professional for assessment.		New procedure robustly tested.		
Croydon Council Commissioned Drug Services					
Drug services to explore the dynamic of domestic violence when working with individuals who use anabolic steroids					

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