DOMESTIC HOMICIDE REVIEW

Safer Hillingdon Partnership

Case of Charlotte

Althea Cribb

April 2016

1. Executive Summary

1.1 Outline of the incident

1.1.1 On 30 January 2015 Charlotte was found at home, having been stabbed a number of times. Charlotte's husband, Preston, was convicted of her murder on 18 August 2015, and sentenced to 27 years imprisonment.

1.2 Domestic Homicide Reviews

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

1.2.2 The purpose of these reviews is to:

(a) 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.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

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

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

1.3 Terms of Reference

1.3.1 The full terms of reference are included at 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.

1.3.2 The Review Panel were asked to review events from 1 January 2012 up to the homicide.

1.3.3 Home Office guidance states that the Review should be completed within six months of the initial decision to establish one. This review has taken longer than that for a number of reasons.

1.3.4 It took some time initially to commission and secure an independent Chair for this review, as well as to ensure that the Review had the necessary comprehensive and dedicated administrative cover. There was subsequently a significant delay in some IMRs and chronologies being received.

1.4 Independence

1.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received training from the then Chief Executive of Standing Together, Anthony Wills. Althea has over eight years experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with Hillingdon or any of the agencies involved in this case.

1.5 Parallel Reviews

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

1.6 Methodology

1.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Charlotte and/or Preston.

1.6.2 London Borough of Hillingdon Housing, Adult Social Care Service and Education Services reviewed their files and notified the DHR Review Panel that they had no involvement with Charlotte or Preston and therefore had no information for an IMR.

1.6.3 All IMRs included chronologies and analysis of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period.

1.6.4 Although information was included about the children in the IMRs, this was only provided for the purpose of context, where necessary, to the agency's contact with Charlotte and/or Preston. The Panel agreed that it was not necessary to analyse agency contact directly with the children.

1.6.5 IMRs were received from:

(a) Central and North West London NHS Foundation Trust – health visiting and school nursing services

(b) Central and North West London NHS Foundation Trust – mental health services

(c) Crown Prosecution Service

(d) General Practice for Charlotte (chronology only)

(e) General Practice for Preston

(f) Hillingdon Hospital

(g) London Borough of Hillingdon Children's Social Care Services

(h) London Borough of Hillingdon Independent Domestic Violence Advocacy Service

(i) Metropolitan Police Service

(j) National Probation Service, London Division

(k) Schools

(l) Southall Black Sisters

1.6.6 The Review Panel members and Chair were:

(a) Althea Cribb, Chair, Standing Together Against Domestic Violence

(b) Anna Fernandez, Hillingdon Hospital

(c) Barbara North, representing Health Visiting and School Nursing Services, Central and North West London NHS Foundation Trust

(d) Christine Edgar, Metropolitan Police Service Critical Incident Advisory Team

(e) Eileen Bryant, NHS England

(f) Erica Rolle, Community Safety, London Borough of Hillingdon

(g) Jean Veysey, Hillingdon Clinical Commissioning Group

(h) Margaret O'Keefe, Her Majesty's Courts and Tribunals Service

(i) Melanie Parrish, Crown Prosecution Service

(j) Nikki Cruikshank, Children's Services & IDVA service, London Borough of Hillingdon

(k) Pragna Patel, Southall Black Sisters

(l) Representatives, Schools

(m) Shaun Hare, representing Mental Health services, Central and North West London NHS Foundation Trust

(n) Superintendent Max Williams, Metropolitan Police Service, Hillingdon

(o) Tendayi Sibanda, Hillingdon Hospital

(p) Teresa McKee, Community Safety, London Borough of Hillingdon

(q) Will Jones, National Probation Service

1.6.7 The Chair wishes to thank everyone who contributed their time, patience

1.7 Contact with the family

1.7.1 At the start of the Review process, the criminal case was ongoing and the trial had not started. As a result, contact with the family, friends and employer of the victim, and with the perpetrator, was not attempted. A letter was written to the family of Charlotte, delivered via the Police, informing them that the Review was underway and giving them an opportunity to review the draft Terms of Reference,

and stating that the independent Chair would make further contact after the conclusion of the trial.

1.7.2 Once the trial had been completed, the independent Chair attempted to make contact with Charlotte's family, friend and employer, through letters that were posted. After replies were not received, the Panel agreed that the Police Family Liaison Officer would speak with the family to ensure that the letters were delivered, and to establish whether they wished to participate in the review. The Family Liaison Officer spoke with the family and it was established that they may be interested in participating in the review, but that they were very busy continuing to deal with the aftermath of Charlotte's death. The independent Chair made contact again, however at the time of submission no response had been received.

1.7.3 The independent Chair also wrote to Preston at the prison in which he is detained. No response was received. It should be noted that at the time of this Review being completed, Preston was appealing his conviction and sentence.

1.8 Summary of the case

1.8.1 Charlotte and Preston had come together to the UK from Zimbabwe in 1999. They had been married in a cultural ceremony in Zimbabwe but were not legally married in the UK[1]. They lived together until November 2013 and had two children together.

1.8.2 Charlotte reported to a number of agencies being a victim of verbal and physical abuse from Preston, first in 2006. In January 2012 Charlotte informed agencies that they were separated albeit continuing to live in the same house. From November 2013 a full separation took place following a police incident and bail conditions preventing Preston from contacting Charlotte.

1.8.3 Preston was convicted of murder on 18 August 2015, and sentenced to 27 years imprisonment.

1.8.4 **Information relating to Charlotte**

1.8.5 Charlotte was 42 at the time of her death, and employed as a nurse. Charlotte was in contact with, including seeking help from, a number of agencies in the years prior to her death: the Police; Southall Black Sisters; the Independent Domestic Violence Advocacy (IDVA) service; Children's Social Care and the Health Visiting service. Her contact with her General Practice was minimal and insignificant.

1.8.6 <u>Metropolitan Police Service and Crown Prosecution Service</u>

[1] NB: the terms 'husband' and 'wife' are used in this report to reflect the language Charlotte used when speaking to agencies.

[2] A form completed by the Police that is automatically passed to Children's Social Care, to alert them to any

1.8.7 Charlotte first sought help from the Police; in 2006 when she reported a domestic abuse incident while pregnant; and then in 2012 and 2013 in which she reported a number of incidents.

1.8.8 The first of these was in January 2012 in which Charlotte reported Preston had made threats to kill against her: she reported that he had said "I don't lose anything if I kill you and the kids". Preston should have been arrested but was not. Charlotte left the area to stay with family. She returned shortly after and made a withdrawal statement in which she stated she had over-reacted to Preston's threats and taken his comments out of context. A risk assessment had been done and Charlotte had been assessed as standard as she was out of the area. A Merlin[2] was completed to notify Children's Social Care of the incident as there were children in the household, and Charlotte was referred to the IDVA service[3].

1.8.9 In December 2012 Charlotte reported that she and Preston were separated but living in the same house, and that there had been an argument. Preston had threatened to put Charlotte's photograph on the internet and told her "the war is just beginning". Officers attended; no offences were recorded. A Merlin was not created although the children were mentioned on the standard incident report form (124d). Charlotte was given information about support from the Community Safety Unit and Citizen's Advice Bureau.

1.8.10 Charlotte called again in March 2014 to report that Preston was playing loud music in the house; she stated that they were going through divorce proceedings. No offences were recorded. In their report of the incident Officers recorded that there were "cultural issues" in the way Preston spoke to Charlotte. The report refers to children in the household however no Merlin was created. Charlotte was risk assessed as 'standard risk'.

1.8.11 On 23 November 2013 Charlotte called Police stating that Preston had tried to strangle her. Preston subsequently assaulted the two officers who were arresting him, and was charged with common assault against Charlotte and one officer, and assault occasioning actual bodily harm on the other officer. Charlotte reported to officers that Preston was controlling, and they recorded that she was "clearly very distressed and fearful" of Preston. They also recorded that Charlotte had said Preston "said that he is going to destroy my life". Once the charges were made Preston was bailed with conditions not to contact Charlotte directly or indirectly and not to attend the family home. A Merlin was created and Charlotte was referred to the IDVA service.

---

[2] A form completed by the Police that is automatically passed to Children's Social Care, to alert them to any police incident in which children are involved

[3] Specialist domestic violence and abuse support service for medium and high risk victims; in this case provided by Hillingdon Borough Council

1.8.12 In December 2013 when Preston formally entered not guilty pleas the case was allocated to Isleworth Crown Court: this was as a result of the charge of assault occasioning actual bodily harm, for which Preston was offered the choice of being heard in the Magistrate's Court or the Crown Court. Preston selected the Crown Court and therefore all three matters were sent to the Crown Court to be heard together.

1.8.13 The trial was scheduled for June 2014. Responsibility for contact with Charlotte as a witness was transferred to the Witness Care Unit within the Police; although the Officer in Case would have been expected to continue contact with her. Charlotte's friend was also listed as a witness for the Witness Care Unit to be in contact with.

1.8.14 After being initially allocated to an officer who knew Charlotte, the case was reallocated in February 2014. The Witness Care Unit attempted (unsuccessfully) to call Charlotte a number of times throughout 2014, and text messages were sent concerning the trial and her attendance as a witness. The Witness Care Unit spoke to Charlotte for the first time on 5 December 2014 informing her that she needed to attend Court on 8 December. There was no record of discussions with regard to support or special measures.

1.8.15 The case was handed to the Crown Prosecution Service for the evidence to be collated and prepared for trial. On a number of occasions from December 2013 onwards the Prosecutor made requests to the Office in Case for additional evidence including the 999 tape; and for a victim impact statement from Charlotte, and a draft restraining order to be prepared. These requests received no response according to Crown Prosecution Service records.

1.8.16 In May 2014 the Crown Prosecution Service were notified, via the Witness Care Unit, that the Officer in Case had heard from the witness (Charlotte's friend) that they wished to withdraw. The Officer in Case subsequently did not confirm whether they had withdrawn and a Witness Summons was later issued. The friend attended court to give evidence.

1.8.17 The trial on the 'warned list' for the two weeks from 23 June 2014, which meant that they would aim to start the trial at any point during that time. One of the police officers (assaulted by Preston) informed the police that he would not be able to attend in the second of those two weeks. The Crown Prosecution Service wrote to the court to attempt to fix the date of the trial to the 23 June but no response was received.

1.8.18 In early June 2014 the court re-listed the trial due to the police officer being unable to attend. It was re-listed for the two week warned list of 1 December 2014. During this time the Crown Prosecution Service continued to request information from the Office in Case. At a hearing in November 2014 the Court ordered the 999 tapes to be served as evidence and this was done.

1.8.19 Charlotte contacted Police on 3 December 2014 reporting that Preston had approached the children in the supermarket; that he had called Children's Social Care making an allegation against her; and that he had contacted her work stating she was keeping confidential work information at home. She also stated she was worried about the trial and fearful of what Preston would do once the trial was over. Police judged that Preston was not breaching his bail conditions and no action was taken.

1.8.20 The trial started on 9 December 2014. Preston was found not guilty of assault on Charlotte, and guilty of the assaults on the two police officers. Sentencing was adjourned for four weeks for Probation Pre-Sentence Reports to be completed, and bail was continued with the same conditions.

1.8.21 On 27 December 2014 Charlotte contacted Police seeking the outcome of the trial. No record was made that Charlotte was contacted.

1.8.22 Charlotte contacted Police on 26 January because she was scared of collecting her children from school, having been informed that Preston had attended the children's schools that day. Police judged Preston not to have breached his bail conditions and Charlotte was advised to contact Citizen's Advice Bureau. The Operator recorded Charlotte as "seeking advice" and therefore the call was not recorded as a domestic incident and a Merlin was not created.

1.8.23 Preston was due to be sentenced on 30 January 2015. Had this gone ahead, the Crown Prosecution Service would have requested a Restraining Order to prevent Preston from contacting Charlotte.

1.8.24 Independent Domestic Violence Advocacy (IDVA) Service

1.8.25 Following the incidents in January 2012 and November 2013, Charlotte was referred to the Independent Domestic Violence Advocacy (IDVA) service.

1.8.26 Following the first incident, the case was closed as Charlotte had been assessed as 'standard risk'[4] (due to her relocating to family outside of Hillingdon), while the IDVA service only works with medium[5] and high-risk[6] victims. The IDVA advised Charlotte that she had options: that she could stay away from Hillingdon; she could approach housing in Hillingdon and speak to a solicitor.

1.8.27 Charlotte's next contact followed the incident in November 2013. The IDVA risk assessed Charlotte as 'high' risk, and a safety plan was developed. This included the need to look at Charlotte's long term security once the bail

[4] Standard risk definition: Current evidence does not indicate likelihood of causing serious harm

[5] Medium risk definition: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse

[6] High risk definition: There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious

conditions were no longer in place; that Charlotte would be willing to move out of area if she could receive help with accessing property, possibly private rented (noting that Charlotte did not want to go into a refuge as it would mean giving up her work and going on benefits); and to refer Charlotte to the Multi-Agency Risk Assessment Conference (MARAC) [7].

1.8.28 The IDVA spoke with Charlotte again shortly after this and discussed Charlotte's housing and mortgage arrears, and the IDVA referred Charlotte to a solicitor for help with this. The next contact was in January 2014 at which time RM stated that she had contacted the solicitor and that "child contact was the only issue".

1.8.29 Charlotte's case was discussed at the MARAC in December 2013. The IDVA shared the risk assessment and safety plan; Children's Services shared that they were conducting an initial assessment. No other information was shared. No actions were recorded. The case was 'reviewed' at the January 2014 meeting; the bail conditions were noted and the case was closed.

1.8.30 Charlotte's next contact with the IDVA was in December 2014 when she called the service due to her concerns over the upcoming trial, and that Preston would be allowed to return to the home once it was over. She told the IDVA she was too afraid to live in the house, and she could not afford to pay the solicitor for an occupation order[8].

1.8.31 The IDVA advised Charlotte that she could represent herself at court to apply for an occupation order, and that Charlotte should contact the court to find out when the trial was due to start. Charlotte contacted the IDVA shortly after this to inform her that Preston had been found "guilty on two counts" (no record of what these were), and said she would contact the IDVA again following sentencing.

1.8.32 Southall Black Sisters

1.8.33 Charlotte contacted Southall Black Sisters (SBS) on two occasions – June 2012 and April 2013 – asking for help in separating from Preston. On both occasions SBS signposted Charlotte to Hillingdon Women's Centre; SBS were not funded to work in Hillingdon and did not have capacity to support Charlotte due to this. During this contact Charlotte stated that she was afraid that Preston would kill her (that he had threatened this) and that she could not afford to privately rent and had no alternative but to continue to live with Preston.

1.8.34 Charlotte next contacted SBS in December 2014, shortly before the trial began. She asked for urgent advice around the trial, and about allegations made by Preston to Children's Social Care about her. At this time, SBS had begun to

[7] A multi-agency forum made up of key local organisations – statutory and voluntary sector – for the purpose of information sharing, and safety planning, for high-risk victims. More information available at: http://www.safelives.org.uk/practice-support/resources-marac-meetings

[8] Regulates who can live in the family home, and can also restrict the abuser from entering the surrounding area

receive London Councils funding to operate across London including Hillingdon, and Charlotte's case was therefore allocated, first to an Outreach Worker and then to an Advocate.

1.8.35 Charlotte told SBS that she was fearful, did not feel safe, and wanted an occupation order. She stated that Preston had made allegations to Children's Social Care that she was abusing the children, and had said that he would "punish" her. No immediate risk was identified due to the bail conditions, and Charlotte's case was not allocated immediately (December 2014) but in January 2015 (although some support continued in the interim).

1.8.36 Charlotte's first appointment with the service was 23 January 2015. The Outreach Worker noted actions in relation to Charlotte's housing (including supporting Charlotte to change the locks as Preston still had keys); ensuring a restraining order was sought at sentencing; assist Charlotte in obtaining protection orders; seek advice with regard to child contact; and to address Charlotte's financial issues. The Outreach Worker took action on some of these immediately, including speaking to a solicitor with regard to child contact.

1.8.37 The Outreach Worker identified Charlotte as high risk due to the imminent sentencing and ending of bail conditions, and Charlotte was then allocated an Advocate for ongoing support. Charlotte had an appointment with the Advocate on 27 January 2015 at which the previous actions were reviewed. Charlotte was noted as not being clear on what action the IDVA service had taken or whether a restraining order was due to be requested at sentencing.

1.8.38 The Advocate spoke with the IDVA who, following advice from the Police MARAC Coordinator, advised that Charlotte could not obtain a restraining order as Preston had been acquitted of the assault against her.

1.8.39 A further appointment was made for Charlotte for 30 January 2015, to follow the sentencing on that day. The Advocate contacted Preston's solicitor with regard to child contact, and began drafting the applications for an occupation order and a non-molestation order for Charlotte, in case a restraining order was not requested / granted.

1.8.40 When Charlotte did not attend her appointment on 30 January 2015, the Advocate made three telephone calls to Charlotte, and the service heard of Charlotte's death through media reports three days later.

1.8.41 <u>Children's Social Care</u>

1.8.42 Children's Social Care received Merlins from the Police following the incidents in January 2012 and November 2013. In January 2012 contact was made with Charlotte who informed Social Care that she was away from Hillingdon with family, and (partly as a result of that) the threshold for an initial assessment was not met; Charlotte was sent a leaflet about local domestic violence/abuse

services and the case was closed. The Merlin was sent to the area in which Charlotte and the children were residing.

1.8.43 The threshold for an initial assessment was met when Children's Social Care were in contact with Charlotte after the domestic incident in November 2013. Contact was made with Charlotte in January 2014. Charlotte stated that she was concerned over Preston having contact with the children. The initial assessment was completed on 15 January 2014, including information from the children's school, and a home visit was undertaken in which both children were spoken to alone. There is no evidence of Preston being spoken with as part of the assessment, or a documented reason why this was not done.

1.8.44 The assessment concluded that Charlotte was safeguarding the children and that she was going to apply for a legal injunction, depending on the outcome of the trial, and therefore that the case should be closed.

1.8.45 On 25 February 2014 the Social Worker called Charlotte. Charlotte confirmed the bail conditions were still in place, and that she would take action with regard to an injunction depending on the outcome of the court case. She confirmed that the children had seen Preston on one occasion – arranged via solicitors – but that Preston had not requested contact since.

1.8.46 The assessment was typed up and the case closed following the Social Worker's supervision on 26 February 2014.

1.8.47 There is a case note on the system that a school report was received in March 2014.

1.8.48 Preston contacted Children's Social Care (Triage Team) on two occasions:

(a) July 2014 in which he claimed the children were being cared for by "an illegal asylum seeker" with no qualifications or Criminal Records Bureau checks[9]; he was advised to contact Ofsted[10].

(b) November 2014 in which he alleged physical abuse by Charlotte against the children. Children's Social Care contacted Charlotte who denied the allegation, and stated that Preston was "known to be violent, bitter and aggressive". The Social Worker saw the children at school and there were no concerns. The case was closed.

1.8.49 <u>Central and North West London NHS Trust (CNWL) Health Visiting and School Nursing services</u>

[9] Anyone working children at that time required a Criminal Records Bureau check; this has now been replaced by the Disclosure and Barring Scheme: https://www.gov.uk/disclosure-barring-service-check

[10] Childcare regulator: https://www.gov.uk/government/organisations/ofsted

1.8.50 The Health Visiting service, in addition to routine visits relating to Charlotte and Preston's younger child, received the two Merlins created by the Police, in January 2012 and November 2013. The School Nursing service have no record of receiving the first Merlin, but did receive the second. In addition both services received information from the MARAC discussion in December 2013.

1.8.51 Following the Merlin received in January 2012, the Health Visitor made contact with Charlotte at the place outside of Hillingdon where she was staying. The record gave a plan for the case to be transferred to this new area, and for the Health Visitor to contact the Social Worker. No further action was taken.

1.8.52 Following receipt of the information about the incident in November 2013, the Health Visiting service recorded that they would contact Charlotte. The School Nursing service made no record of any action. The Health Visitor contacted the Social Worker, and was told that an initial assessment had been completed and no further action would be taken. The Health Visitor made a plan to contact Charlotte; there is no record of this taking place.

1.8.53 Preston's contact to Children's Social Care in July 2014 relating to the children's childcare was passed to the School Nursing service; no action was recorded.

1.8.54 <u>Schools</u>

1.8.55 Both children attended the same school until a month before the homicide when the older child moved to another school.

1.8.56 The school were aware of domestic violence/abuse from Preston to Charlotte after the incident in January 2012: Charlotte contacted the school to explain the child's absence as being due to the domestic incident and Charlotte taking the children to family out of area. Following this, the Head Teacher spoke with Children's Social Care, who advised giving Charlotte details of the IDVA service, which was done.

1.8.57 The Head Teacher met with Preston and Charlotte together to discuss the children in July 2013; no issues with the relationship were disclosed or noted. When the school contacted Charlotte in December 2013 Charlotte informed them of the incident in November 2013, and that Preston had bail conditions not to contact her or being in the family home. The school noted having made a referral to Children's Social Care.

1.8.58 Preston attended the school on 26 January 2015 requesting he be able to collect the child; he stated he had been found not guilty of the domestic assault, and made allegations against Charlotte regarding physical abuse against the children. The school advised he contact Children's Social Care. The school contacted Charlotte and she confirmed Preston could collect the child. On 29 January 2015 Preston attended the older child's new school and asked to collect her; the school contacted Charlotte who gave her permission. On both

occasions, the next day the schools checked that the child had arrived, and they had.

1.8.59 **Information relating to Preston**

1.8.60 Preston was 41 at the time of the homicide and sporadically employed as a mechanic.

1.8.61 Metropolitan Police Service

1.8.62 In 2004 Preston received a caution for domestic abuse related common assault, outside of Hillingdon, against a different partner.

1.8.63 National Probation Service

1.8.64 Following his conviction (for two assaults on police officers) on 16 December 2014, Preston met with a Probation Officer (contracted by the National Probation Service through an agency called Blue Bay) for a Pre Sentence Report to be completed through assessment with Preston.

1.8.65 This assessment was carried out on 8 January 2015, and the Pre Sentence Report was completed on 14 January 2015. It recommended a Community Penalty for Preston with a requirement to complete Unpaid Work.

1.8.66 General Practice (GP)

1.8.67 Preston attended his GP 24 times in the three years of the Terms of Reference timeframe, primarily for physical complaints, and also for psychological issues (in May 2014 he was prescribed anti-depressants having reported feeling stressed).

1.8.68 On 26 November 2013 Preston attended reporting he had been assaulted by police after a domestic incident and from this point forward nearly all of his attendances were for physical complaints relating to this, and in addition his anti-depressant medication was increased.

1.8.69 In November 2014 his reports of his mental health issues increased and this led to a referral to the CNWL Improving Access to Psychological Therapies service (see below).

1.8.70 Central and North West London NHS Trust (CNWL) Mental Health service

1.8.71 Preston's GP referred him to CNWL Improving Access to Psychological Therapies (IAPT)[11] on 18 December 2014. The referral stated Preston was presenting with Post Traumatic Stress Disorder following an alleged police assault during a domestic incident [the one on 23 November 2013]; it also stated that Preston "maintains his relationship with his wife is ok".

[11] Improving Access to Psychological Therapies, IAPT, is a national programme (locally delivered and managed) supporting the NHS to get patients into counselling or other mental health support

1.8.72 The IAPT assessment took place on 19 January 2015 and Preston was noted as feeling distressed and saddened by his own physical health difficulties, which he reported as resulting from the alleged assault. He stated “no” in answer to routine questions around whether he was a risk to others.

1.8.73 Preston was offered a Stress Management Course, which was due to start in February 2015.

1.8.74 Hillingdon Hospital

1.8.75 Preston was brought to the Hospital Emergency Department on 23 November 2013 by ambulance and in Police custody, following the domestic incident and assault against the arresting police officers. He was treated and discharged back to custody.

1.8.76 Preston attended in September and November 2014 for scans relating to the physical complaints reported to his GP following the alleged assault by the police officers during this incident. The scans showed nothing abnormal. One record stated “allegations of Domestic Violence by wife and therefore involvement of Police??” Nothing further was recorded in relation to this statement.

1.9 Issues raised by the review

1.9.1 The disclosures made by Charlotte to the many agencies she spoke to made it clear that she was a victim of domestic violence/abuse from Preston. This was primarily verbal abuse, harassment and stalking, with few, albeit significant, occasions of physical abuse.

1.9.2 Charlotte was very aware of the risk she faced, and attempted to make her fears and anxiety over what Preston would do clear to a number of agencies including the Police, IDVA service and Southall Black Sisters.

1.9.3 Given all the information presented in the review, it would be difficult to state with certainty that Charlotte’s murder could have been prevented. Up to the day of the homicide, Preston had (broadly) abided by the bail conditions that had been in place from November 2013. The agencies in contact with Charlotte looked to the ending of those bail conditions (i.e. after the sentencing hearing on the 30 January 2015) as the point after which risk would be heightened.

1.9.4 Charlotte had made clear to agencies that she was afraid, and concerned over what Preston would do after the sentencing. Preston was known by agencies to feel that it was his right to treat Charlotte in any way he chose – he didn’t hide this, demonstrating his sense of entitlement even at the point of arrest for assault. These “cultural issues” had been noted but not identified as leading to additional risk to Charlotte, which could have led to a heightened response, particularly around the time of the trial and sentencing.

1.9.5 It could be suggested that there was too much emphasis placed on his most recent behaviour – of avoiding Charlotte – rather than listening to what Charlotte was saying about her fears and anxieties about his future behaviour.

1.9.6 Research[12] has shown that victim's perception of their risk can be as accurate as risk identification/assessment tools, and it would have been helpful and potentially transforming if certain services had paid more attention to Charlotte's stated fears and anxieties.

1.9.7 Additionally, Charlotte could have been supported by the IDVA in November 2013 to move away to where her family was. This was what she asked for but that support didn't materialise. Charlotte was offered refuge by the IDVA service but she did not wish to pursue that as it would have meant giving up work. The safety plan specifies that the IDVA advised Charlotte to move away from Hillingdon, and Charlotte was willing to do this. The plan then states Charlotte "would be grateful if the local housing department in [family area] assists with this process" but no action was taken to involve them. Charlotte did not mention this wish to move to SBS, and the focus was therefore on applying for an occupation order to not allow Preston to enter the house; this was in progress when Preston killed Charlotte.

1.9.8 This meant that Charlotte remained in Hillingdon, with Preston knowing her whereabouts at all times; and as he always had keys to the house, could gain access to her at any time (the issue of the locks was starting to be addressed by the SBS Advocate at the time of Charlotte's death).

1.9.9 <u>How victims are perceived</u>

1.9.10 Charlotte sought help from a number of different agencies, and in addition disclosed some of the abuse she experienced to other agencies. This Review has noted, and this report discusses, the fact that Charlotte was perceived by different agencies in very different ways.

1.9.11 The Independent Domestic Violence Advocacy (IDVA) service believed Charlotte to be capable, proactive and not in need of additional support. Southall Black Sisters (SBS) saw a vulnerable woman in need of a great deal of help to unravel her issues and become safe. As a result, the actions of the services were very different: the IDVA service, after an initial risk assessment, safety plan and MARAC referral, did not contact Charlotte at all, and when she made contact, gave advice about how she could do things for herself; SBS made frequent contact with Charlotte and began to take actions on her behalf.

1.9.12 The IDVA service should have responses to Charlotte with the same level of service as all victims of domestic abuse/violence presenting to their service.

---

[12] Klein, A. 'Practical Implications of Current Domestic Violence Research Part I: Law Enforcement' US Department of Justice, April 2008

They should have followed up with Charlotte, regardless of how capable she appeared, to ensure that she was taking the actions she committed to do – and when it was discovered that she wasn't, this should have been recognised as due to her vulnerability. In addition, Charlotte should have been supported throughout the court process. All of this learning has been recognised in the IDVA service IMR.

1.9.13 Risk identification and assessment

1.9.14 The Police, IDVA service and SBS carried out risk assessments with Charlotte, and Children's Social Care were aware of the IDVA assessment – these were all through the use of the DASH Risk Identification Checklist. Despite the outcomes of these risk assessments, all the agencies were swayed by either Charlotte's location (January 2012) or Preston's bail conditions (from November 2013). As a result, the extensive risks identified in the assessments by IDVA and Police were effectively ignored in favour of Preston's current actions; and SBS put back the allocation of Charlotte's case for one month (it should be noted that this was as a result of both the risk assessment and a backlog of cases).

1.9.15 Communication in relation to court process and trial

1.9.16 Charlotte should have been in contact with the Officer in Case, the Witness Care Unit and the IDVA service in relation to the Court case; in fact from January to December 2014 she had no apparent contact at all. Given the lengthy delay from the incident to the trial, this is a significant omission, and Charlotte is to be commended for nevertheless having the courage to attend court and give evidence. This lack of communication continued post trial, as Charlotte was unclear as to why Preston had been acquitted of assaulting her, and did not know whether a restraining order was to be requested at sentencing.

1.9.17 Intersection of race and gender

1.9.18 Gender is a risk factor for domestic abuse/violence, with women more likely to be victims. Race and/or national or ethnic background are not risk factors for experiencing domestic abuse/violence, but they are potentially aggravating factors in both the type of abuse experienced and the help seeking patterns/perceptions of services for victims. A domestic abuse/violence victim's race can also impact on the way in which services are delivered.

1.9.19 It has been noted above that Charlotte kept returning to Southall Black Sisters. We can't know why that was, but given that it is a service that explicitly works with Black, Asian and Minority Ethnic women, it is reasonable to suggest that this was a reason.

1.9.20 The intersection of gender and race in this case can be seen in the "cultural issues" noted by the IDVA service and the Police. Preston had an evident sense of entitlement in relation to his abuse against Charlotte. The Children's Social Care IMR quotes the recorded notes as follows: "Father is said to be revengeful

and comes from a background where the man is the boss and women have to obey. He has said that if mother leaves him he won't lose anything by killing her and the children anyway." Charlotte told agencies that Preston was "revengeful" and "unpredictable" but these risk factors were not sufficiently recognised.

1.9.21 While this was noted by agencies, there was no apparent additional action in relation to these issues, or recognition that these could heighten Charlotte's risk in any way. Greater awareness is therefore needed within mainstream services of the additional risks and issues faced by victims in situations such as Charlotte's.

1.9.22 Awareness of and responses to perpetrator of domestic violence/abuse

1.9.23 A number of agencies should have paid more attention, and responded more robustly, to Preston as a perpetrator (or at times alleged perpetrator) of domestic violence/abuse.

1.9.24 Police failed to arrest Preston following Charlotte's allegations of threats to kill in January 2012; Children's Social Care did not speak to Preston during the initial assessment in December 2014; Preston's GP and CNWL mental health services should have shown more professional curiosity in relation to Preston's presentation in the context of an alleged police assault during a 'domestic assault'.

1.9.25 Partnership Working and Governance

1.9.26 A number of issues with the partnership responsible for domestic abuse/violence were recognised by the Panel during discussion of the IMRs, including MARAC governance, inclusion of the voluntary sector and the structure and function of the partnership.

1.9.27 Impact of domestic violence/abuse on children

1.9.28 This was recognised by agencies; when Merlins were created for the Police, this was an effective tool for alerting Children's Social Care services, Health Visiting and School Nursing of the domestic abuse – which otherwise they may not have been alerted to.

1.9.29 Children's Social Care services' response to the two Merlins they received demonstrated an understanding that living in a household with a domestic violence/abuse perpetrator impacts on children. It was unfortunate that the responsibility for the safety of the children was placed on Charlotte, not on Preston.

1.9.30 Risk to others from known perpetrator

1.9.31 The IDVA service, Police, Children's Social Care, Health Visiting, and the MARAC were aware of Preston's "other" partner/family. Action should have been taken to ensure their safety.

1.10 Recommendations

1.10.1 Recommendation 1

The recommendations below should be acted on through the development of a partnership owned action plan. This is in addition to the actions identified in individual IMRs: initial reports on progress by agencies on their IMR action plans should be made to the Safer Hillingdon Partnership within six months of the Review being approved by the Partnership.

1.10.2 Recommendation 2

A briefing to be prepared jointly by the Crown Prosecution Service, Her Majesty's Court and Tribunals Service (HMCTS) and the Metropolitan Police outlining the current processes in place for partnership working and sharing of performance and case information (including any meetings), and for this to be distributed appropriately through each agency. The Crown Prosecution Service, HMCTS and the Metropolitan Police to meet to identify the development required to improve these processes; and to take action on these. Updates to be provided to the Safer Hillingdon Partnership.

1.10.3 Recommendation 3

Metropolitan Police Service, Crown Prosecution Service and the IDVA service to jointly establish a multi-agency procedure in relation to Restraining Orders, with reference to the learning in this case.

1.10.4 Recommendation 4

Southall Black Sisters and the IDVA service to ensure – through procedure, training and ongoing supervision – that all support staff establish contact with the Officer in the Case for clients who are engaged in the criminal justice system, and remain in contact with them until cases are completed. The Safer Hillingdon Partnership to also disseminate this learning to other agencies in Hillingdon that support domestic abuse victims.

1.10.5 Recommendation 5

The Safer Hillingdon Partnership to ensure that all domestic abuse specialist services operating in Hillingdon are notified of new domestic homicides at the earliest point possible.

1.10.6 Recommendation 6

The Safer Hillingdon Partnership to raise awareness – through for example fact sheets, awareness sessions and/or training, and drawing on appropriate expertise in relation to BAME female victims of domestic abuse – of the intersections of race and gender and how they impact on women's experiences of domestic abuse. With reference to the learning from this case; and to include

directions to staff on where further advice can be sought. For information to also be added to standard Domestic Abuse Awareness training.

1.10.7 Recommendation 7

In the redevelopment of the local MARAC process, the MARAC Steering Group to develop a process through which education services (schools) and General Practices can be appropriately involved (though not necessarily always attend) in the MARAC process.

1.10.8 Recommendation 8

The Safer Hillingdon Partnership to ensure, through regular reports from the MARAC Steering Group, that the MARAC redevelopment outlined in this review continues to make progress. In particular that a review of the MARAC Steering Group terms of reference, chairing and membership has taken place with reference to the points made in this review, and that the Local Safeguarding Children and Adult Safeguarding Boards are appropriately involved.

1.10.9 Recommendation 9

Children's Social Care to review the free materials available from http://endingviolence.com and, also with reference to the learning in this case:

- ensure that fathers are always spoken with in domestic violence/abuse cases (where safe to do so, and in those cases where it is not, to document it)
- ensure that perpetrators are held accountable for domestic violence/abuse, and that non-abusive parents are therefore fully supported and not expected to stop the abuse themselves

For this to be regularly reviewed in supervision, and for a dip sample audit to take place six months after changes have been made, with the results reported to the Safer Hillingdon Partnership.

1.10.10 Recommendation 10

For the school to ensure that domestic violence/abuse policies, procedures and training for staff include the need to see parents alone when there has been a disclosure or suspicion of domestic violence/abuse.

1.10.11 Recommendation 11

CNWL to review their domestic abuse policy in light of the learning from this case, and in particular to ensure that it contains adequate information and guidance on warning signs/triggers in relation to domestic violence/abuse perpetrators.

1.10.12 Recommendation 12

Hillingdon Hospital to ensure that Hospital database systems link family members together so that they can be identified when an individual attends.

1.10.13 Recommendation 13

Safer Hillingdon Partnership to carry out a review to establish service users' and partner agencies' views on the IDVA service being located in a statutory service. The experiences of other boroughs to be sought, and the findings to be acted on accordingly in relation to service delivery.

1.10.14 Recommendation 14

The Safer Hillingdon Partnership (or a delegated short term working group) to review the use of the DASH risk identification checklist in Hillingdon agencies, covering (other issues may also be identified):

- the purpose of DASH completion
- the use of DASH as an ongoing risk identification tool (rather than as a one off threshold tool)
- the sharing of risk identification outcomes between agencies involved with the same client

1.10.15 Recommendation 15

Metropolitan Police Service to review the ongoing contact by Officers in the Case with victims as investigations and trials progress, in light of the learning from this case.

1.10.16 Recommendation 16

The Specialist Domestic Violence Court (SDVC) Steering Group to review, with the IDVA service and other relevant services, the support provided at the SDVC to victims of domestic abuse/violence, with particular reference to victims in cases that are transferred from the Magistrate's Court to the Crown Court. To report to the Safer Hillingdon Partnership on the Review and any actions taken as a result.

1.10.17 Recommendation 17

Safer Hillingdon Partnership to carry out a review of existing domestic abuse specialist support services, that includes all services operating in Hillingdon (not just those based in Hillingdon), to establish how the needs of minority ethnic victims are met. To also include consultation with minority ethnic women in the borough on whether they feel their needs are met, and their opinion on how services should operate. For the learning from the review to be acted upon and progress reported back to the Safer Hillingdon Partnership.

1.10.18 Recommendation 18

Metropolitan Police Service to review their processes (and conduct a dip sample audit) in relation to arrest, and withdrawal statements, with reference to the learning in this case, and to report back to the Safer Hillingdon Partnership addressing these learning points.

1.10.19 Recommendation 19

All members of the DHR Panel and Safer Hillingdon Partnership to conduct internal reviews of their domestic violence/abuse policies and procedures in relation to how they identify, risk assess, refer and respond appropriately to perpetrators (including alleged), to make changes as appropriate and report to the Safer Hillingdon Partnership.

1.10.20 Recommendation 20

The Safer Hillingdon Partnership to review the structure, governance, membership and Terms of Reference of the partnership responsible for domestic violence/abuse, to address the points made in this review, including but not limited to:

- The need to provide governance of the MARAC and MARAC Steering Group; including the necessity of different partner agencies chairing the MARAC and the MARAC Steering Group. The MARAC Steering Group to report into an appropriate partnership group.
- The need for the partnership to be inclusive of the voluntary sector.
- Ensuring that all organisations in Hillingdon understand the purpose and role of the partnership responsible for domestic abuse/violence; their role within it and their ability to present issues and potential to effect change.

1.10.21 Recommendation 21

The Safer Hillingdon Partnership and MARAC Steering Group to establish a procedure for all agencies and the MARAC to respond appropriately to situations in which a known perpetrator poses a risk to someone not known to agencies, including those out of area.

2. DHR Safer Hillingdon Partnership, Charlotte

Overview Report

Introduction

2.1 Outline of the incident

2.1.1 On 30 January 2015 Charlotte was found at home, having been stabbed a number of times. Charlotte's husband, Preston, was convicted of her murder on 18 August 2015, and sentenced to 27 years imprisonment.

2.2 Domestic Homicide Reviews

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

2.2.2 The purpose of these reviews is to:

(a) 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.

(b) 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.

(c) Apply those lessons to service responses including changes to policies and procedures as appropriate.

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

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

2.3 Terms of Reference

2.3.1 The full terms of reference are included at 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.

2.3.2 The first meeting of the Review Panel was held on 13 May 2015. The Review Panel were asked to review events from 1 January 2012 up to the homicide. Agencies were asked to summarise any relevant contact with Charlotte or Preston prior to this date.

2.3.3 Home Office guidance states that the Review should be completed within six months of the initial decision to establish one. This review has taken longer than that for a number of reasons.

2.3.4 It took some time initially to commission and secure an independent Chair for this review, as well as to ensure that the Review had the necessary comprehensive and dedicated administrative cover. There was subsequently a significant delay in some IMRs and chronologies being received.

2.3.5 The criminal case was completed six months after the Review had been established, and there was therefore further delay while the independent Chair waited to make contact with the family, friends and employer of the victim, and the perpetrator.

2.4 Independence

2.4.1 The Chair of the Review was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea has received training from the then Chief Executive of Standing Together, Anthony Wills. Althea has over eight years experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with Hillingdon or any of the agencies involved in this case.

2.5 Parallel Reviews

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

2.6 Methodology

2.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Charlotte and/or Preston. 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.

2.6.2 London Borough of Hillingdon Housing, Adult Social Care Service and Education Services reviewed their files and notified the DHR Review Panel that they had no involvement with Charlotte or Preston and therefore had no information for an IMR.

2.6.3 All IMRs included chronologies and analysis of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period of 1 January 2012 to the date of the homicide.

2.6.4 Although information was included about the children in the IMRs, this was only provided for the purpose of context, where necessary, to the agency's contact with Charlotte and/or Preston. The Panel agreed that it was not necessary to analyse agency contact directly with the children.

2.6.5 On the whole, the IMRs provided were comprehensive and the analysis supported the findings. Following comments, questions and suggestions some IMRs were redrafted and once complete were comprehensive and high quality. IMRs were received from:

(a) Central and North West London NHS Foundation Trust – health visiting and school nursing services

(b) Central and North West London NHS Foundation Trust – mental health services

(c) Crown Prosecution Service

(d) General Practice for Charlotte (chronology only)

(e) General Practice for Preston

(f) Hillingdon Hospital

(g) London Borough of Hillingdon Children's Social Care Services

(h) London Borough of Hillingdon Independent Domestic Violence Advocacy Service

(i) Metropolitan Police Service

(j) National Probation Service, London Division

(k) Schools

(l) Southall Black Sisters

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

2.6.7 The Review Panel members and Chair were:

(a) Althea Cribb, Chair, Standing Together Against Domestic Violence

(b) Anna Fernandez, Hillingdon Hospital

(c) Barbara North, representing Health Visiting and School Nursing Services, Central and North West London NHS Foundation Trust

(d) Christine Edgar, Metropolitan Police Service Critical Incident Advisory Team

(e) Eileen Bryant, NHS England

(f) Erica Rolle, Community Safety, London Borough of Hillingdon

(g) Jean Veysey, Hillingdon Clinical Commissioning Group

(h) Margaret O'Keefe, Her Majesty's Courts and Tribunals Service

(i) Melanie Parrish, Crown Prosecution Service

(j) Nikki Cruikshank, Children's Services & IDVA service, London Borough of Hillingdon

(k) Pragna Patel, Southall Black Sisters

(l) Representatives, Schools

(m) Shaun Hare, representing Mental Health services, Central and North West London NHS Foundation Trust

(n) Superintendent Max Williams, Metropolitan Police Service, Hillingdon

(o) Tendayi Sibanda, Hillingdon Hospital

(p) Teresa McKee, Community Safety, London Borough of Hillingdon

(q) Will Jones, National Probation Service

2.6.8 In addition to the above, information was sought from Ealing Hospital in relation to Charlotte's two pregnancies. While this was outside of the initial Terms of Reference, it was felt necessary to explore this – and then if appropriate to amend the Terms of Reference – given subsequent information that there had been a police-recorded domestic incident at the time of Charlotte's first pregnancy. On review, there was nothing of note in these records.

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

2.7 Contact with the family

2.7.1 At the start of the Review process, the criminal case was ongoing and the trial had not started. As a result, contact with the family, friends and employer of the victim, and with the perpetrator, was not attempted. A letter was written to the family of Charlotte, delivered via the Police, informing them that the Review was underway and giving them an opportunity to review the draft Terms of Reference, and stating that the independent Chair would make further contact after the conclusion of the trial.

2.7.2 Once the trial had been completed, the independent Chair attempted to make contact with Charlotte's family, friend and employer, through letters that were posted to their home addresses. After replies were not received, the Panel agreed that the Police Family Liaison Officer would speak with the family to ensure that the letters were delivered, and to establish whether they wished to participate in the review. The Family Liaison Officer spoke with the family and it was established that they may be interested in participating in the review, but that they were very busy continuing to deal with the aftermath of Charlotte's

death. The independent Chair made contact again, however at the time of submission no response had been received.

2.7.3 The independent Chair also wrote to Preston at the prison in which he is detained. No response was received. It should be noted that at the time of this Review being completed, Preston was appealing his conviction and sentence.

3. The Facts

3.1 Outline

3.1.1 Charlotte and Preston had come together to the UK from Zimbabwe in 1999. They had been married in a cultural ceremony in Zimbabwe but were not legally married in the UK. They lived together until November 2013 in a jointly owned (mortgaged) private property. Charlotte and Preston had two children together.

3.1.2 Charlotte reported to a number of agencies being a victim of verbal and physical abuse from Preston; the first report of this was in 2006, while Charlotte was pregnant. In January 2012 Charlotte informed agencies that they were separated albeit continuing to live in the same house. From November 2013 a full separation took place following a police incident and bail conditions preventing Preston from contacting Charlotte.

3.1.3 Preston was found not guilty of that offence against Charlotte, however he was found guilty of assaulting the two police officers who arrested him at that incident; he was due to be sentenced for those assaults on the day he killed Charlotte.

3.1.4 Preston was convicted of murder on 18 August 2015, and sentenced to 27 years imprisonment.

3.2 Information relating to Charlotte

3.2.1 Charlotte was 42 at the time of her death. She was a qualified Health Visitor, working part-time outside of London.

3.2.2 Charlotte sought help from a number of different agencies, and in addition disclosed some of the abuse she experienced to other agencies. This Review has noted, and this report discusses (in sections four and five), the fact that Charlotte was perceived by different agencies in very different ways.

3.2.3 It should also be noted that, where the terms ‘husband’ and ‘wife’ are used in this report, and were used by agencies in contact with Charlotte and Preston, this reflects the terms used by Charlotte and Preston. At times agencies did not seem to be aware that the marriage was not a legal UK marriage.

3.3 Metropolitan Police Service (MPS)

3.3.1 The Police recorded one incident outside of the Terms of Reference timeframe, which is included as it is relevant to the Review. This was a domestic incident reported by Charlotte in January 2006, when she was 28 weeks pregnant (with her first child). Charlotte told police that she had denied Preston access to the home as he had been away for six days and had threatened her in the past; she stated that she did not want to live with him anymore. Preston managed to enter the premises; Charlotte left the house barefoot and called police from a phone box (it later transpired that Preston had taken Charlotte’s phone).

3.3.2 Charlotte did not provide a statement or go to court; Preston was spoken with on the phone and the IMR notes that he stated he "did not care if he was arrested". No further action was taken; there was no record of a Merlin[13] or risk assessment being completed. A letter was sent to Charlotte offering help and advice.

3.3.3 The first incident within the Terms of Reference timeframe was when Charlotte called the police on 9 January 2012. She alleged to police that she looked at Preston's phone on 31 December 2011, as she believed he was having an affair; after this he became aggressive and left the house. He returned the next day (1 January 2012) and during an argument he threatened to kill her, shouting "I don't lose anything if I kill you and the kids, look at what is on the telly". He repeated the threat on 8 January 2012 when Charlotte told him she was not happy and wanted to leave.

3.3.4 Charlotte reported feeling scared, and told officers that Preston had always been aggressive towards her, though had not hit her. Charlotte left the home and went to stay with family outside of Hillingdon.

3.3.5 The Domestic Abuse Stalking Harassment and Honour-Based Abuse (ACPO-CAADA DASH) risk identification checklist was completed and Charlotte was judged to be at 'Medium' risk[14]; this was reassessed as 'Standard'[15] on the basis that Charlotte was not in Hillingdon. A referral was made to the Independent Domestic Violence Advocacy (IDVA) Service[16] and a Merlin completed.

3.3.6 A Computer Aided Despatch (CAD) was created for Preston to be arrested; Preston could not be located and it was referred back to the Officer managing the case (Officer in the Case: OIC). Preston was subsequently asked to report to the Police Station on 1 February 2012; there is no record of whether he attended. There was no further information recorded with regard to arresting Preston.

3.3.7 The OIC made further attempts to contact Charlotte. Then on 29 January 2012 the OIC spoke with Preston who stated that Charlotte had returned to their home the previous week. The OIC then spoke with Charlotte who stated she was "happy to be with her husband and they were seeing a counsellor to address any problems that may arise". On 2 February 2012 Charlotte provided a withdrawal statement She returned shortly after and made a withdrawal statement in which

---

[13] A form completed by the Police that is automatically passed to Children's Social Care, to alert them to any police incident in which children are involved.

[14] Medium risk definition: There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

[15] Standard risk definition: Current evidence does not indicate likelihood of causing serious harm.

[16] Specialist domestic violence and abuse support service for medium and high risk victims; in this case provided by Hillingdon Borough Council.

she stated she had over-reacted to Preston's threats and taken his comments out of context. No further action was taken.

3.3.8 The next incident was eleven months later on 3 December 2012. Charlotte called police as, although separated she and Preston were living in the same house, and there had been an argument. Preston threatened to put Charlotte's photograph on the internet and told her "the war is just beginning". Officers noted that Preston was defensive, and filmed officers on his camcorder. No offences were disclosed.

3.3.9 The children were mentioned on the '124d' report (this is the form completed by all officers attending a domestic abuse/violence incident) but not on the CRIS report (the report entered onto the Police computer system); no Merlin was created. Charlotte was advised of support available from the Community Safety Unit and the Citizens' Advice Bureau. No further action was taken.

3.3.10 Charlotte next called the Police three months later on 24 March 2013, stating that her husband was playing loud music in the house; she informed police they were going through divorce proceedings. No offences were disclosed.

3.3.11 Preston was noted to be argumentative with Charlotte and the officers attending. Officers noted "cultural issues" in their report in relation to the way Preston spoke to Charlotte but this was not expanded upon, or followed up on. An ACPO-CAADA DASH risk identification checklist was completed and Charlotte was assessed as 'standard'. The CRIS report refers to children but no Merlin was created.

3.3.12 On 23 November 2013 police attended after Charlotte reported Preston had tried to strangle her. Charlotte's friend and the children witnessed the incident (the friend became a witness at the trial). Preston assaulted officers who were trying to prevent him from re-entering the property to "get to Charlotte". The children were noted as having witnessed the incident, and a Merlin was created.

3.3.13 Charlotte disclosed that Preston had destroyed furniture in the past; had written a letter to her college tutor; had controlled her movements and who she was allowed to see; and that she was looking for somewhere to live away from him. Officers noted that Charlotte "is clearly very distressed and fearful of [Preston]" and she was noted as having told officers "he said that he is going to destroy my life".

3.3.14 The initial risk assessment was that Charlotte was 'standard' risk; this was initially upgraded, but then downgraded to standard again by an inspector, on the basis that Preston was in custody. It was noted that this should be reviewed if Preston were to be released or granted bail. There is no record of this review occurring.

3.3.15 Preston was charged with assault by beating on Charlotte, common assault occasioning actual bodily harm on one police officer and assault of a police

constable. On 25 November 2013 Preston was granted bail with the following conditions: not to contact directly or indirectly Charlotte, except via a solicitor with regard to child contact; not to enter/go within 100 yards of Charlotte's address; to live and sleep each night at a designated address (a member of Preston's family).

3.3.16 A referral to the Independent Domestic Violence Advocacy (IDVA) service was made following this incident.

3.3.17 Any further contact between the OIC and Charlotte would not have been recorded on the Police system and so is not known.

3.3.18 The next recorded police contact with Charlotte was nearly a year later, when on 3 December 2014 Charlotte called the police to report that Preston had approached the children in a supermarket while she was shopping with them. Charlotte also told police that she had received a call from Children's Social Care on 28 November 2014 informing her that Preston had called them and alleged she was mistreating the children. She also told police that her Manager had told her that Preston had called her work, stating she was keeping patients' confidential information at home. Preston subsequently took the documents, and Charlotte was investigated by her work. Police advised Charlotte to report this as theft, which she did not do.

3.3.19 Charlotte told police she was worried about the trial, and fearful of what he may do once the trial is over. The case was closed as there was judged to be no breach of bail conditions.

3.3.20 The trial took place on 16 December 2014 (see below in the Crown Prosecution Service section for an explanation of the delay), and Charlotte gave evidence. Preston was acquitted of assaulting Charlotte; he was found guilty of the assault occasioning actual bodily harm and assault against a police constable. His bail conditions continued "as before" until sentencing on 30 January 2015.

3.3.21 Charlotte called police on 27 December 2014 seeking the outcome of the court case. An entry was placed on the crime report for the Officer in Case to contact Charlotte. There is no record of this taking place.

3.3.22 Charlotte called police again on 26 January 2015, stating that she had been informed by the children's schools that Preston had attended earlier in the day, and that the school believed he would return to collect the children later; as there were no court orders in place, the school would have to allow him to do this. Charlotte was calling police because she was scared about attending the school to collect the children, as Preston had been violent in the past. Charlotte also believed Preston was breaching his bail conditions.

3.3.23 It was judged that Preston was not breaching his bail conditions; Charlotte was advised to speak to her solicitor or Citizens' Advice Bureau. The contact was not listed as a domestic incident as "no contact has taken place at all, either directly

or indirectly". The operator believed Charlotte to be seeking advice only; therefore the matter was not passed to a uniformed unit to attend, and a Merlin was not created. This was the last contact Charlotte has with police.

3.4 Witness Care Unit (WCU)

3.4.1 The information concerning the Witness Care Unit's contact with Charlotte (and her friend who was a witness in the case) was included within the MPS IMR, as this is a Police service. It has been included as a separate section here for clarity.

3.4.2 Charlotte was referred to the WCU once Preston was charged with common assault against her, following the incident of 23 November 2013. Her case was allocated on 26 November 2013, however the Witness Care Officer (WCO) knew Charlotte and requested the case be reallocated.

3.4.3 The case was reallocated three months later on 27 February 2014. This was the day after the Plea and Case Management Hearing, at which point the trial was listed to commence on 23 June 2014.

3.4.4 On 28 February 2014, the WCU alerted all witnesses, including Charlotte, of the trial date in June. This was done via text message, and contact details for the WCU were also provided.

3.4.5 The WCU attempted to call Charlotte on 9 May 2014, there was no reply and they were unable to leave a message. A text message was sent.

3.4.6 The WCU sent a text message to Charlotte on 11 June 2014 asking her for 'dates to avoid' in the next six months. There is no record of a reply, or follow up.

3.4.7 Following information from the Crown Prosecution Service (CPS) that the trial was scheduled for the week commencing 1 December 2014, the WCU attempted to contact Charlotte on 14 October 2014 to give an update. The records imply that this was not successful.

3.4.8 The WCU emailed the Officer in the Case (OIC) on 17 November 2014, asking them to contact Charlotte as the WCU had been unable to reach her. The WCU emailed the OIC again on 21 November. On 26 November the OIC contacted the WCU to confirm witness details, but did not confirm whether there had been any contact with Charlotte.

3.4.9 When the trial was scheduled to start, the WCU telephoned Charlotte and spoke with her on 5 December, informing her of the need to attend court on 8 December. This was the last recorded contact by the WCU with Charlotte.

3.5 Crown Prosecution Service (CPS)

3.5.1 The CPS involvement with the case centred on the trial for the incident of 23 November 2013. Their role means that they had no direct contact with Charlotte, with the exception of the day of the trial. This section therefore sets out the

process of the trial, and includes relevant information supplied by Her Majesty's Courts and Tribunals Service (HMCTS).

3.5.2 On 24 November 2013 the CPS were contacted by the Police for charging advice following Preston's arrest on 23 November 2013 for assaulting Charlotte and the two police officers.

3.5.3 The prosecutor authorised a charge of common assault by beating in relation to Charlotte, one of assaulting a police constable and one of assault occasioning actual bodily harm in respect of the two officers.

3.5.4 The Prosecutor recorded that the case was domestic violence, and therefore applied the Domestic Violence Checklist, which provides written prompts to the Prosecutor in providing an enhanced level of evidence gathering including information regarding any previous history of violence.

3.5.5 The Prosecutor gave the following instructions regarding bail: "Suspect to be remanded in custody as he has refused to provide an alternative address … [and] there are clearly substantial grounds that he will return to the family home and that further offences will be committed and he will interfered with witnesses all of whom live there or nearby."

3.5.6 The Prosecutor noted that a restraining order was to be applied for.

3.5.7 In addition to the above, the Prosecutor created an action plan for the Officer in the Case:

(a) To request the 999 tape to explore its use at trial.

(b) Suitable domestic violence advice to be provided to the victim including help and advice on contacting a civil solicitor to arrange a divorce and housing for the family as she may be entitled to stay in the house – will clearly require legal action to do this.

(c) Restraining order to be drafted by Office in the Case.

(d) Victim Personal Statement requested from Charlotte.

3.5.8 At the first hearing at Uxbridge Magistrates Court on 25 November 2013, the CPS served the evidence on Preston's defence solicitors, and Preston pleaded not guilty. The case was allocated to Isleworth Crown Court: this was as a result of the charge of assault occasioning actual bodily harm, for which Preston was offered the choice of being heard in the Magistrate's court or the Crown Court. Preston selected the Crown Court and therefore all three matters were sent to the Crown Court to be heard together. A preliminary hearing date at the Crown Court was set for 11 December 2013.

3.5.9 At this preliminary hearing Preston indicated again he would plead not guilty to all three charges; the Court set a provisional trial date of 26 June 2014. The CPS was ordered to serve all evidence by 22 January 2014.

3.5.10 The allocated Prosecutor reviewed the case on 23 December 2013 and emailed the Officer in the Case to request the required evidence, including: typed statements from all witnesses; medical evidence of injuries; photos; unused material; copies of the mobile phone footage of the incident; and any items requested when the charging advice was given (see above, 24 November 2013). The deadline given was 10 January 2014.

3.5.11 On 13 January 2014 the Prosecutor emailed the Officer in the Case (OIC) to request the outstanding evidence, including the mobile phone footage, 999 tapes and medical evidence.

3.5.12 On 22 January 2014 the Prosecutor emailed the Borough Commander alerting him to the fact that material was still outstanding for the case meaning that the CPS could not meet the Court's deadline for evidence to be served. No response was received. An extension was sought from the Court.

3.5.13 The CPS served the evidence on the Court and defence on 5 February 2014, despite items remaining outstanding: Victim Personal Statement, draft restraining order, medical evidence and the 999 tape.

3.5.14 On 26 February 2014 there was a Plea and Case Management Hearing at which the trial date was confirmed as the two-week warned list commencing 23 June. This meant that the trial would start any day during that two week period.

3.5.15 A formal list of witnesses was submitted to the Witness Care Unit. The Court confirmed that any outstanding evidence had to be submitted by 12 March 2014 in order for it to be relied upon at trial. The Prosecutor sent a written memo to the OIC detailing the material required; this did not specifically mention the 999 tape, restraining order or Victim Personal Statement.

3.5.16 On 3 March 2014 the CPS were notified that one of the Police Officer witnesses had booked leave and would therefore not be able to attend Court as a witness after 27 June 2014. As a result the Prosecutor wrote to the Court Manager seeking a fixed trial date of 23 June 2014 so that the trial could commence before the witness went away. This was not followed up and no response was received.

3.5.17 On 9 May 2014 the CPS were emailed by the Witness Care Unit advising that the witness to the assault (Charlotte's friend) had indicated to the OIC that they wanted to withdraw, as they were worried about attending court. The Witness Care Officer advised that contact had been attempted and had not been able to reach them.

3.5.18 On 19 May 2014 the Prosecutor wrote to the OIC requesting an update with regard to Charlotte's friend wish to withdraw as a witness, in particular so that a Witness Summons could be requested if it was required. They also asked for contact to be made with Charlotte to ascertain her willingness to give evidence at trial.

3.5.19 On 28 May 2014, the Prosecutor noted having not heard from the OIC and therefore asked the Court for the case to be listed urgently, with the Officer in the Case to attend, to apply for a fixed trial date to avoid attendance problems from the Police Officer who had booked leave.

3.5.20 The case was listed for mention on 12 June 2014; the Court were unable to accommodate the period 23 to 27 June, and vacated the trial. A new trial date was made for the warned list commencing 1 December 2014.

3.5.21 On 9 July 2014 the Prosecutor emailed the OIC asking them to respond to earlier requests to contact Charlotte and her friend to clarify whether they would attend to give evidence at the trial. The Officer in Case responded on 23 July 2014 that they had left voicemails for the friend but had not heard back; Charlotte was not mentioned.

3.5.22 The Prosecutor emailed again on 22 October regarding this issue. On 17 November the Witness Care Unit emailed the OIC (and copied this to the CPS) to ask them to contact Charlotte and her friend. The Witness Care Officer emailed again (and again copied in the CPS) on 21 November asking for an urgent response to the previous email.

3.5.23 On 20 November the case was listed for mention to try to clarify the position regarding Charlotte and her friend as witnesses. A Witness Summons was issued for the friend based on the email from the OIC to the WCU on 9 May 2014. It was unclear whether the OIC had been in touch with Charlotte or the friend.

3.5.24 The OIC collected the Witness Summons and confirmed it had been served on Charlotte's friend on 5 December but that this had been done without 'conduct money'. This had been requested by the Witness Care Officer on 4 December; conduct money must always accompany a Witness Summons as, if the witness does not attend, the Judge can issue a warrant and ask for the witness to be brought to court, but this can only be done if conduct money has been served.

3.5.25 At the 20 November hearing the CPS were also ordered to serve the 999 call as evidence; this was done and the 999 tape was played at the trial.

3.5.26 The trial commenced on 9 December with the jury being sworn in; however they were then stood down for the evidence to be heard the next day. The trial then ran from 10 December for five days. Charlotte and her friend gave evidence. The jury found Preston not guilty of the assault against Charlotte and guilty of the assaults against the two Police Officers. Prosecution counsel informally fed back to the CPS that they felt the jury were left with doubts due to inconsistencies between the evidence given by Charlotte and her friend.

3.5.27 The case was adjourned to sentence on 30 January 2015. Bail conditions were continued as before.

3.5.28 The Prosecution Counsel attended on 30 January 2015 ready to apply for a restraining order for Charlotte (see more detail below).

3.6 Restraining Order

3.6.1 The IDVA recorded in the risk assessment following the incident in November 2013 “client to apply for a restraining order”. The safety plan noted: “Request for restraining order made to OIC [Officer in the Case]”. It is not clear whether the IDVA had taken – or would take – this action, or whether she expected Charlotte to take action on this.

3.6.2 The trial was completed in December 2014; when Charlotte spoke with the Southall Black Sisters (SBS) Support Worker on 15 January 2015, she did not know whether a restraining order had been applied for or obtained. The IDVA sought advice from the Police MARAC Administrator who stated that a restraining order could not be applied for, as Preston had been acquitted of assaulting Charlotte and was awaiting sentence for other matters (the assaults on police officers). The IDVA informed the SBS Support Worker of this on 27 January 2015.

3.6.3 The CPS (as outlined above) had noted that a restraining order was requested, and asked the OIC to draft this. While there are no records to clarify the process taken, it is clear that a restraining order was to be applied for at sentencing on 30 January 2015: the Prosecution Counsel’s brief contained evidence from Charlotte to put before the Judge that met the criteria for a restraining order to be applied for.

3.7 Southall Black Sisters (SBS)

3.7.1 Charlotte first contacted Southall Black Sisters (SBS) for help on 26 June 2012, via a message sent through the SBS website. Charlotte stated that she wanted to end her relationship with Preston, but that she was afraid he would kill her – something he had threatened to do in the past.

3.7.2 She informed SBS that they had two children together, and that she was financially responsible for the family. Charlotte stated that due to this, and her studying to become a Health Visitor, she could not afford to rent privately and therefore “had no option but to continue to live with Preston”[17].

3.7.3 The Operations Manager sent the message to the Advocacy Coordinator and SBS Helpline; the procedure was and is to send to both in case the SBS Helpline is too busy to respond.

3.7.4 On 2 July 2012 the Advocacy Coordinator responded to Charlotte, as the SBS Helpline was managing a backlog. The Advocacy Coordinator apologised for the

[17] This and all quotes in this section are direct quotes from the Individual Management Review, not Charlotte, unless otherwise indicated.

delay in responding, and expressed concern for Charlotte's safety. The Coordinator outlined to Charlotte that SBS were unable to support her, as they did not have capacity to support anyone outside of the London Borough of Ealing (SBS at that time were not funded to work in Hillingdon). Despite this, the Coordinator offered for an SBS Helpline Worker to call Charlotte if she wished. Charlotte was also advised to call the Police with regard to the threats to kill made by Preston, and to contact Hillingdon Women's Centre for further advice and help. The website address for Hillingdon Women's Centre was provided.

3.7.5 The Advocacy Coordinator also informed Charlotte that she could contact SBS again in the future. This was the end of the contact.

3.7.6 Charlotte contacted SBS again on 3 April 2013, nine months later, by calling the SBS Helpline. She told the Helpline Worker that she had not followed up on the advice given the previous July, and that she was still seeking to separate from Preston – she also stated that she had discussed this with Preston, and he was refusing a divorce.

3.7.7 Charlotte told the Helpline Worker that she had called the Police "several times", the last being on 14 March 2013, when she had called because Preston was playing his music very loud and she was unwell and trying to sleep. Charlotte stated that the Police had told her they "could not do anything". She also referred to an incident in December 2012 when Preston had smashed a wardrobe after an argument; Charlotte told the Helpline Worker that the Police had not attended but had "made a note of the incident". (NB: this does not match with Police recorded incidents.)

3.7.8 Charlotte also stated that she had called the Police over Preston's threats to kill, some time in 2012; she told the Helpline Worker "they could not find him as he had left the property and so no arrest was made".

3.7.9 As with Charlotte's first contact with SBS in June 2012, SBS were not in a position to help Charlotte as they were not funded to work in Hillingdon and did not have the capacity to work with victims outside of the London Borough of Ealing. Charlotte was again signposted to Hillingdon Women's Centre: their address, phone number and drop-in advice opening times were provided to Charlotte, along with directions on how to get to them. This was the end of the contact.

3.7.10 More than 18 months later, on 5 December 2014, Charlotte contacted the SBS reception desk for "urgent advice" regarding a court hearing, and also about allegations made by Preston to Children's Social Care. Charlotte stated she was "afraid for her life". By this time, SBS were receiving funding from London Councils to work with victims in Hillingdon (and other London Boroughs).

3.7.11 The SBS reception desk referred Charlotte to the SBS helpline immediately, and a Helpline Worker called Charlotte back the same day. A voicemail was left, and later that day the Worker called Charlotte again, and this time Charlotte

answered. Charlotte gave the Worker a brief history of her relationship with Preston, and described the assault against her in November 2013 for which Preston had been arrested, and bailed not to contact her (see MPS section above). Charlotte stated that the trial was due to start on 8 December 2014.

3.7.12 Charlotte told the Helpline Worker that Preston had not breached the bail conditions and she had no contact with him, but that she was nevertheless fearful, did not feel safe, and wanted an occupation order. Charlotte stated that Preston had called Children's Social Care claiming she was abusing the children and preventing him from seeing them; and that Preston had "often" threatened her, telling her that he would "punish" her (quote from Charlotte in the IMR). Charlotte asked for help with protection orders[18], her property and housing options.

3.7.13 The Helpline Worker identified no immediate risk to Charlotte due to the bail conditions. The Worker informed Charlotte that SBS would help her, and that her case would be allocated according to SBS casework procedures. Charlotte was provided with a solicitor's contact details.

3.7.14 On 10 December Charlotte's case was discussed at a case allocation meeting; the allocation of her case was put back to January 2015. This was due to the high number of cases needing allocation on that day, and the assessment that there was no immediate risk to Charlotte, largely due to the bail conditions in place.

3.7.15 In the interim, an SBS Advocate contacted Charlotte to support her in progressing an occupation order (as there were a number of women being supported at a solicitor's on a particular day, that Charlotte could be part of if she wished). The Advocate contacted Charlotte twice from 12 to 15 December 2014, but received no response.

3.7.16 Charlotte's case was allocated at the next case allocation meeting on 9 January 2015. Since her initial contact, the SBS Hillingdon Outreach Advice Surgery had been established and an appointment was reserved for her on 23 January 2015.

3.7.17 The SBS Outreach Worker called Charlotte on 15 January to arrange the appointment. Charlotte informed the Worker that Preston had been found not guilty of assaulting her, and guilty of assaulting the two police officers; on being asked, Charlotte stated she did not know whether a restraining order had been applied for when the not guilty verdict was returned; however she did state that the police had talked to her about obtaining one (see MPS and CPS sections above for more detail on the restraining order). The Worker advised Charlotte to speak to the Police Officer in charge of the investigation about a restraining

[18] *Non-Molestation Order*: Aimed at preventing the abuser from using or threatening violence, or intimidating / harassing the victim or their child(ren); *Occupation Order*: regulates who can live in the family home, and can also restrict the abuser from entering the surrounding area.

order being applied for when sentence was made for the other two assaults. Charlotte also stated that she had been in touch with the solicitor (whose details she had been provided with on 5 December) and that she could not afford to go ahead with the non-molestation order or occupation order.

3.7.18 Charlotte was given the appointment at the Hillingdon Outreach Advice Surgery. The Worker advised Charlotte to request a supporting letter from the Independent Domestic Violence Advocacy (IDVA) service; and asked for the details of the Police Officer so that the Worker could contact directly with regard to the restraining order.

3.7.19 At the appointment on 23 January, Charlotte stated that Preston still had keys to her property; and that although bail conditions were still in place, she "did not know why he was found not guilty of assaulting her". She told the Worker that the Police had not told her whether a restraining order had been applied for.

3.7.20 Although Charlotte stated that Preston had not breached his bail conditions, she did tell the Worker that Preston had been texting her via his brother about child contact, and was "generally harassing her", for example through contacting the children's schools, and calling her employer and "telling lies about her" such as she was breaching client confidentiality.

3.7.21 The following set of actions were agreed:

(a) to seek advice from the police on the likely outcome of Preston's sentencing hearing;

(b) to request if possible a restraining order at the end of the sentencing hearing;

(c) to assist Charlotte in obtaining protection orders;

(d) to seek legal advice in respect of Charlotte's child contact matters;

(e) to obtain housing/financial advice in relation to Charlotte's mortgage arrears and in respect of alternative housing options so that she could separate from Preston;

(f) to consider other safety measures for Charlotte.

3.7.22 During the appointment, the Worker contacted a solicitor for advice on child contact and occupation orders for Charlotte: that Charlotte did not need to respond immediately to the letter she had received from Preston's solicitors, and that she could insist on contact taking place at a contact centre; and that she would need to wait for the sentencing to be completed before progressing applications for protection orders, divorce proceedings and property matters.

3.7.23 The Worker identified that Charlotte would face an increased risk once Preston's sentencing hearing was concluded, and therefore conducted safety planning with Charlotte. The Hillingdon Sanctuary Scheme[19] was explored but Charlotte was not eligible as Charlotte and Preston jointly owned the home. Charlotte was advised to inform her GP of the abuse she was experiencing.

3.7.24 The Outreach Worker identified Charlotte as "a potential high risk case" due to the imminent ending of bail conditions, and the fact that Preston was using the issue of child contact to harass her. Her case was therefore referred to SBS for allocation to another worker for long-term advice and support. The Worker gave Charlotte her contact details so that she could stay in touch.

3.7.25 On 26 January Charlotte's case was allocated to a named SBS advocate. On that day Charlotte emailed the Outreach Worker with the details of the Police Officer (as previously requested) and also informed them that Preston had gone to the child's school and stated he would be collecting them at the end of the day. Charlotte was frightened of going to the school to collect the children but felt she had no choice. Charlotte also informed the Worker that she had contacted the Police about Preston harassing her by contacting the children's school, but had been told this did not constitute a breach of his bail conditions.

3.7.26 The Advocate allocated to Charlotte was busy that day and so the Outreach Worker contacted Charlotte. The Worker advised Charlotte that she could obtain a Prohibited Steps Order[20] to prevent Preston taking the children; Charlotte stated that she had spoken with a solicitor recommended previously by the SBS Helpline, but had not followed it up. The Worker advised Charlotte to inform the school of the situation.

3.7.27 The allocated Advocate called Charlotte later that day for an update. The Advocate told Charlotte to contact the Police concerning Preston's harassment, and also asked for Charlotte's written consent so that the Advocate could speak to the Police on her behalf. The Advocate made an appointment with Charlotte at SBS for 27 January 2015 to discuss next steps.

3.7.28 The Advocate made a second call on that day to find out whether Charlotte had been able to change her locks; Charlotte had not had time to do this. The Advocate subsequently researched the costs of changing locks.

---

[19] The purpose of a Sanctuary Scheme is to improve the safety of the victim's home and prevent the abuser from gaining entry, for example with: new/improved locks; changing of locks if the abuser has keys; safety lights; reinforced doors; and in some extreme cases the installation of a 'sanctuary room' in which the victim and child(ren) can hide securely if the abuser gains entry.

[20] Prevents either parent from carrying out certain actions or making specific trips with the children without the express permission of the other parent.

3.7.29 Charlotte attended her appointment on 27 January. The Advocate completed the CAADA-DASH Risk Identification Checklist[21] and categorised Charlotte as high risk (this was on the professional judgement of the Advocate, as Charlotte had not scored highly due to the bail conditions in place). The Advocate contacted the Independent Domestic Violence Advocacy (IDVA) Service to obtain further information and to refer Charlotte to the Multi-Agency Risk Assessment Conference (MARAC)[22]. It was noted that Charlotte was "not sure" what actions had been taken by the IDVA.

3.7.30 The Advocate recorded the following in the notes: "Spoke to Hillingdon IDVA and OIC [Officer in the Case] to request a restraining order. Told this was not possible as perp[etrator] had been found not guilty of assaulting Charlotte. Charlotte had been told to be 'proactive' and instead get protective orders."

3.7.31 The Advocate asked the IDVA to find out whether the restraining order had been – or would be – applied for. The IDVA called back later in the day to inform the Advocate that a restraining order could not be obtained, as Preston had been found not guilty of assaulting Charlotte and the sentencing was for the other assaults against police. This was advice the IDVA had received from the Police MARAC Coordinator.

3.7.32 The IDVA informed the Advocate that Charlotte had been discussed at the December MARAC, and agreed to forward the minutes of that meeting to the Advocate. The referral form was subsequently sent (see below for further information about the MARAC process in this case).

3.7.33 In this email the IDVA outlined the previously made safety plan, which included an action to request the police apply for a restraining order. It also stated that Charlotte did not want to go into refuge as it would mean giving up her job and going on benefits; and that Charlotte would be grateful for assistance in applying for housing in the area in which a member of her family lived. In the email, the IDVA "confirmed that there was an additional safety plan but that this appeared incomplete".

3.7.34 The SBS Advocate noted, and informed Charlotte, that the following actions would be taken: to assist Charlotte in applying for an occupation order and non-molestation order; the need for Charlotte to change the locks on her property (which Charlotte stated she did not feel she could spend money on, as she needed her money to save for a deposit to move to another property); the Advocate would contact Preston's solicitor to inform them he should apply for supervised contact via a contact centre and that they should not write to

[21] This is the same as the ACPO-CAADA DASH Risk Identification Checklist used by the Police and explained above.

[22] A multi-agency forum made up of key local organisations – statutory and voluntary sector – for the purpose of information sharing, and safety planning, for high-risk victims. More information available at: http://www.safelives.org.uk/practice-support/resources-marac-meetings

Charlotte directly as this constituted intimidation and harassment; the Advocate would help Charlotte gain urgent housing advice with regard to her mortgage arrears and alternative housing options; and that Charlotte should call the police if she felt threatened.

3.7.35 A further appointment was made for 30 January 2015.

3.7.36 In preparation for this appointment, the Advocate started the applications for the non-molestation order and occupation order and completed a referral for Charlotte to the Shelter housing advice surgery held at SBS. When Charlotte did not attend for the appointment, the Advocate made three telephone calls but there was no answer.

3.7.37 On 2 February SBS learnt of Charlotte's death via media reports.

3.8 Independent Domestic Violence Advocacy (IDVA) Service

3.8.1 Charlotte was referred to the IDVA service on two occasions, each following police incidents.

3.8.2 The first followed the incident on 9 January. Charlotte told the IDVA:

"He calls me names, shouts at me when things don't go his way. … He took my phone and car keys. He became abusive. He says I won't lose anything if I kill you, see what happens on T.V, people kill their families. He said this. This happened Sunday – 2 weeks ago. He said this again on Sunday 08/01/12 we left. I called the police and reported it. I took kids and went to [family]. Since I left he's not been contacting me I have changed my number. He doesn't know [family] number or where they live. He has called childminder to get my new number. She told him she doesn't have it. I want to move back to Hillingdon. I saw solicitor yesterday they suggested injunction to get him out. I feel he is more likely to take revenge if I make him leave the house. I don't want to change [child's] school. I am doing my studies in Reading if I go to Hillingdon I can still go to study. I still want him to see the kids."

3.8.3 The IDVA noted that Charlotte and Preston were married 'culturally' but not legally in the UK; that there were no immigration issues; that Preston had never been physically violent to Charlotte but was verbally abusive and had made threats to kill her; that he had nothing to lose by doing this.

3.8.4 The IDVA advised Charlotte that it would not be safe to move back to Hillingdon as Preston would find her easily (through the child's school), and that the safest thing would be for her to stay with her family.

3.8.5 The IDVA completed a risk assessment and Charlotte was assessed as 'standard', due to Charlotte not residing in Hillingdon at the time. The IDVA service does not work with standard risk cases, and therefore the case was closed.

3.8.6 Charlotte was again referred to the IDVA service following the incident of 23 November 2013. The IDVA completed a risk assessment with Charlotte, and she was assessed as 'high' risk. The IDVA's assessment of Charlotte's experience included Preston's threats to kill, and also his threats to harm the children.

3.8.7 The IDVA noted that there had been "not a lot of physical but a lot of verbal, emotional and threatening behaviour. He is very dominant and controlling (part of patriarchal culture)". The IDVA noted Preston had an 'other' partner, who also had children with him. Charlotte was noted as working part time; that the mortgage was in both their names but heavily in arrears; that the "marriage problems" were known to the school; that Preston was not abusive to the children but that they have witnessed him abusing Charlotte and he "undermines her mothering". The bail conditions were noted, and Charlotte stated she wanted to move to be near her family.

3.8.8 A safety plan was made covering the following:

(a) Current bail conditions in place for immediate safety but need to review long-term safety.

(b) Request for restraining order made to OIC.

(c) Client does not want to access Refuge as this would mean her giving up her job and going onto benefits.

(d) Client advised to move out of the Borough for her safety and therefore will be homeless due to Domestic Violence. Client would be willing to rent privately where she has a local connection and [family] can help with childcare, so she can work full time.

(e) Client would be grateful if the local housing department in [family area] assists with this process.

(f) Numbers given for Hillingdon Law Centre and Citizens Advice Bureau.

(g) Refer client to MARAC.

(h) Client to collect copy of MARAC.

3.8.9 Following this initial assessment and safety plan, the IDVA spoke with Charlotte at the beginning of December 2013 about Charlotte's housing and mortgage arrears. The IDVA referred Charlotte to a solicitor for an occupation order. New actions were recorded: to sort out the Sanctuary Scheme and clear Charlotte's debts.

3.8.10 The IDVA spoke to Charlotte again in January 2014, at which time Charlotte confirmed she had a solicitor and that "child contact was the only issue".

3.8.11 The next contact was when Charlotte called the IDVA on 7 December 2014 (11 months later). She reported feeling very concerned due to the upcoming court case, as she believed Preston may then be allowed to return to the home (the

bail conditions preventing him at that time). Charlotte told the IDVA she was too frightened to live in the property, and she could not afford to pay the solicitor for the occupation order[23].

3.8.12 The IDVA contacted the court to ascertain whether Charlotte could represent herself to apply for the relevant orders. The IDVA then advised Charlotte to do this, and that Charlotte should contact the court to find out when Preston's hearing would be.

3.8.13 Charlotte called the IDVA again on 17 December 2014 to advise that Preston "was guilty on two counts (charges unknown)". Charlotte said that she would tell the IDVA the outcome of sentencing.

3.8.14 The last contact with the IDVA service was from Southall Black Sisters, asking for information on Charlotte's case, and for advice relating to the restraining order. The IDVA informed the SBS Worker that the MARAC Administrator (a Police Officer) had advised that a restraining order could not be applied for, and that Charlotte should seek a non-molestation order.

3.9 Multi-Agency Risk Assessment Conference (MARAC)

3.9.1 Charlotte was referred to the MARAC by the IDVA service and was discussed at the meeting on 12 December 2013.

3.9.2 A 'MARAC Case Summary' was shared with the Review by the IDVA service, which captured the referral and meeting information. This set out the risk assessment and summary of Charlotte's situation that is presented above in the IDVA section.

3.9.3 The Case Summary highlighted the following key risk factors, which it is assumed were shared at the MARAC meeting:

(a) Perpetrator profile suggests cultural based violence and abuse and revengeful personality, no respecter of the law, volatile and unpredictable.

(b) Child protection issues.

(c) Escalation and point of separation.

3.9.4 The IDVA's safety plan (see above) was contained in the Case Summary and it is assumed this was shared at the MARAC meeting.

3.9.5 Children's Social Care confirmed at the meeting that they were carrying out an assessment. No information was recorded on the minutes or the Case Summary as having been shared from other agencies.

[23] Regulates who can live in the family home, and can also restrict the abuser from entering the surrounding area

3.9.6 The MARAC minutes do not list any actions except that the case would be reviewed at the next MARAC in January; the rest of the minutes show that this was standard practice.

3.9.7 Charlotte was therefore discussed again at the MARAC meeting on 14 January 2014. The minutes recorded no new police incidents. The minutes contain details of the bail conditions for Preston. Children's Social Care shared that they had no concerns with regard to the welfare of the children, and no other new information was shared.

3.9.8 The case was closed.

3.10 London Borough of Hillingdon Children's Social Care

3.10.1 Children's Social Care involvement with Charlotte and the two children began as a result of information passed to them from the Police, following the incident on the 9 January 2012.

3.10.2 A Family Support Worker made contact with Charlotte, who informed them that she was staying away from Hillingdon with family.

3.10.3 A Manager reviewed this contact on 12 January 2014, and considered that the threshold had not been met for an Initial Assessment to be undertaken, or any other action. This was on the basis that Charlotte would be receiving support from the Police Community Safety Unit, and that the children were not in the area.

3.10.4 The Merlin report was however sent on to the Children' Social Care service in the area the children were residing, in case the children came to their attention.

3.10.5 A letter was sent to Charlotte advising her of this, and providing her with information about local domestic violence/abuse services.

3.10.6 There was subsequently no contact with the family until a further Police Merlin report, following the incident on 23 November 2013.

3.10.7 Children's Social Care noted the following concerns:

(a) "DV between parents witnessed by children.

(b) Father is said to be revengeful and comes from a background where the man is the boss and the women have to obey. He has said that if mother leaves him he won't lose anything by killing her and the children anyway.

(c) DV has been on-going for approximately 8 years

(d) Mother was assaulted while pregnant

(e) Father has previously stalked mother and kept a detailed description of her whereabouts.

(f) Father has another partner who has also had to call the Police due to an incident with him.

(g) Father has tried to strangle and choke mother."

3.10.8 The case was assessed as meeting Level 4 of the Barnardo's Domestic Violence Matrix[24], so it met the threshold for a statutory social work assessment. The case notes record that the IDVA had risk assessed Charlotte and judged her to be 'medium to high' risk.

3.10.9 A telephone call with Charlotte was made on 7 January 2014, in which she reported that Preston was seeking contact with the children via a solicitor. Charlotte stated she was concerned with Preston having contact, as he may "involve them in their issues and feed inappropriate information", and that it would influence the children's behaviour, for example being defiant towards her.

3.10.10 The initial assessment was completed on 15 January 2014. Information was gathered from the children's school, and a home visit had been undertaken during which the children were spoken with alone. There is no evidence that Preston was spoken with as part of the assessment, or evidence of a decision not to involve him.

3.10.11 The assessment concluded that Charlotte had been seen to be safeguarding the children and trying to ensure their needs were met. Charlotte was going to apply for a legal injunction depending on the outcome of the court case, and the children were recorded as being happy and receiving support at school.

3.10.12 On 25 February 2014 the Social Worker called Charlotte. Charlotte confirmed the bail conditions were still in place, and that she would take action with regard to an injunction depending on the outcome of the court case. She confirmed that the children had seen Preston on one occasion – arranged via solicitors – but that Preston had not requested contact since.

3.10.13 The assessment was typed up and the case closed following the Social Worker's supervision on 26 February 2014.

3.10.14 There is a case note on the system that a school report was received in March 2014.

3.10.15 Preston contacted Children's Social Care (Triage Team) at the end of July 2014 with concerns that his children were being cared for by "an illegal asylum seeker" with no qualifications or Criminal Records Bureau checks[25]. Children's Social Care advised him to contact Ofsted[26] and the Police, and no further action was taken.

---

[24] http://www.barnardos.org.uk/resources/research_and_publications/barnardos-domestic-violence-risk-identification-matrix/publication-view.jsp?pid=PUB-2380

[25] Anyone working children at that time required a Criminal Records Bureau check; this has now been replaced by the Disclosure and Barring Scheme: https://www.gov.uk/disclosure-barring-service-check

[26] Childcare regulator: https://www.gov.uk/government/organisations/ofsted

3.10.16 Preston contacted Children's Social Care again on 28 November 2014 alleging physical abuse from Charlotte to the children. Children's Social Care contacted Charlotte who denied this, and informed the Worker that Preston was "known to be violent, bitter and aggressive" and that the trial was due to start in two weeks concerning the incident of November 2013. Charlotte stated she was happy for Preston to have contact with the children but that he was not initiating that. Charlotte also stated that one of the children was receiving counselling at school "because of domestic violence". The Social Worker saw the child at school and there were no concerns. No further action was taken.

3.10.17 The Police sent a Merlin following the incident (in which Preston approached the children at a shop) on 3 December 2014, informing Children's Social Care of all the information they received during that report from Charlotte. On the basis of the actions taken by the Police, Children's Social Care took no further action. This was their last involvement.

3.11 Central and North West London NHS Trust (CNWL) Health Visiting, School Nursing Services

3.11.1 Two IMRs were received, one from the Health Visiting service and one from School Nursing; as these services are operated by the same organisation, and run concurrent to each other (Health Visiting hand the child's care over to School Nursing when the child starts school), they are combined here.

3.11.2 During the Terms of Reference timeframe, the older child was only within the remit of the School Nursing service, and the younger child within Health Visiting and subsequently school nursing.

3.11.3 A Health Visitor visited the family home on 20 April 2009 for a 'new birth visit' following the birth of Charlotte and Preston's second child. No concerns were noted. A follow up visit was made on 28 April 2009, and again no concerns were raised.

3.11.4 The Health Visiting service sent a letter to the family on 29 September 2009 concerning non-attendance at an appointment for the child's two-year health review.

3.11.5 The Health Visiting service received the Merlin produced by police after the incident of 9 January 2012 (there is no record of it being received by the School Nursing service). The service recorded that Preston had been abusive towards Charlotte, and that Charlotte wanted to leave. It was also noted that Charlotte had taken the two children to stay with family. The record stated that the plan was to transfer the case to the Health Visiting services in that area.

3.11.6 The service called Charlotte on receipt of the information, and discussed her situation with her. Charlotte confirmed where she was living with the children, and that she had sought legal advice with regard to the family home. The record stated that the plan was for the Health Visitor to contact the allocated Social

Worker, and for Charlotte to contact the Health Visitor as and when she needed to. There is no record that the Health Visitor contacted the Health Visiting service in the area Charlotte was residing, and no further action was taken.

3.11.7 On 24 December 2013 it was recorded that Charlotte had been discussed at the MARAC meeting; the following was noted: “children witnessing violence towards police, volatile and unpredictable behaviour, on point of separation. Social Services involved”. The case was allocated to a Health Visitor immediately.

3.11.8 This information was also recorded on the system for the attention of the School Nurse. No action in response to the information was recorded.

3.11.9 The Health Visiting service recorded that they would contact Charlotte after they received notification of her child’s attendance at Accident and Emergency on 27 December 2014; this contact did not take place.

3.11.10 Further information regarding the MARAC referral and meeting was recorded on the system on 8 January 2014; this was recorded as having been seen by the Health Visiting and School Nursing service. Preston was noted as having been abusive since 2005; that he was volatile and unpredictable, and that the abuse had escalated since Charlotte had been trying to separate from Preston; that he had another family elsewhere was also noted. The children were noted as witnessing the behaviour. (No action recorded by School Nursing.)

3.11.11 The Health Visitor contacted the allocated Social Worker, who informed the service that Charlotte was judged to be safeguarding the children, and that steps were in place to prevent Preston from seeing the children. The Social Worker confirmed that the case would not progress to a Child in Need plan. The Health Visitor recorded a plan to contact Charlotte; there is no evidence this contact took place. The Health Visitor contacted the Social Worker again on 1 April 2014 and was informed that the case had been closed.

3.11.12 The Health Visiting service’s involvement with the family ended when the younger child was transferred to the School Nursing service in April 2014.

3.11.13 However, the Health Visitor noted on the system when Preston contacted Children’s Social Care with concerns over the children’s care. This was forwarded to the School Nursing service, which recorded on the system that the information was received one month later on 31 December 2014. No action was recorded as having been taken.

3.12 Schools

3.12.1 The school knew Charlotte and Preston from when their older child started in reception class in September 2010. The older child later moved schools, while the younger child was still in attendance when the homicide occurred.

3.12.2 The school were first alerted to domestic violence/abuse following the incident of 9 January 2012, following which Charlotte took the children to stay with family.

Charlotte attended the school and told the senior teacher in attendance on that day that she and the children had to leave due to domestic violence. Charlotte said that she would get the child back to school as soon as possible.

3.12.3 Following this contact, the Head Teacher spoke with Children's Social Care, and was advised to give Charlotte the contact details of the IDVA service, which the Head Teacher subsequently did.

3.12.4 The next involvement was on 15 July 2013 when the school met with Charlotte and Preston together, at the school's invitation. [NB details relating to the child are not included here as they are not relevant.] No issues with the relationship were mentioned by Charlotte or Preston.

3.12.5 The school contacted Charlotte on 11 December 2013 [details of why are omitted], and Charlotte informed the Head Teacher that Preston had been arrested, and his bail conditions prevented him from living in the family home or having any contact with the children. The Head Teacher made a referral to Children's Social Care [NB: reason was unrelated to the information provided by Charlotte during the phone call]. At this time, Social Care were carrying out an initial assessment following the police incident on 23 November 2013; the school records indicate they were not aware of this until a record made on 11 March that the Social Worker contacted them for an update on the children's welfare.

3.12.6 Preston attended the school and asked to see the Head Teacher on 26 January 2015. He showed them a copy of a letter sent from his solicitors to Charlotte setting out Preston's requested child contact arrangements; it did not confirm that the arrangements were in place.

3.12.7 Preston informed the school he had been found not guilty of domestic violence but was still not allowed in to the family home. Preston alleged abuse from Charlotte to the child, and played a recording of him asking his daughter questions for her to confirm that abuse; the recording was apparently made just before the incident of assault in November 2013. The Head Teacher advised Preston to contact Children's Social Care.

3.12.8 The Head Teacher contacted Charlotte to inform her of the visit. Charlotte confirmed that there was no reason why Preston could not collect the child from school. Preston collected the child from school.

3.12.9 The next day, the school checked that the child had arrived, and they had. Charlotte attended at the end of the day and collected the child.

3.12.10 Charlotte and Preston's older child started at a new school on 6 January 2015.

3.12.11 On 29 January 2014 Preston called the school asking to collect the child, stating he had done this with their other child at their school the previous week. The school contacted Charlotte who gave her permission.

3.12.12 On attending the school later that day, Preston gave the school the same letter from his solicitors as he had with the other school. The child left with Preston, and attended the next day.

3.13 General Practice (GP)

3.13.1 Charlotte's contact with her GP in the timeframe of the Terms of Reference was rare and routine. Reasons for appointments were flu vaccination, eczema, and a sore throat. She also attended due to an ankle injury caused by a road traffic accident.

3.14 Hillingdon Hospital

3.14.1 On 26 December 2013, Charlotte brought the two children to the hospital having accidentally given them the wrong medicine. The children were checked and discharged.

3.15 Information from the Family (Charlotte)

3.15.1 Please see paragraph 2.7 above for details of what attempts were made at involving the family, friends and employer of Charlotte in the review.

3.16 Information relating to Preston

3.16.1 Preston was aged 41 at the time of the homicide. It was noted in the Police report that he was sporadically employed as a mechanic.

3.17 Metropolitan Police Service (MPS)

3.17.1 In addition to the contact with Preston outlined above, brought about through Charlotte's contacting the police, the police noted one further incident of significance. In 2004, Preston was cautioned for a domestic violence/abuse related common assault; it is believed this was against the same 'other' partner referred to by Charlotte. This occurred outside of Hillingdon and the MPS area.

3.17.2 Although this incident was important to note, as it fell outside of the Review's Terms of Reference and would have risked the confidentiality of the victim, no further analysis was done.

3.18 National Probation Service (NPS)

3.18.1 The NPS involvement with Preston began following his conviction on 16 December 2014 for assaulting the two police officers during the domestic incident on 23 November 2013. Sentencing was adjourned for the preparation of Pre Sentence Reports by NPS.

3.18.2 The Crown Prosecution papers, which includes a summary of the case and previous convictions were requested and received as per procedure.

3.18.3 Procedure also requires that a child safeguarding and borough police intelligence check be completed to assist in the analysis of the offending and

establish whether other local agencies were involved. There is no record of these checks being completed.

3.18.4 The report was allocated to a sessional report writer, employed by an agency (Blue Bay) contracted by NPS. A letter was sent to Preston on 29 December 2014 with an appointment for 8 January 2015 with the report writer. Preston attended this appointment and the interview was conducted.

3.18.5 The report was completed on 14 January 2015; it recommended Preston for a Community Penalty with a requirement to complete Unpaid Work.

3.18.6 The report was sent to Isleworth Crown Court on 14 January 2015 in time for the hearing on 30 January 2015. It was not presented, as Preston did not attend.

3.19 General Practice (GP)

3.19.1 Preston attended his GP 24 times in the Terms of Reference timeframe (three years); the last time was four days before the homicide. Preston attended primarily for physical complaints; the majority of attendances (17) came following the police incident of 23 November 2013.

3.19.2 On 26 November 2013 Preston attended and reported Police had assaulted him – while he was trying to get away, he stated – after a domestic incident.

3.19.3 From this point onwards Preston's attendances were for physical symptoms and pain related to this incident, including headaches and blurred vision. Many tests were done, but none suggested that his injuries would cause the symptoms he was having. Preston twice organised private medical procedures in relation to these complaints.

3.19.4 Preston had been prescribed an anti-depressant on 8 May 2013; this was to help with anxiety as well as to help with chronic lower back pain. The dosage was increased on 27 February 2014 in response to Preston's complaints of tension headaches and chronic facial pains linked to the assault.

3.19.5 From November 2014 Preston started to report more psychological issues: anxiety, post-traumatic stress disorder and depression were noted. On 26 November 2014 Preston was referred for IAPT counselling; see the CNWL section above for further information.

3.19.6 The last attendance was on 26 January 2015 in which depression was noted.

3.20 Central and North West London NHS Trust (CNWL) Mental Health Service

3.20.1 Preston was referred to CNWL Improving Access to Psychological Therapies (IAPT)[27] by his GP on 18 December 2014. The GP stated that the referral was following Preston presenting with Post Traumatic Stress Disorder, following an alleged police assault during the domestic incident on 23 November 2013. The referral stated "he maintains his relationship with his wife is ok". The symptoms noted by the GP were anxiety, flashbacks, low mood, irritability and chronic lower back pain.

3.20.2 A 45-minute IAPT telephone assessment took place on 19 January 2015 by a Psychological Wellbeing Trainee. The assessment confirmed Preston's symptoms as severe anxiety, low mood and physical health difficulties; that he was separating from his wife and finding it difficult not seeing his children. Preston was noted as appearing very distressed and saddened by his own physical health difficulties, which he reported as resulting from the alleged police assault.

3.20.3 On being asked, as part of a risk assessment, whether "you find yourself as being a risk to others" he answered "no", and the assessment was that he did not pose a risk to others or a risk of suicide.

3.20.4 Following supervision of both the Trainee and the assessment by a senior therapist, Preston was offered a Stress Management Course. Preston had requested Cognitive Behavioural Therapy to manage anxiety and low mood and current issues, stating he did not want to deal with past issues. Preston agreed to the Stress Management Course, and his treatment was due to commence on 3 February 2015.

3.21 Hillingdon Hospital

3.21.1 Preston was brought to the Hospital by the London Ambulance Service on 23 November 2013. He was in the custody of the Police having been arrested that morning for assault on Charlotte. The Hospital were not informed of the nature or victim of the assault. Preston was treated and discharged back to Police custody.

3.21.2 Preston attended an appointment at the Hospital on 9 September 2014 for a CAT scan to be carried out, a referral made following his physical issues following the alleged police assault in November 2013. On the patient front sheet Preston is recorded as being single and not employed, and no next of kin is noted. He gave his address as the one he previously shared with Charlotte.

3.21.3 A letter was subsequently sent to Preston's GP concerning the scan, stating that no concerns or abnormalities were identified. The record stated "allegations of Domestic Violence by wife and therefore involvement of Police??" Nothing further was recorded regarding this statement.

[27] Improving Access to Psychological Therapies, IAPT, is a national programme (locally delivered and managed) supporting the NHS to get patients into counselling or other mental health support.

3.21.4 An MRI scan was recommended and this was carried out on 3 November 2014, the results of which were again normal. Another CAT scan appointment was made for 4 November 2014; Preston did not attend, with no reason given. A further MRI scan was conducted on 27 November 2011. The report to Preston's GP from the Practitioner recorded that there was no cause detected for Preston's reported giddiness or blurred vision.

3.22 Information from Preston

3.22.1 No information was received. Please see paragraph 2.7 above for details of what attempts were made at involving Preston in the review.

4. Analysis

4.1 Domestic Abuse/Violence Definition

4.1.1 The government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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

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

4.1.2 The disclosures made by Charlotte to the many agencies she spoke to made it clear that she was a victim of domestic violence/abuse from Preston. This was primarily verbal abuse, harassment and stalking, with few, albeit significant, occasions of physical abuse.

4.1.3 Charlotte was very aware of the risk she faced, and attempted to make her fears and anxiety over what Preston would do clear to a number of agencies including the Police, IDVA service and Southall Black Sisters.

4.2 Metropolitan Police Service (MPS)

4.2.1 In the Terms of Reference timeframe, Charlotte contacted the Police on seven occasions.

4.2.2 The first of these incidents, on 9 January 2012, was recorded as an offence and Preston should have been arrested. The records are not clear as to why he was not arrested, and Charlotte subsequently made a withdrawal statement. Assuming the records are an accurate record of the attempts to arrest Preston, there was a lack of follow up that, had it been done, could have demonstrated to Preston that his actions were wrong and would lead to a positive police response.

4.2.3 The Panel noted and agreed that the wording of Charlotte's withdrawal statement (that she had "over-reacted" and taken the threats "out of context") should have aroused concern, as it was so far from her original statement (that

Preston had threatened to kill her and stated he had “nothing to lose” by killing her and the children).

4.2.4 The IMR does not detail any concerns by the Police, or action, in relation to the fact that the children were included in the threat to kill, although a Merlin was created.

4.2.5 For this offence also, there was an over-emphasis on the fact that Charlotte was residing with family away from Hillingdon. The assumption seemed to be that this meant that she was safe: despite her disclosure of high risk factors including Preston’s threats to kill and the separation. Charlotte was risk assessed as ‘standard’ based on her location only, despite the fact that police were aware she was likely to return to Hillingdon. Following discussion on this matter, the Panel noted that there does not appear to be a system in place for police to re-visit a case or victim where the risk is known to have changed.

4.2.6 The OIC showed good practice in repeated attempts to speak to Charlotte about the offence. However, when on 29 January 2012 the OIC spoke with Preston, who informed them that Charlotte had returned home, this did not trigger additional action – or an arrest given that the officer now knew where Preston was – in relation to Charlotte’s risk. When the officer subsequently spoke with Charlotte, it is not clear whether this was in Preston’s presence, which would have been an unsafe action for the officer to take.

4.2.7 The Panel discussed the fact that the Police could have proceeded against Preston using both Charlotte’s original statement, and her withdrawal statement, if they felt that this had been made following duress or pressure from Preston – such withdrawals being common following domestic violence/abuse incidents.

4.2.8 The next two contacts by Charlotte to the police led to no action being taken, as no offences were recorded. With regard to the report on 3 December 2012, there was no record of a risk assessment being carried out with Charlotte, and no Merlin was created relating to the incident. As this was a domestic incident in which separation was mentioned along with a threat from Preston to Charlotte that “the war is just beginning” and the history check showing the previous incident (of threats to kill) in January of that year, this was not good practice.

4.2.9 The incident of 24 March 2013 did involve a risk assessment; despite Charlotte disclosing separation and the police witnessing Preston being aggressive to her, Charlotte was assessed as standard risk. Given the significance of separation as a risk factor for domestic homicide, and the fact that Preston felt sufficiently entitled in his abusive behaviour towards Charlotte that he felt comfortable doing this in front of the police, this risk assessment is surprising.

4.2.10 The Panel discussed what could have happened had Charlotte been referred to a support agency at this point, and their risk assessment had been higher. Police risk assessment is a key factor in decisions made by Police / CPS – if another agency does a risk assessment, this can be fed back to the Police, especially if

there is a different outcome – could be due to further disclosures / incidents that the Police are not aware of.

4.2.11 As with the previous incident, no Merlin was created. This means that Children's Social Care were unaware of both incidents, and so when they received the Merlin for the later incident in November 2013, as far as they were concerned that was the first incident since January 2012, rather than the fourth.

4.2.12 The Police noted "cultural issues" in relation to Preston's way of speaking to Charlotte in their presence; however the IMR notes that this was not expanded or acted upon. The fact that the officers noted it shows that it must have had some significance in the incident; therefore it is disappointing that it was not followed up on, or led to the officers looking again at their risk assessment.

4.2.13 The initial response to Charlotte's next contact, on 23 November 2013, showed good practice and positive action by the police. Preston was immediately arrested, a risk assessment and Merlin completed, and Charlotte was referred to the IDVA service. It was unfortunate that history checks were not completed to inform the officers of the prior incidents, however this would not have impacted on the actions taken. Further good practice was seen in that the Officer in the Case (OIC) attended court on the day Preston applied for, and was granted, bail, and informed Charlotte of the outcome and bail conditions.

4.2.14 As with the incident on 9 January 2012, the risk assessment here was that Charlotte was standard risk, based on location: on this occasion as Preston was in custody. Also similar to the previous incident, there was no process to revisit this risk assessment once Preston was granted bail, however as the bail was conditional on Preston not contacting Charlotte directly or indirectly, or being within 100 yards of her home, it can be assumed that the risk level was likely to remain the same.

4.2.15 These two risk assessments suggest an over emphasis on location by the police, leading to a potential lack of support for Charlotte when her situation changed. Risk is dynamic, not static, whereas these risk assessments were one-off and not reviewed. This is a difficult process for the police to act upon, as their involvement with a victim can be brief, and ends when a case is closed or completed. However the police do have very good links with services such as IDVA where concerns can be handed over via referral for the victim, and in the incident of 23 November 2013 this referral did take place.

4.2.16 The Police IMR outlines that the internal review demonstrated a lack of awareness of the Service Level Agreement (SLA) between the MPS and Crown Prosecution Service (CPS). If this were followed, then the CPS lawyer would pass the result of any bail hearing to the Police Liaison Officer, unless the investigating officer is present. There is then a process whereby the Police Liaison Officer passes this information to the relevant Community Safety Unit and borough Intelligence Unit. A recommendation is therefore made in the IMR

to address this lack of awareness, and the IMR author informed the Panel that this is already in being implemented.

4.2.17 Following the charge against Preston for the assault of 23 November 2013, Charlotte's case was handed over to the Witness Care Unit (WCU); their involvement is analysed in the section below. It would have been the responsibility of the WCU to keep in touch with Charlotte about the progress of the trial, however some contact would have been expected from the OIC, and there is no record of this taking place.

4.2.18 In addition, there were issues around contact between the Police and the Crown Prosecution Service in relation to this case; these are addressed in the CPS section below.

4.2.19 The next two contacts Charlotte had with the police involved her belief that Preston was breaching his bail conditions, reporting that he was harassing her and contacting her 'indirectly', as well as her fears and anxieties relating to his behaviour and the trial.

4.2.20 On the first occasion (3 December 2014) the case was closed as the officer judged there to be no breach of bail conditions. Preston's behaviour was as follows: speaking to the children in Charlotte's presence in a public place; contacting Charlotte's work and Children's Social Care and making allegations about her – it is therefore unfortunate that more action was not taken to support Charlotte, for example through another referral to the IDVA service, or at least a check with her that she was accessing support through another route. Charlotte stated that she was worried about the trial and what Preston would do once it was over; the police officer attending did not act on these concerns, or carry out a risk assessment.

4.2.21 In discussing this incident, the view of the Panel was that Preston should have been arrested and brought before the court for breaching bail conditions. The contact he was making could be seen as 'indirect' contact, and potentially done with the intention of harassing or intimidating Charlotte.

4.2.22 On 27 December 2014 Charlotte called the Police to find out the outcome of the trial; there is no record of Charlotte being contacted back, and in light of the lack of contact throughout 2014 from the WCU and IDVA service (see below), this is disappointing. The IMR outlines that Charlotte, as a victim of domestic violence/abuse, should have received an enhanced service and been contacted to be informed of the trial outcome.

4.2.23 Charlotte's last contact with police, on 26 January 2015, was only with the Despatch team, and was not recorded as a domestic incident. The IMR outlines how correct procedure was not followed on this occasion. A recommendation is made to ensure that training takes place for this team to ensure that domestic incidents are recognised and acted upon appropriately and in line with procedures.

4.2.24 Recommendations are also made in the IMR to improve the completion of Merlin reports.

4.3 Witness Care Unit (WCU)

4.3.1 Charlotte's case was referred internally within the Police to the WCU once a charge was confirmed against Preston after the incident of 23 November 2013. After it became clear that the Officer initially allocated knew Charlotte, her case was not re-allocated until February 2014, three months later. It is not clear why this delay occurred.

4.3.2 Up to December 2014, the Officer allocated to Charlotte's case made all contact with Charlotte, and other witnesses in the case, via text message. The Officer did not have a conversation with Charlotte until just before the trial was due to start in December 2014. Given the extremely lengthy delay in the trial taking place (over a year after the incident) this means that Charlotte was without support, or updates about the trial, for all that time.

4.3.3 The IMR outlines that the management of Charlotte's case failed to adhere to procedure, there was no assessment of her needs (for example special measures in court while giving evidence) and she was not referred to the Witness Service for support at court.

4.3.4 The IMR author states that the review has identified a need for induction and training for all Witness Care Officers to ensure understanding of and compliance with policies and procedures. Serious failings were identified through the review, but these were due to a lack of awareness and understanding of the existing policies and procedures. The recommendations made in the IMR have been progressed urgently.

4.4 Crown Prosecution Service (CPS)

4.4.1 The response of the CPS to the request for charging advice from Police in November 2013 was to a high standard. The domestic violence nature of the incident was recognised, and the Prosecutor acted according to internal procedure in flagging the case as domestic violence and working through the Domestic Violence Checklist to ensure enhanced evidence gathering. They were proactive in the action plan given to the Officer in the Case (OIC) which addressed both evidence gathering and support for Charlotte as a victim.

4.4.2 Subsequent to this, it is unfortunate that the communication between the CPS and the OIC was not consistent, and many emails went unanswered. This is particularly of note in the exchanges concerning contact with Charlotte and her friend as witnesses, as this reflects the issues highlighted elsewhere in this report in the lack of communication by the OIC and Witness Care Unit with Charlotte.

4.4.3 The IMR author addresses the fact that the case moved to the Crown Court. There would have been recognition that this would lead to an extended waiting

time for trial, trial dates usually being fixed from four to six months ahead. In Magistrates Courts, the trial wait time is usually six to eight weeks. However, the view of the IMR author – endorsed by the Panel – is that it was appropriate and correct to keep the three charges together, once the Court agreed for the assault occasioning actual bodily harm charge to be heard in the Crown Court. This prevented the whole nature of the case (i.e. the domestic incident) being lost; and prevented the witnesses from having to give evidence twice.

4.4.4 The trial took place a significant length of time after the incident: thirteen months. This was due to the need for the trial to be 're-listed' once, in June 2014, it became apparent it could not go ahead in the time required before the Police Officer witness went away.

4.4.5 In March 2014 the CPS did request a fixed date from the Court for 23 June; this was not followed up on, however the IMR author notes that fixed dates for trials are very unusual and rarely granted. However, given the domestic violence related nature of the case, and the recognised impact of delay on victims in these cases, it would have been helpful for the CPS to pursue this option.

4.4.6 The IMR author similarly points out that the CPS could have requested a re-listing at an earlier date: in March/April 2014, when the Police Office witness first advised that they would be away in June. If the trial had been re-listed then, for six months time (as standard), this would have meant the trial could have taken place in October.

4.4.7 The Panel discussed the contact between the CPS and the Police in relation to this case, and other cases like this. The CPS confirmed that they are aiming to make more contact via telephone rather than always relying on email (as here) to ensure that cases progress properly.

4.4.8 Regular meetings between Police, CPS, Court and Probation services were discussed, and the Chair received information on these. It is very positive that there is ongoing partnership working between these agencies to discuss performance and trends, and in particular how to better support victims of domestic violence/abuse.

4.4.9 However, the information from Police and CPS was at times contradictory, suggesting that knowledge of the meetings may not be widespread across both agencies and that further development of this partnership working may be required. A recommendation (2) is made for a briefing to be prepared on the current processes, and in addition to ensure that any developments required to improve these processes are identified and actioned.

4.5 Restraining Order

4.5.1 Courts can make a restraining order for the purpose of protecting a person (the victim or victims of the offence or any other person mentioned in the order) from conduct which amounts to harassment or which will cause a fear of violence.

Requirements can be for a fixed period or 'until further order' and often involve no direct or indirect contact by the perpetrator with the victim or children (sometimes save through solicitors regarding child contact), and exclusion from, for example, the victim's home/street/area. A restraining order for Charlotte therefore would have effectively carried on the same conditions as bail.

4.5.2 Section 5 of the Protection from Harassment Act 1997 (PHA 1997) permitted a criminal court to make a restraining order when sentencing or otherwise dealing with a defendant convicted of an offence of harassment (contrary to section 2 PHA 1997) or an offence of putting someone in fear of violence (contrary to section 4 PHA 1997).

4.5.3 Section 12 of the Domestic Violence, Crime and Victims Act 2004 came into force on 30 September 2009, amending section 5 of the PHA 1997. The amendment enables the court to impose a restraining order in a much wider range of circumstances, for example following conviction for any offence (not just a domestic violence/abuse related one), or following acquittal.[28]

4.5.4 The process usually followed is for the IDVA service, Witness Care Unit, or Officer in the Case (OIC) to find out from the victim whether they would like a restraining order to be applied for at the conclusion of the trial. The details of the request (e.g. addresses for the defendant to be excluded from) would then be drafted, and passed to the Crown Prosecution Service, who would make the request at court.

4.5.5 For Charlotte, a restraining order could have been applied for at the point of acquittal or at sentencing. The latter was chosen as the bail conditions were continued up to then. Crown Prosecution Service have confirmed that it was in the Prosecution Counsel's brief to apply for a restraining order. We cannot say whether it would have been granted, and of course the events of that day superseded this issue.

4.5.6 The learning from this case is rather in the fact that no professional appeared to have lead responsibility in communicating with Charlotte about the restraining order. It is assumed that the Officer in the Case drafted the restraining order, as the details were provided to the CPS. Panel discussions indicate that further work needs to be done to ensure this process works smoothly and all professionals are aware of their responsibilities. A recommendation (3) is made below to address this.

4.6 Southall Black Sisters

4.6.1 The IMR from Southall Black Sisters (SBS) is very detailed and outlines the lengths staff went to in trying to support Charlotte. It should be noted that for the first two contacts Charlotte made to the service, SBS were not in a position to

[28] Paragraphs 3.6.1, 2, 3: from www.cps.gov.uk/legal/p_to_r/restraining_orders/ (Crown Prosecution Service)

fully support her, and it was not until her third contact that the service were able to offer her ongoing support.

4.6.2 Despite this, SBS offered Charlotte as much support as they were able to during the first two contacts, via advice, emotional support and signposting to Hillingdon Women's Centre as a service that would be able to support her. Charlotte was honest with the SBS Worker during her second contact (April 2013) that she had not acted on the previous advice given (June 2012): the service did not judge her, and offered sympathy and understanding for the difficult and frightening situation Charlotte was in.

4.6.3 In hindsight, it would have been good practice for SBS to actively refer Charlotte to the local service, rather than only giving the contact details. However in the circumstances of a backlog of cases, and the need to prioritise those in funded areas, SBS's actions can be understood.

4.6.4 Charlotte's third contact to SBS fortunately came at a time when SBS had started to receive funding to work in Hillingdon (from London Councils), and this marks the start of an intense period of contact between the service and Charlotte. The service concluded that Charlotte was vulnerable, fearful and with a need to unravel many issues and problems in order to improve her safety.

4.6.5 Like the Police (see above) and the IDVA service (below), SBS were initially swayed in their assessment of risk by the bail conditions Preston was under, and had so far adhered to. This led to an assessment that Charlotte was not at high risk and therefore the allocation of her case was deferred for a month, which, given how close this was to the sentencing hearing and the ending of bail conditions, was not ideal. This is recognised in the SBS IMR, and a recommendation is made – and is being implemented – that amends allocation procedures and underlines the need to look at the totality of risk factors and not just the location of the victim / perpetrator.

4.6.6 Although her case was not allocated, support did continue to be offered to Charlotte via the telephone as well as offering to take her to see a solicitor. As this contact continued it became clear that Charlotte was confused about the trial (for the incident of 23 November 2013), why Preston was found not guilty of assaulting her, whether a restraining order had – or would be – applied for, and what the outcome of the whole trial was. The Worker showed good practice and partnership working in contacting the Police and IDVA service in attempts to understand the situation further. Unfortunately the Worker relied on the advice of the IDVA service (gained from the police MARAC Coordinator) with regard to the restraining order, and it would have been better if the Worker had continued with her original plan of speaking with the Officer in Case, who would have had the correct information. A recommendation (4) is made below aiming to ensure that this does not occur again.

4.6.7 The IMR from SBS is very challenging to the IDVA service, and this was discussed at length in the Panel meeting. The Panel agreed that Charlotte was perceived by the two services very differently, and that this – along with presumptions of Charlotte's capability on the part of the IDVA – had led to the very differing views of the SBS Worker and the IDVA in relation to Charlotte's ability to act for herself.

4.6.8 The SBS Workers saw a vulnerable woman in need of a great deal of help to unravel her multiple problems in order to improve her safety, and they acted in response to that by keeping in regular contact and taking action on her behalf where she felt unable to do something.

4.6.9 It should also be noted that the IMR highlights that they were not informed of Charlotte's death, and instead found out via media reports. Given some of the Workers' close involvement with Charlotte, this should not have happened and therefore a recommendation (5) is made for improved processes to be put in place to alert relevant services to domestic homicides.

4.6.10 The SBS IMR highlights the significance of Charlotte's national and cultural background, noting that she persistently returned to their service despite previously being unable to access support. The Panel discussed and tentatively agreed that this may have been because she wanted a service that was explicitly for black and minority ethnic women. This is discussed below.

4.7 Independent Domestic Violence Advocacy (IDVA) Service

4.7.1 As has been noted above the IDVA service's perception of Charlotte was very different to that of Southall Black Sisters. There was an assumption by the IDVA that Charlotte was competent, not additionally vulnerable and capable of acting on the issues she needed to resolve, and this led to a lack of support following an initial positive contact following the incidents of January 2012 and November 2013. The IDVA service should not have been influenced by their perception of Charlotte's capability in this way, and offered her the same level of support as any victim presenting to their service.

4.7.2 On reviewing the case, the IMR author notes that the IDVA now feels that the service should have gone back to Charlotte to check whether she had remained out of area following the incident in January 2012. Instead, the case was closed due to the assessment of risk being standard (a risk assessment based on Charlotte's location), which the service does not deal with. Had they checked back with Charlotte, they would have found out that she had returned not just to Hillingdon but also to the relationship with Preston, and support could have been offered around this.

4.7.3 Good practice can be seen in the IDVA's initial response to the second referral for Charlotte, following the incident in November 2013. A risk assessment was completed, and a safety plan put in place. A referral to the MARAC was made and there is recognition of the range of risk factors Charlotte faced. Referrals

and signposting was made for Charlotte to access the help of a solicitor and the Sanctuary Scheme.

4.7.4 The IDVA service has clarified that at this point the IDVA would not necessarily have been referring Charlotte onto other services, unless it was clear that she was in need of something specific at that stage. Referrals to other domestic violence/abuse support services are part of discussions with clients once risk has been reduced through IDVA support. These referrals may be to Hestia, Hillingdon Women's Centre, counselling services and also specific support services depending on the clients needs, for example EACH, IKWRO, Karma Nirvana, Homestart, or the Forced Marriage Unit.

4.7.5 The records suggest that there was no further action taken; the safety plan was not reviewed and the IDVA did not attempt contact with Charlotte after January 2014. The next contact came from Charlotte, when she contacted the IDVA service to ask about the court case, and disclose her fears for the outcome and what Preston would do after the trial was over.

4.7.6 It is notable that Charlotte took the step to contact the IDVA service at that point, having heard nothing from them for almost a year, and was perhaps a sign of Charlotte's desperation in the face of the upcoming trial and ending of the bail conditions that up to then Preston had adhered to.

4.7.7 It appears from the IMR that the IDVA's actions were focused on what Charlotte could do for herself, rather than on what the IDVA could do for her. There is no offer of support at the trial, and no suggestion that the IDVA would either take on, or support Charlotte in taking on, any of the actions that were needed in her situation. The IDVA suggested that Charlotte should represent herself in relation to obtaining protection orders. The fact that there had been so long between contacts, and yet Charlotte had felt unable to take the actions that had previously been agreed, should have alerted the IDVA to Charlotte being more in need of support than had been assumed.

4.7.8 In light of the lack of contact from the Police and Witness Care Unit in relation to the Court Case, this absence of contact or support from the IDVA service is particularly noticeable, and Charlotte was therefore entirely without support throughout the year from the offence to the trial, and also without support at the trial itself, at which she gave evidence – something that many domestic violence/abuse victims, understandably, feel too fearful to undertake.

4.7.9 As highlighted in the Southall Black Sisters section above, it is unfortunate that the IDVA sought advice from the Police MARAC Administrator in relation to the restraining order, rather than going to the Officer in Case. Had the latter been done, accurate and specific information and guidance could have been provided. A recommendation (4) has been made below.

4.7.10 The IMR author, and the IDVA service, have approached the review of this case openly and critically, and the learning outlined above has been highlighted by the

IMR author, in particular the recognition that, had Charlotte been perceived as more vulnerable and less capable, she would have received a more proactive service.

4.7.11 The IMR recommends that the IDVA service reviews, and takes action to improve, the support provided to victims going through court processes, and how the IDVA service links with the Multi-Agency Safeguarding Hub (MASH). In addition the following recommendations were made:

(a) Revised guidance on information sharing and communication between IDVA and Children's Social Care to include multi-agency meetings at point of crisis for victims

(b) Court Hearing tracker to support victims

(c) Agreed lines of communication between the courts and IDVA regarding outcomes of hearings

(d) Revised guidance on trigger points for reassessment of risk to victims to include court appearances

4.7.12 "Cultural issues" were noted by the IDVA in response to Charlotte's outlining of her relationship with Preston and his attitudes and behaviour. However, there was no action taken in direct response to this. This was also noted in relation to the Police, Children's Social Care and Probation IMRs.

4.7.13 A discussion on what could have been done differently was held at the Panel meeting, and it was agreed that a recommendation (6) was required to develop greater awareness of how race and gender can intersect and impact on a woman's experience of domestic violence/abuse (utilising the expertise and experience of a relevant specialist service), and that this should be incorporated into standard domestic violence/abuse awareness training. In addition it was agreed that where a professional was aware of these issues, advice or guidance should be sought – where appropriate – from an expert or specialist service, to ensure that individuals are fully supported.

4.8 Multi-Agency Risk Assessment Conference (MARAC)

4.8.1 The concerns of the Panel relating to the MARAC led to immediate action by the Children's Social Care and Hillingdon Police Panel representatives, and this section outlines both the concerns and the actions taken.

4.8.2 The concerns were as follows:

(a) Limited information sharing from other agencies (other than IDVA, police and Children's Social Care); lack of recording of discussion (or lack of discussion)

(b) No actions recorded

(c) Cases being reviewed at subsequent meetings, which is not the official MARAC guidance from SafeLives[29]; and yet in the review no further discussion or full update / further actions were recorded

(d) A possible assumption that the IDVA had responsibility for the case and therefore other agencies need not take any action

(e) Potential lack of governance of the MARAC process, Terms of Reference, or clear process

(f) No recording of the need for all MARAC agencies to 'flag' their databases to indicate Charlotte as a high-risk MARAC case

(g) Absence of action relating to Preston's 'other partner', for example an action to alert the MARAC in that area

4.8.3 Following staff moving within the borough Police, a new MARAC Chair is now in place, and this opportunity has been used to revise and tighten the processes. MARACs from neighbouring boroughs have been reviewed and good practice adopted from those.

4.8.4 The IDVA Service is working with Police to amend the Terms of Reference, Referral Form and to review the membership. The administration of the MARAC and how the minutes and actions are recorded have also been reviewed and improvements made. The Panel welcomed these changes. A recommendation (7) is added to this report to ensure that the membership review includes the development of a system for including education in the MARAC.

4.8.5 The Governance of the MARAC continues to need action, as recognised by the Panel, and by the Police as the administrators of the MARAC. Currently the MARAC Steering Group is chaired by the MARAC Chair, and the Panel agreed that this was not appropriate. Better links and reporting to the Local Safeguarding Children Board and the Safeguarding Adults Board need to be established. A recommendation (8) is therefore made in this report to address the governance.

4.9 London Borough of Hillingdon Children's Social Care

4.9.1 Children's Social Care's first involvement with the family was following the incident in January 2012, and a Merlin being received from the Police. This demonstrates the necessity of Merlins being created, as without this there would have been no opportunity for Children's Social Care to assess the family and offer any support.

4.9.2 Again, however, the assessment was based on the location of Charlotte and the children, and despite recognition that they were likely to move back to Hillingdon

[29] http://www.safelives.org.uk

(including through provision of a leaflet for local domestic violence/abuse services) the case was not revisited once this move occurred. There does not appear to be recognition of the fact that Preston's threat was against the children, as well as against Charlotte.

4.9.3 The IMR highlights (and this is also highlighted in the IDVA IMR) the lack of contact between Children's Social Care and the IDVA service. Of particular note is that both services were in contact with Charlotte following this incident but there did not appear to be any communication between the two services.

4.9.4 The next contact for Children's Social Care was following the incident in November 2013. As noted in the police section above, for Children's Social Care this was the second incident they were aware of, rather than the fourth that had in fact taken place, due to the absence of Merlins being created following the other two.

4.9.5 Using the Barnardo's Domestic Violence Matrix Children's Social Care were able to identify the seriousness of the situation and the risk in relation to the domestic violence/abuse, for Charlotte and for the children. However, some of the language recorded suggests a less than full understanding of the nature of domestic violence/abuse, and how it can impact on victims and children.

4.9.6 For example, it refers to "DV between parents witnessed by children". Domestic violence cannot happen 'between' two people; it is a matter of power and control being exerted by one person – the perpetrator – over another – the victim. To use such language implies a joint responsibility of both parents for the violence/abuse the children are witnessing, which is not appropriate.

4.9.7 Stalking, assault during pregnancy, previous domestic violence/abuse against another partner by Preston, attempted strangulation and the fact that Preston "comes from a background in which the man is the boss and women have to obey" were all noted. Despite this, the assessment concluded that as Charlotte was "safeguarding the children", was a protective factor and would be seeking a legal injunction following the end of the criminal trial – perceiving Charlotte as being proactive and able to be responsible for her own safety – and the case was therefore closed.

4.9.8 The assessment was carried out appropriately in that Charlotte was spoken with, information was gathered from the children's school, and the children were seen and spoken with alone.

4.9.9 There is a discrepancy of records here between Children's Social Care and the School: Social Care have a record that the school were spoken with on 16 January; the School records hold no information about the initial assessment until 11 March. The Review was unable to explain this discrepancy.

4.9.10 Preston was not spoken with and there is no record to show that a decision was made not to contact him. The IMR author can see no reason why he wouldn't

have been spoken with as part of the assessment. The author further states that more care should have been taken in relation to possible contact between Preston and the children, in light of his violence against Charlotte and the police.

4.9.11 The focus on Charlotte, the assessment that she is "safeguarding" the children and the subsequent lack of action, all suggest that Children's Social Care did not sufficiently recognise that Preston was the perpetrator and instigator of all the abuse. Charlotte could no more "safeguard" the children than she could herself, if he chose to perpetrate abuse: she could not stop him. She could certainly be a protective factor for the children, as the non-abusive parent, and she was working to ensure their needs were met. But, she could not prevent the abuse and it was inappropriate to suggest that she could and close the case because of this.

4.9.12 Whether the children met the threshold for continued support from Children's Social Care due to their own needs or not, additional support should have been offered (e.g. through referral, or liaison with the IDVA service) to ensure that Charlotte was fully supported, in recognition that supporting the non-abusive parent (and holding the perpetrator to account where possible) is the best way to support the children.

4.9.13 The IMR highlights further concerns with the two contacts Preston made to the service on two occasions (November and December 2014). More exploration should have taken place over his allegation in relation to the children's carer (e.g. referral to the LADO[30]). There should have been recognition of the history of domestic violence/abuse when Preston made accusations against Charlotte and was known to be contacting her work; this should have been seen as escalation of abuse (albeit not directly at Charlotte due to the bail conditions) and appropriate action / referral taken place.

4.9.14 In recognition of the learning in the IMR, the following recommendations have been made:

(a) Revised guidance on information sharing and communication between IDVA and Children's Social Care to include multi-agency meetings at point of crisis for victims.

(b) A dedicated IDVA for the MASH team in Children's Social Care.

(c) A 'DV flag' on ICS so if any closed cases receive further contacts of any nature a case is taken through the MASH regardless of level of concern at point of contact to include liaison with education and health.

[30] Local Authority Designated Officer: Works within Children's Social Care Services and should be alerted to all cases in which it is alleged that a person who works with children has: behaved in a way that has harmed, or may have harmed, a child; possibly committed a criminal offence against children, or related to a child; behaved towards a child or children in a way that indicates s/he is unsuitable to work with children. The LADO role applies to paid, unpaid, volunteer, casual, agency and self-employed workers.

4.9.15 This Overview Report makes a recommendation (9) for Children's Social Care to implement the following: improved contact with fathers in domestic violence/abuse cases; review of (and change to) the emphasis on non-abusive parents (mothers) responsibility to protect themselves and children from an abuser.

4.10 Central and North West London NHS Trust (CNWL) Health Visiting and School Nursing Services

4.10.1 Health Visiting services' contact with the family was routine in relation to the new birth and one year checks on the younger child. There was non-attendance for the two-year check that resulted in a letter to the family. It is standard practice for further follow up not to be done in these cases, unless particular concerns have previously been noted.

4.10.2 Their involvement increased on receipt of Merlins from the Police, and information received via the MARAC. Each time, the service responded in a proactive way to contact Charlotte, however there was a lack of follow up when contact was not achieved, or there was a plan to make contact with Charlotte at a later point.

4.10.3 School nursing also received the information that health visiting had from Merlins and the MARAC; there is no record of any action, and the absence of this can be seen in the school not being informed of the subsequent domestic violence/abuse incidents after January 2012, that school nursing could have told them about.

4.10.4 The IMR for health visiting outlines that routine enquiry is now in place for domestic violence/abuse; this was not in place at the time Charlotte was in contact with the service, and the introduction of this new procedure is welcome.

4.10.5 The Health Visiting IMR provides recommendations to address any issues:

(a) That the agreed health visiting routine domestic violence pathway will be adhered to at all times

(b) That the agreed disclosure of domestic violence and abuse screening to be adhered to at all times

(c) To ensure compliance with these: shared learning events – led by Children's Services Managers and in conjunction with the Safeguarding Children's Team – will take place for all Health Visitors

4.10.6 The School Nursing IMR notes that appropriate procedure was not followed in response to receipt of information, and makes the following recommendations:

(a) Ensure all School Nurses are reminded of the importance of accurate and contemporaneous record keeping in line with their professional body.

(b) School nurses must ensure they have a clear plan when there are tasks that may involve more than one member of the team i.e. opening the generic mail box, assessing the need and allocating the work to the most appropriate team member. Team Leader to spot check monthly that generic emails are opened, assessed and actioned daily.

4.10.7 This latter action is important in light of the lack of information the school had in relation to the domestic abuse/violence from Preston to Charlotte, which could have informed their actions, including support for the children.

4.11 Schools

4.11.1 The school received information about Preston's abuse of Charlotte on a number of occasions, starting with the incident in January 2012. They also liaised with Children's Social Care on a number of occasions to ensure the children were adequately supported. As noted above (4.9.9) there is a discrepancy of records in relation to the initial assessment. In addition, Children's Social Care had no record on their system of the referral made by the school on 11 December 2013.

4.11.2 A recommendation is made in the IMR that any future allegations or disclosures of domestic violence/abuse that are shared with the school lead to a plan being put in place for regular follow up with the informant.

4.11.3 The IMR also recognises that it would have been helpful to pass on the information they had about the previous domestic violence/abuse to the new school when the older child moved there.

4.11.4 The Panel asked that any policies, procedures and training for staff on responding to domestic violence/abuse includes the need to see parents alone when there has been a disclosure or suspicion of domestic violence/abuse. This is addressed in a recommendation (10) below.

4.11.5 Charlotte's older child started at the second school less than one month before the homicide occurred, and there was nothing of any concern that occurred in that time.

4.12 Central and North West London NHS Trust (CNWL) Mental Health Service

4.12.1 CNWL's involvement with Preston occurred very shortly before the homicide. It involved an assessment by a Psychological Wellbeing Trainee, which was supervised by a senior therapist. The IMR author is confident that appropriate procedure was followed, including the Trust's domestic violence and abuse policy.

4.12.2 Nevertheless, there were a number of potential triggers for concern in relation to the referral and assessment: primarily that Preston's mental health difficulties followed the incident in which he assaulted Charlotte, and yet he maintained to his GP, who noted it in the referral, that "his relationship with his wife is ok".

When he subsequently referred to separation from Charlotte in the assessment, this could have led to questioning to understand further the nature of the relationship, and the potential risk faced by Charlotte. There appears to be a face value acceptance of Preston's answer 'no' to the question 'do you find yourself as being a risk to others?'.

4.12.3 This may imply a lack of awareness of the signs to be aware of when speaking with a domestic violence/abuse perpetrator, and a recommendation (11) is therefore given in this report for CNWL's policy to be reviewed to ensure it contains adequate information and guidance specifically in relation to perpetrators of domestic violence/abuse.

4.12.4 Other than this, appropriate procedure and pathways were followed in responding to Preston's stated needs.

4.13 General Practices (GPs)

4.13.1 Charlotte's contact with her GP was very minimal, and there were no issues of concern.

4.13.2 Preston's GP was aware of the domestic incident in November 2013 when Preston attended reporting injuries and other symptoms following an alleged assault by police. Preston also referred to his relationship with Charlotte when the referral to IAPT was made, mentioning that they were separated but that their relationship was fine.

4.13.3 Following further questioning by the Panel, Preston's GPs confirmed the following:

(a) "At no time did he [Preston] express any adverse intention towards his wife and/or children. Indeed he always came across as a quiet, understanding caring person."

(b) Preston's GPs were not aware of the ongoing court case following the incident in November 2013: "Preston blamed the police for the assault [i.e. they assaulted him] and there was no mention of blame attached to his wife or any threats made. At no time was he felt to be a risk to his wife or family."

4.13.4 In addition the GP referred to the fact that the whole family were not registered with the practice; they knew only Preston, and he was reluctant to discuss anything other than his physical symptoms.

4.13.5 Preston's GP confirmed that the surgery received domestic abuse training within the mandatory adult safeguarding training provided by the Clinical Commissioning Group. In addition, the local network has purchased further online training, which includes modules on domestic abuse/violence awareness.

4.13.6 While Preston's presentation to his GPs did not raise any obvious concerns, enough information was provided by Preston to suggest that he might pose a risk to Charlotte: in particular that he had been arrested for assaulting her but

took no responsibility for it. If the GP had been involved in the MARAC process, they could have taken action in relation to the risk Preston posed to Charlotte by contacting the Coordinator either for further information or to make a referral. A recommendation is made below (7) with reference to General Practices' involvement in the MARAC.

4.14 Hillingdon Hospital

4.14.1 The IMR author for the Hospital recognises that staff should have demonstrated more 'professional curiosity' during Charlotte's attendance with the children following the attendance for incorrect medicine intake on 27 December 2013. The author notes that health and other professionals have been encouraged to 'think the unthinkable' in relation to child safeguarding, and a recommendation is made in the IMR to address this through training.

4.14.2 The IMR author recognises a similar lack of curiosity during Preston's attendance with Police on 23 November 2013: while an assault was mentioned, staff did not follow up on what kind of assault, or who the victim was, or whether Preston had children. This would have been appropriate and could have led to a safeguarding alert being made.

4.14.3 Similarly when Preston disclosed domestic violence allegations during his appointment on 9 September 2014: there is no record of any follow up questions, or any attempt to establish whether Preston posed a risk to anyone. It is additionally noted that Preston gave Charlotte's address at this appointment; if the hospital systems linked patients together, it could have been noted that this address was Charlotte's and the children's, and led to safeguarding action in light of his disclosure.

4.14.4 The IMR author and Panel recognised that Hillingdon Hospital's response to domestic violence/abuse victims was more developed that the response to (alleged/possible) perpetrators; the IMR makes recommendations to improve this through an improved policy and training, as well as outlining the Hospital's responsibilities and actions in relation to MARAC. These are to attend; to flag cases on the Hospital system, and to log minutes and actions.

4.14.5 The Panel also agreed with the author on the significance of Hospital systems linking up so that family members could be linked together, and a recommendation (12) is made in this report for this to be addressed.

4.15 National Probation Service (NPS)

4.15.1 The NPS is a statutory service responsible (amongst other things) for preparing Pre Sentence Reports for Courts supervising high-risk offenders subject to Court imposed community orders as well as offenders leaving prison.

4.15.2 In this case, their involvement with Preston began when he was convicted in December 2014 of assaulting two police officers during the domestic incident of 23 November 2013.

4.15.3 The IMR author notes that the Pre Sentence Report assessment and recommendation had to focus on the offences for which Preston had been convicted: two assaults on police officers. However the report did address the fact that the context of those assaults was a domestic call-out.

4.15.4 The IMR author interviewed the Pre Sentence Report author as part of the production of the IMR. The Pre Sentence Report author stated that they had attempted to discuss the domestic aspect of the incident on more than one occasion but that Preston completely denied that part of it. The Pre Sentence Report author had the details of Preston's caution for a domestic incident in 2004, but had no information from the Police in relation to the call outs made by Charlotte in relation to domestic abuse/violence from Preston.

4.15.5 It is standard for Pre Sentence Report authors to request this information from the Police. It is not possible to say in this case whether the request was made: no information was recorded as having been provided and the Pre Sentence Report author did not complete the request. As a result, the Pre Sentence Report author had no information on the domestic history. While this was unlikely to have changed the sentencing recommendation, the IMR author notes that it may have impacted on the risk of harm assessment relating to Preston.

4.15.6 The IMR author recognises that the significant changes brought to the Probation system by Transforming Rehabilitation in 2013 has led to reduced capacity in certain areas, and notes that work is required to increase these type of requests as per the current policy and procedure, and improve the process itself.

4.15.7 The IMR author outlines that sessional report writers are a frequent resource used by NPS for the completion of Pre Sentence Reports, due to the limited capacity of existing NPS staff and the increasing demands of the Courts. These sessional report writers are noted to be qualified Probation Officers. The author does note however that NPS are working to reduce the use of sessional report writers, and this forms a recommendation in the IMR.

4.15.8 The NPS are working with the Police to improve the provision of call out information. A recommendation is made within the IMR for the NPS and Police to continue this work. This is welcome; the Panel discussion suggested there may be some confusion as to where requests for call out information go within the Police.

4.15.9 The Panel discussed what additional information could be requested by or made available to NPS in addition to Police call outs, for example information from the MARAC (the MARAC discussion in this case came prior to Preston's involvement with NPS). The NPS IMR author agreed that this would be useful and that this would be taken back to NPS to discuss how it could be taken forward.

4.15.10 In the absence of additional information in this case, the IMR author confirmed that, if the Pre Sentence Report author had concerns about Preston or his risk to

others, then they would have discussed this with a senior officer, and made a referral to for example MARAC or Children's Social Care.

4.15.11 The report writer mentioned in the Pre Sentence Report that there might be a cultural component to Preston's attitudes and behaviour. This was not expanded on in the Pre Sentence Report; this is address in section five below.

4.16 Diversity

4.16.1 *Gender*

This is addressed in the conclusions section below.

4.16.2 *Race*

This is addressed in the conclusions section below.

4.16.3 *Marriage / civil partnership*

Charlotte referred to Preston as her husband and as far as most of the agencies she was in contact with were aware, they were married. Charlotte and Preston had been 'culturally' married in their country of origin but had not had a legal marriage in the UK. The IDVA service noted this in January 2012, but for Southall Black Sisters and the Crown Prosecution Service, the need for a divorce was part of their action plans with Charlotte.

Had more been known about the nature of their relationship, this might have led to different advice from services that were supporting Charlotte. In addition they may have worked with Charlotte differently, for example supporting her to explore and understand the nature of her marriage and what this meant legally, practically and emotionally for her.

4.16.4 *Age; religion and belief; disability; sexual orientation; gender reassignment; pregnancy and maternity*

No information was presented within the review to indicate these were issues.

5. Conclusions and Recommendations

5.1 Preventability

5.1.1 Given all the information presented in the review, it would be difficult to state with certainty that Charlotte's murder could have been prevented. Up to the day of the homicide, Preston had (broadly) abided by the bail conditions that had been in place from November 2013. The agencies in contact with Charlotte looked to the ending of those bail conditions (i.e. after the sentencing hearing on the 30 January 2015) as the point after which risk would be heightened.

5.1.2 Charlotte had made clear to agencies that she was afraid, and concerned over what Preston would do after the sentencing. Preston was known by agencies to feel that it was his right to treat Charlotte in any way he chose – he didn't hide this, demonstrating his sense of entitlement even at the point of arrest for assault. These "cultural issues" had been noted but not identified as leading to additional risk to Charlotte, which could have led to a heightened response, particularly around the time of the trial and sentencing.

5.1.3 It could be suggested that there was too much emphasis placed on his most recent behaviour – of avoiding Charlotte – rather than listening to what Charlotte was saying about her fears and anxieties about his future behaviour.

5.1.4 Research[31] has shown that victim's perception of their risk can be as accurate as risk identification/assessment tools, and it would have been helpful and potentially transforming if certain services had paid more attention to Charlotte's stated fears and anxieties.

5.1.5 Additionally, Charlotte could have been supported by the IDVA in November 2013 to move away to where her family was. This was what she asked for but that support didn't materialise. Charlotte was offered refuge by the IDVA service but she did not wish to pursue that as it would have meant giving up work. The safety plan specifies that the IDVA advised Charlotte to move away from Hillingdon, and Charlotte was willing to do this. The plan then states Charlotte "would be grateful if the local housing department in [family area] assists with this process" but no action was taken to involve them. Charlotte did not mention this wish to move to SBS, and the focus was therefore on applying for an occupation order to not allow Preston to enter the house; this was in progress when Preston killed Charlotte.

5.1.6 This meant that Charlotte remained in Hillingdon, with Preston knowing her whereabouts at all times; and as he always had keys to the house, could gain

[31] Klein, A. 'Practical Implications of Current Domestic Violence Research Part I: Law Enforcement' US Department of Justice, April 2008

access to her at any time (the issue of the locks was starting to be addressed by the SBS Advocate at the time of Charlotte's death).

5.2 Issues raised by the review

5.2.1 *How victims are perceived*

(a) Outlined in sections three and four are the contrasting ways in which Charlotte was perceived by the IDVA service and Southall Black Sisters. The IDVA believed Charlotte to be capable, proactive and not in need of additional support. They expected her to be able to take action by herself, including gaining protection orders by representing herself in court and giving evidence at the trial and therefore did not offer the same level of response as they would to others presenting to the service. Southall Black Sisters saw a vulnerable victim of domestic violence and abuse, who needed a great deal of help to unravel her issues and take action. The service therefore provided a high level of service to Charlotte in the weeks before her death, contacting her frequently and taking actions on her behalf.

(b) As a result, the actions of the services were very different. After an initial risk assessment of high risk, a referral to MARAC and thorough safety plan, the IDVA service then made no attempts to contact Charlotte. When Charlotte then made contact ten months later, the fact that she had not taken the actions she had said she would was not picked up on as an indicator of her vulnerability. The implication from the Southall Black Sisters' IMR is that the IDVA appeared to be frustrated with Charlotte, not understanding why she was not doing the things she knew she needed to do and appeared capable of doing. (This is from the SBS worker's notes: we do not know the exact nature of the IDVA's views.)

(c) Putting ourselves in Charlotte's shoes, we could suggest that she wanted to present to these services as capable, as she perceived them as statutory – the IDVA linked with the Police and located in the Council – and she had concerns over Children's Social Care involvement, or her job. She may also have wanted to be as capable as she presented herself as being, perhaps aspiring to be able to take these actions, and needing a sensitive and proactive support worker to recognise her need for help. A recommendation is therefore made (13) for a review to be conducted of views of the IDVA service being located in a statutory service, and of other borough's approaches / experiences.

(d) Charlotte's case highlights that, regardless of how a victim presents themselves, they should expect the same level of service from a victim support agency such as the IDVA service, and that perceptions over how they present themselves should not form part of the assessment around level of response.

(e) The Panel heard from (Panel member) Pragna Patel of Southall Black Sisters who stated that her own and her service's experience suggests that Afro-Caribbean women are often perceived – or assumed – to be capable and independent, and that this stereotype may have been part of agencies' responses to Charlotte, particularly as she was clearly educated and in work.

(f) What is unfortunate in this situation is that the IDVA assumed a level of capability in Charlotte, and did not follow normal practice in following up with Charlotte and supporting her in the court case and meeting her other needs. With the absence of support from the Police (Officer in the Case and the Witness Care Unit), Charlotte spent the year between the alleged assault in November 2013 and the trial in December 2014 with no support at all.

(g) The IDVA service, in the completion of the IMR for this review, has evidently recognised all of these issues, and it will be important for the service to continue to have the awareness of this learning in unconditionally supporting all victims – whatever their background and however they present.

5.2.2 *Risk Identification and Assessment*

(a) Charlotte faced multiple risk factors, as identified by the DASH Risk Identification Checklist. Although it is a long list, it is worth stating them here, from the IDVA risk assessment in November 2013, to demonstrate the situation in which Charlotte was having to live:

(i) His behaviour is becoming worse.

(ii) She has been assaulted whilst pregnant whereby he pushed her and was verbally threatening.

(iii) She is trying to leave the relationship.

(iv) He drinks alcohol in excess.

(v) He is likely to seek cultural revenge and that if she leaves him he would kill her and the children. He said he would lose us anyway so he won't lose anything by killing us.

(vi) He has a revengeful personality – he has said he will report her [to employer] so she will lose her job.

(vii) He has stalked her – gave her specific details and times of her whereabouts and the clothes she was wearing. He knows where she is and is always checking her movements.

(viii) He persistently harasses her. He reads her stuff, checks her room, and checks all her things. If she gets home late from work there is always constant questions.

(ix) He has attempted to strangle her.

(x) He has threatened to kill her. She has reported this to the police.

(xi) He has threatened to harm her children; he has threatened to take them out of her care.

(xii) There are current child contact issues.

(xiii) He has been abusive in previous relationship and was arrested in [other area].

(xiv) He is known to the police for violent crimes and that there has been an assault on a police officer.

(xv) He always blames her for his violence.

(xvi) He verbally and emotionally abuses her by calling her an idiot, daft, stupid and put downs and criticism.

(xvii) He displays obsessively jealous, isolating and controlling behaviours. He does not want her friend or relatives to come and see her, and if they do come he will make them feel uncomfortable.

(xviii) He financially controls her.

(xix) He comes from a violent background.

(xx) “I feel unsafe on a day-to-day basis”.

(xxi) Mortgage is now in arrears.

(xxii) Injunction previously in place, expired in October 2013.

(b) Despite this extensive list, clearly and explicitly detailed by the IDVA, Charlotte was effectively left to manage these risks alone.

(c) The IDVA service and the Police – and to a certain extent Southall Black Sisters and Children’s Social Care – were swayed by the bail conditions placed on Preston. The conditions required him not to contact, directly or indirectly, Charlotte, or to attend the family home. It was assumed by all services that these bail conditions would protect Charlotte, and that the key risk time would be once the bail conditions were over, following sentencing on 30 January 2015. They were reassured in this assessment by Preston’s lack of direct contact with Charlotte; however, all of the risks listed above remained true.

(d) Preston’s contact with her employer, with Children’s Social Care and the school were not perceived as ‘indirect contact’ and he was not judged to be breaching his bail conditions. As a result, no action was taken. Charlotte told agencies she was afraid, and concerned with what he would do. He had threatened to ‘report her’ to her employer so she would lose her job, and he did contact them. He had threatened to take the children away, and he

reported Charlotte to Children's Social Care accusing her of abusing them. To Charlotte, this showed that the threats he made were real and that he would follow through: so her fears were realised. He had threatened to kill her, and that is what he did.

(e) Similarly, in January 2012 services were swayed in their assessment of risk by Charlotte's location, on this occasion because she was staying with family.

(f) This case shows that the DASH risk identification checklist is an effective tool in identifying and assessing risk to victims of domestic violence/abuse, and accurately on this occasion outlined the risks Charlotte faced, and the seriousness of the (at that time potential) outcome. Unfortunately, the IDVA service and Police did not heed the risk assessment outcomes, choosing rather to focus on the location of Charlotte and/or Preston, or Charlotte's presentation as capable.

(g) A recommendation (14) below has been made for the use of the DASH – and the outcomes of its use – to be reviewed by the IDVA service and Police; and for the partnership to review how risk assessment outcomes are shared, when it is known that a victim is in contact with more than one agency.

5.2.3 *Communication in relation to court process and trial*

(a) Between the IDVA service, the Police Officer in Case and the Witness Care Unit, Charlotte should have received regular updates and contact in relation to the trial following the incident in November 2013. In fact she had almost no contact, and no support was provided. The Review was unable to establish whether Charlotte received support from the Witness Service at the Court on the day of the trial, as the provider has changed. The previous provider (Victim Support) checked what records they were able to but were unable to establish whether support was provided.

(b) From the conversations recorded between Charlotte and the IDVA service and Southall Black Sisters, it is clear that Charlotte did not understand what had taken place at the trial. She did not know why Preston had been found not guilty of the assault on her, and she did not know the outcome of the overall trial (in relation to the assaults on the police officers).

(c) What is striking is that, despite this lack of support, Charlotte took the courageous step to give evidence at the trial. Many victims of domestic violence/abuse feel unable to do this, even without the substantial delay and even with full support. This can be due to fear of standing in the court in front of the abuser or fear of further abuse as 'punishment' for giving evidence. Further, due to the lack of contact and support from the Witness Care Unit, special measures (for example a screen for her to give evidence

behind so she could not be seen / did not have to see Preston) were not applied for (we do not know if they were provided on the day).

(d) These issues around communication have been addressed in the IDVA IMR through recommendations for a court progress tracker and dedicated court IDVA. The Police have already taken action in relation to the Witness Care Unit, as outlined above.

(e) In addition to the recommendations already made by the individual agencies, a recommendation (15) is added here in relation to the role of the Officer in the Case (OIC). While the Witness Care Unit should take the lead in contact with the victim/witness around the trial, this should not mean that the OIC has no role, and they should still be expected to be in contact with the victim/witness, particularly in relation to Restraining Orders.

(f) The Hillingdon Specialist Domestic Violence Court (SDVC) was established in 2008 and runs every Wednesday at Uxbridge Magistrates Court. The aim of the SDVC is to wherever possible list all domestic violence cases to take place on a Wednesday in Court Room Two. The intention of this 'cluster-style' court is to enable victims and witnesses to benefit from enhanced support services. Charlotte's case would have initially been heard at the Magistrate's Court (we do not know if it was part of the SDVC) and then moved to the Crown Court, which does not follow the same system.

(g) The significance of the SDVC being in place at the time of Charlotte's case being heard is that this should have facilitated Charlotte getting additional support, and this does not appear to have been the case. It is hoped that this will be addressed through the IDVA IMR recommendation to review how the IDVA service provides support to victims through court processes. In addition, a recommendation (16) is made here for the SDVC Steering Group to work with the IDVA service – and other appropriate services – to understand what support is provided to victims at Court, with particular reference to when cases are transferred from the Magistrate's to the Crown Court.

5.2.4 *Intersection of race and gender*

(a) Gender is a risk factor for domestic abuse/violence, with women more likely to be victims. Race and/or national or ethnic background are not risk factors for experiencing domestic abuse/violence[32], but they can be potentially

[32] Walby, S. & Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey* Home Office Research, Development and Statistics Directorate

aggravating factors in both the type of abuse experienced and the help seeking patterns/perceptions of services for victims[33].

(b) It has been noted above that Charlotte kept returning to Southall Black Sisters. We can't know why that was, but given that it is a service that explicitly works with Black, Asian and Minority Ethnic (BAME) women, it is reasonable to suggest that this was a reason. Imkaan, in a survey of BAME women accessing domestic abuse/violence support services, found that 89% preferred a specialist BAME service[34].

(c) The intersection of gender and race in this case can be seen in the "cultural issues" noted by the IDVA service, the Police and National Probation Service. Preston had an evident sense of entitlement in relation to his abuse against Charlotte. The Children's Social Care IMR quotes the recorded notes as follows:

"Father is said to be revengeful and comes from a background where the man is the boss and women have to obey. He has said that if mother leaves him he won't lose anything by killing her and the children anyway."

(d) While this was noted by agencies, there was no apparent additional action in relation to these issues, or recognition that these could heighten Charlotte's risk in any way. Greater awareness is therefore needed within mainstream services of the additional risks and issues faced by victims in situations such as Charlotte's. This could be achieved through training, awareness raising sessions and/or fact sheets, including all DHR Panel and Safer Hillingdon Partnership members (particularly the IDVA service and the Police Community Safety Unit) on increasing awareness and understanding. A recommendation (6) is made below, recognising also the need to integrate this learning into standard domestic violence/abuse awareness training.

(e) Further, this review notes that the first occasions when Charlotte contacted Southall Black Sisters, they were not funded to work in Hillingdon; and the SBS IMR outlines their difficulties in accessing funding, venues to deliver services, and access to the partnership in general. While this review cannot comment on funding decisions, the learning from this case suggests that it would appropriate for the Community Safety Partnership to review how services for victims – involving all existing specialist service providers – meet the needs of minority ethnic victims; a recommendation (17) is therefore made.

5.2.5 *Awareness of and responses to perpetrators of domestic violence/abuse*

---

[33] Thiara, R. & Roy, S. (2012) *Vital Statistics 2: Key findings on black, minority ethnic and refugee women's and children's experiences of gender-based violence* Imkaan

[34] ibid.

(a) There were a number of instances in this case where proper attention was not paid to Preston as a perpetrator of domestic violence/abuse.

(b) Following the incident of January 2012, the Police failed to arrest Preston, and there are no records to suggest why this omission occurred. Also following this incident, the officer spoke with Preston about Charlotte and her whereabouts, and then appeared to speak to Charlotte immediately afterwards. Shortly after that Charlotte submitted a withdrawal statement and the case was closed.

(c) Preston should have been arrested; proper care should have been taken in speaking with Preston about Charlotte, and in speaking with Charlotte, in case she was in Preston's presence and therefore could not speak freely. There could have been more concern that Charlotte's withdrawal statement was so far removed from her original statement, and appropriate questioning over whether she felt coerced into making the withdrawal.

(d) A recommendation (18) is therefore made for the Police to look at their processes in relation to arrest, and withdrawal statements, to ensure that the above situation is not being repeated.

(e) Children's Social Care did not speak to Preston at all during their contact with the family following the incidents in January 2012 and November 2013. It is not clear why Preston was not spoken to, however the Panel understands it to be a frequent omission by Children's Social Care, and not just in Hillingdon. See further discussion on this below (5.2.7).

(f) The outcome of not speaking with Preston was that Children's Social Care relied wholly on Charlotte, and put all the responsibility on to her, which represents a failure to recognise the nature of domestic violence/abuse, and the power and control that domestic violence/abuse perpetrators exercise.

(g) The CNWL IAPT team had the most contact with Preston immediately prior to the homicide. As indicated above, more probing was required given that they knew he had previously been accused of a domestic violence/abuse offence; and particularly in light of the fact that separation was mentioned, contradicting his statement to his GP that his relationship with his wife was ok.

(h) The IDVA service, Children's Social Care and Police all noted Charlotte's perception of Preston's 'revengeful' and 'unpredictable' behaviours, however these did not receive due attention as risk factors, particularly as the end of the trial and bail conditions approached.

(i) A recommendation (19) is made in this review for all agencies within the DHR Panel and Safer Hillingdon Partnership to review their domestic abuse/violence policies and procedures to ensure they include information and guidance on appropriate responses to perpetrators.

5.2.6 *Partnership Working and Governance*

(a) During discussion, the Panel recognised a number of issues related to partnership working. There was confusion over the nature and role of what was referred to as the Domestic Violence Forum, although this was not a group known to all; and there were questions over the membership of this group as a result of this lack of knowledge.

(b) There was a lack of awareness/understanding of the governance, structure and makeup of the partnership responsible for domestic violence/abuse, and how partner organisations could present any local issues e.g. service provision or the needs (in this case) of black and minority ethnic women.

(c) Queries were also raised about the involvement of the voluntary sector in partnership working, since Southall Black Sisters had been working in the borough for some time but were struggling to link in with statutory agencies.

(d) The discussion around the MARAC highlighted a lack of governance, including the fact that both the MARAC itself, and the MARAC Steering Group, are chaired by the Police, which could lead to a lack f proper scrutiny. The Panel felt strongly that the MARAC Steering Group should be chaired by another partner agency. In addition, there was a lack of knowledge as to where the MARAC Steering Group reports into in relation to performance, issues and practice, and this should be addressed.

(e) A recommendation (20) is made to address these.

5.2.7 *Impact of domestic violence/abuse on children*

(a) The impact of living with domestic violence/abuse was recognised by a number of agencies. When Merlins were created by the police, it demonstrated effective practice and information sharing, allowing Children's Social Care to take action in recognition of the children's situation.

(b) The Merlins also meant that information got to the Health Visiting service where it otherwise wouldn't have done – although the service could have done more, as outlined above.

(c) Children's Social Care's action demonstrated an understanding that in situations where children are witnessing abuse, some assessment or action needs to be taken. Not all those children will meet a threshold for Social Care intervention, and where this was the case, in January 2012, a leaflet was provided for Charlotte to gain support elsewhere.

(d) While the Service appropriately recognised that Charlotte's relationship with the children was a mitigating factor in the impact of the abuse on them, they wrongly assumed that Charlotte as a domestic violence/abuse victim could safeguard herself and the children from the abuser.

"Perpetrators/fathers frequently undermine mother-child relationships as part of their abuse (Morris 2009; Humphreys et al 2006) in an attempt to reduce supportiveness between mothers and children and make them both weaker. Maintaining strong mother-child relationships in the context of domestic violence is therefore often difficult. However, it can be vital to survival and recovery. Much research suggests that strong and supportive mother-child relationships may be an important protective factor in helping mothers and children to survive and recover from domestic violence (Semaan et al 2013; Mullender et al 2002)."[35]

(e) It also did not appear that attention was paid to the fact that Preston's threats to kill in January 2012 were directed not just at Charlotte but also at the children.

(f) This focus on the non-abusive parent has been highlighted well in the work of David Mandel, who has produced the 'Safe and Together' Model:

"systems often do not coordinate and collaborate to intervene with and hold accountable domestic violence perpetrators as parents. Even when processes are working as designed, they often do not address the perpetrator as a parent."[36]

(g) The Safe and Together Model states that: "Child welfare agencies must be "domestic violence informed" in order to accomplish their core mission of addressing child safety, permanency and well-being."[37]

(h) A recommendation (9) is made for Children's Social Care to review the free materials available from http://endingviolence.com in light of the learning from this case and improving responses to perpetrators as parents.

5.2.8 *Risk to others from known perpetrator*

(a) Preston's 'other partner/family' was mentioned to the IDVA service, Police, Children's Social Care, Health Visiting, and were referred to at the MARAC. However no agency, nor the MARAC, took action in relation to the potential risk they faced from Preston.

(b) Action could have included alerting the MARAC in that area, or for the police to notify that police area, who in turn could have spoken with the other partner to identify the risk they faced.

---

[35] 'Strengthening mother-child relationships as part of domestic violence recovery' Centre for Research on Families and Relationships, Briefing 72, September 2014
[36] http://endingviolence.com/2015/10/nobody-owns-the-domestic-violence-perpetrator/ [accessed 5 October 2015]
[37] http://endingviolence.com/our-programs/safe-together/faq/why-is-the-safe-and-together-model-relevant-for-child-welfare-workers-2/ [accessed 5 October 2015]

(c) A recommendation (21) is therefore made in this review for processes in relation to perpetrators posing risks to others in addition to the known victim to be reviewed or produced.

5.3 Recommendations

5.3.1 Recommendation 1

The recommendations below should be acted on through the development of a partnership owned action plan. This is in addition to the actions identified in individual IMRs: initial reports on progress by agencies on their IMR action plans should be made to the Safer Hillingdon Partnership within six months of the Review being approved by the Partnership.

5.3.2 Recommendation 2

A briefing to be prepared jointly by the Crown Prosecution Service, Her Majesty's Court and Tribunals Service (HMCTS) and the Metropolitan Police outlining the current processes in place for partnership working and sharing of performance and case information (including any meetings), and for this to be distributed appropriately through each agency. The Crown Prosecution Service, HMCTS and the Metropolitan Police to meet to identify the development required to improve these processes; and to take action on these. Updates to be provided to the Safer Hillingdon Partnership.

5.3.3 Recommendation 3

Metropolitan Police Service, Crown Prosecution Service and the IDVA service to jointly establish a multi-agency procedure in relation to Restraining Orders, with reference to the learning in this case.

5.3.4 Recommendation 4

Southall Black Sisters and the IDVA service to ensure – through procedure, training and ongoing supervision – that all support staff establish contact with the Officer in the Case for clients who are engaged in the criminal justice system, and remain in contact with them until cases are completed. The Safer Hillingdon Partnership to also disseminate this learning to other agencies in Hillingdon that support domestic abuse victims.

5.3.5 Recommendation 5

The Safer Hillingdon Partnership to ensure that all domestic abuse specialist services operating in Hillingdon are notified of new domestic homicides at the earliest point possible.

5.3.6 Recommendation 6

The Safer Hillingdon Partnership to raise awareness – through for example fact sheets, awareness sessions and/or training, and drawing on appropriate expertise in relation to BAME female victims of domestic abuse – of the

intersections of race and gender and how they impact on women's experiences of domestic abuse. With reference to the learning from this case; and to include directions to staff on where further advice can be sought. For information to also be added to standard Domestic Abuse Awareness training.

5.3.7 Recommendation 7

In the redevelopment of the local MARAC process, the MARAC Steering Group to develop a process through which education services (schools) and General Practices can be appropriately involved (though not necessarily always attend) in the MARAC process.

5.3.8 Recommendation 8

The Safer Hillingdon Partnership to ensure, through regular reports from the MARAC Steering Group, that the MARAC redevelopment outlined in this review continues to make progress. In particular that a review of the MARAC Steering Group terms of reference, chairing and membership has taken place with reference to the points made in this review, and that the Local Safeguarding Children and Adult Safeguarding Boards are appropriately involved.

5.3.9 Recommendation 9

Children's Social Care to review the free materials available from http://endingviolence.com and, also with reference to the learning in this case:

- ensure that fathers are always spoken with in domestic violence/abuse cases (where safe to do so, and in those cases where it is not, to document it)
- ensure that perpetrators are held accountable for domestic violence/abuse, and that non-abusive parents are therefore fully supported and not expected to stop the abuse themselves

For this to be regularly reviewed in supervision, and for a dip sample audit to take place six months after changes have been made, with the results reported to the Safer Hillingdon Partnership.

5.3.10 Recommendation 10

For the school to ensure that domestic violence/abuse policies, procedures and training for staff include the need to see parents alone when there has been a disclosure or suspicion of domestic violence/abuse.

5.3.11 Recommendation 11

CNWL to review their domestic abuse policy in light of the learning from this case, and in particular to ensure that it contains adequate information and guidance on warning signs/triggers in relation to domestic violence/abuse perpetrators.

5.3.12 Recommendation 12

Hillingdon Hospital to ensure that Hospital database systems link family members together so that they can be identified when an individual attends.

5.3.13 Recommendation 13

Safer Hillingdon Partnership to carry out a review to establish service users' and partner agencies' views on the IDVA service being located in a statutory service. The experiences of other boroughs to be sought, and the findings to be acted on accordingly in relation to service delivery.

5.3.14 Recommendation 14

The Safer Hillingdon Partnership (or a delegated short term working group) to review the use of the DASH risk identification checklist in Hillingdon agencies, covering (other issues may also be identified):

- the purpose of DASH completion
- the use of DASH as an ongoing risk identification tool (rather than as a one off threshold tool)
- the sharing of risk identification outcomes between agencies involved with the same client

5.3.15 Recommendation 15

Metropolitan Police Service to review the ongoing contact by Officers in the Case with victims as investigations and trials progress, in light of the learning from this case.

5.3.16 Recommendation 16

The Specialist Domestic Violence Court (SDVC) Steering Group to review, with the IDVA service and other relevant services, the support provided at the SDVC to victims of domestic abuse/violence, with particular reference to victims in cases that are transferred from the Magistrate's Court to the Crown Court. To report to the Safer Hillingdon Partnership on the Review and any actions taken as a result.

5.3.17 Recommendation 17

Safer Hillingdon Partnership to carry out a review of existing domestic abuse specialist support services, that includes all services operating in Hillingdon (not just those based in Hillingdon), to establish how the needs of minority ethnic victims are met. To also include consultation with minority ethnic women in the borough on whether they feel their needs are met, and their opinion on how services should operate. For the learning from the review to be acted upon and progress reported back to the Safer Hillingdon Partnership.

5.3.18 Recommendation 18

Metropolitan Police Service to review their processes (and conduct a dip sample audit) in relation to arrest, and withdrawal statements, with reference to the learning in this case, and to report back to the Safer Hillingdon Partnership addressing these learning points.

5.3.19 Recommendation 19

All members of the DHR Panel and Safer Hillingdon Partnership to conduct internal reviews of their domestic violence/abuse policies and procedures in relation to how they identify, risk assess, refer and respond appropriately to perpetrators (including alleged), to make changes as appropriate and report to the Safer Hillingdon Partnership.

5.3.20 Recommendation 20

The Safer Hillingdon Partnership to review the structure, governance, membership and Terms of Reference of the partnership responsible for domestic violence/abuse, to address the points made in this review, including but not limited to:

- The need to provide governance of the MARAC and MARAC Steering Group; including the necessity of different partner agencies chairing the MARAC and the MARAC Steering Group. The MARAC Steering Group to report into an appropriate partnership group.
- The need for the partnership to be inclusive of the voluntary sector.
- Ensuring that all organisations in Hillingdon understand the purpose and role of the partnership responsible for domestic abuse/violence; their role within it and their ability to present issues and potential to effect change.

5.3.21 Recommendation 21

The Safer Hillingdon Partnership and MARAC Steering Group to establish a procedure for all agencies and the MARAC to respond appropriately to situations in which a known perpetrator poses a risk to someone not known to agencies, including those out of area.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Charlotte and Preston following her death in 2015. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

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 should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Charlotte and Preston during the relevant period of time: 1 January 2012 – the date of the homicide.
3. To summarise agency involvement prior to 1 January 2012.
4. 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.
5. 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.
6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
7. To commission a suitably experienced and independent person to:
    a) chair the Domestic Homicide Review Panel
    b) co-ordinate the review process
    c) quality assure the approach and challenge agencies where necessary
    d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
9. On completion present the full report to the Hillingdon Community Safety Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative

must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

11. IMRs have been requested from the following agencies:

    a) Children's Social Care

    b) Central North West London NHS Trust (CNWL)

    c) Crown Prosecution Service (CPS)

    d) GPs for Charlotte and Preston

    e) Hillingdon Hospital

    f) IDVA Service

    g) Metropolitan Police Service

    h) National Probation Service, London Division

    i) Schools for both children

    j) Southall Black Sisters

    k) Urgent Care Centre (CareUK)

12. Southall Black Sisters, in addition to contributing to the Review as a substantive member, will also act as specialist experts in relation to domestic abuse victims from a minority ethnic background.

13. The Panel notes that, depending on the outcome of the criminal case, a Mental Health Review may be established.

14. If there are other investigations into the death, the panel will agree to either:

    a) run the review in parallel to the other investigations, or

    b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

15. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

16. Each agency must provide a chronology of their involvement with the Charlotte and Preston during the relevant time period.

17. Each agency is to prepare an Individual Management Review (IMR), which:

    a) sets out the facts of their involvement with Charlotte and Preston

    b) critically analyses the service they provided in line with the specific terms of reference

    c) identifies any recommendations for practice or policy in relation to their agency

d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

18. 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 Charlotte and Preston in contact with their agency.

Analysis of findings

19. In order to critically analyse the agencies' responses to the family, this review should specifically consider the following six 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, alleged 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.

20. The Review notes that the victim and alleged perpetrator are Black African (Zimbabwean) immigrants to the UK. Therefore, in critically analysing agencies' responses to the family, attention should be paid to the ethnic and national background of the victim, perpetrator and children, to identify whether there is any specific learning related to this.

Liaison with the victim's and alleged perpetrator's family

21. Sensitively involve the family of Charlotte in the review, following the completion of criminal proceedings. Also to explore the possibility of contact with the alleged perpetrator who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

22. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

23. Coordinate with any other review process concerned with the child/ren of the victim and/or alleged perpetrator.

Development of an action plan

24. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will set out the requirements in relation to reporting on action plan progress to the Community Safety Partnership: for agencies to report to the CSP on their action plans within six months of the Review being completed.

25. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

26. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

27. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

31. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

Appendix 2: Action Plan

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1. The recommendations below should be acted on through the development of a partnership owned action plan. This is in addition to the actions identified in individual IMRs: initial reports on progress by agencies on their IMR action plans should be made to the Hillingdon Community Safety Partnership within six months of the Review being approved by the Partnership	Local	LBH Community Safety Team to co-ordinate action plan and monitor progress on behalf of SHP	Safer Hillingdon Partnership (c/o Community Safety Team)	May 2016 - First progress report to SHP	Initially a report on progress in May 2016, and then quarterly until all actions are complete	All recommendations completed
2. A briefing to be prepared jointly by the Court team, CPS and Police outlining the current processes in place for partnership working and sharing of performance and case information (including any meetings), and for this to be distributed appropriately through each agency. The Court team, CPS and Police to meet to identify the development required to improve these processes; and to take action on these. Updates to be provided to the Safer Hillingdon Partnership.	Local	SDVC Steering Group (which includes representatives from the court, CPS and Police) to discuss the recommendation and include within their work stream	SDVC Steering Group	Proposed plan of work presented and approved by senior leadership team Detailed action plan to follow	Q3 2016/17	
3. Metropolitan Police Service, Crown	Local	SDVC Steering Group	SDVC Steering	Further actions to	Q3 2016/17	Procedure

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Prosecution Service and the IDVA service to jointly establish a multi-agency procedure in relation to Restraining Orders, with reference to the learning in this case		(which includes representatives from the court, CPS and Police) to discuss the recommendation and include within their work stream	Group	follow		implemented by all relevant agencies
4. Southall Black Sisters and the IDVA service to ensure – through procedure, training and ongoing supervision – that all support staff establish contact with the Officer in the Case for clients who are engaged in the criminal justice system, and remain in contact with them until cases are completed. The Safer Hillingdon Partnership to also disseminate this learning to other agencies in Hillingdon that support domestic abuse victims	Local	IDVA and Southall Black Sisters to review current internal practices and produce toolkit for advocates in relation to liaising between them and the Officer in the Case. Toolkits to be shared with all partner agencies for their own internal use.	IDVA and Southall Black Sisters	Review of current practice Toolkit produced and shared with advocates Advocates implement new practices.	Q3 2016/17	All victims of domestic abuse are better supported and kept updated throughout the criminal justice element through better liaison between advocates and the Police Officer in the Case.
5. The Community Safety Partnership to ensure that all domestic abuse specialist services operating in Hillingdon are notified of new domestic homicides at the earliest point possible	Local	Develop a protocol across the DV partnership in relation to domestic homicides	Community Safety Team, London Borough of Hillingdon	Establish a protocol that covers the procedure for informing agencies of domestic homicides, establishing a DHR, expectation of DV agencies and involvement of panel members.	Q4 2016/17	Protocol agreed by SHP and adopted by all DV agencies.

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
6. The Safer Hillingdon Partnership to raise awareness – through for example fact sheets, awareness sessions and/or training, and drawing on appropriate expertise in relation to BAME female victims of domestic abuse – of the intersections of race and gender and how they impact on women's experiences of domestic abuse. With reference to the learning from this case; and to include directions to staff on where further advice can be sought. For information to also be added to standard Domestic Abuse Awareness training.	Local	Review and expand the Domestic Abuse Awareness training to include a section on race and gender	Community Safety Team, London Borough of Hillingdon	Working alongside expert partners, develop an additional section to the current training. First updated training session delivered Future dates planned	Q3 2017/18	Better understanding among front-line DV support services of the intersection of race and gender and how they impact on a person's experience of domestic abuse
7. In the redevelopment of the local MARAC process, the MARAC Steering Group to develop a process through which education services (schools) and General Practices can be appropriately involved (though not necessarily always attend) in the MARAC process.	Local	Full MARAC review of processes and procedures	Met Police (Hillingdon) - Superintendent	MARAC agendas and client summaries disseminated to relevant partners (including education, children's services and YOS) via MASH When specific cases arise which need direct input, then personal invite sent to relevant welfare officer	June 2016	MARAC review and improvements completed

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
8. The Safer Hillingdon Partnership to ensure, through regular reports from the MARAC Steering Group, that the MARAC redevelopment outlined in this review continues to make progress. In particular that a review of the MARAC Steering Group terms of reference, chairing and membership has taken place with reference to the points made in this review, and that the Local Safeguarding Children and Adult Safeguarding Boards are appropriately involved.	Local	LBH Community Safety Team to receive regular updates regarding the redevelopment of the MARAC.	Met Police (Hillingdon) - Superintendent	New chair for MARAC Steering Group in place Hillingdon Hospital to engage in MARAC	July 2016	New steering group in place
9. Children's Social Care to review the free materials available from http://endingviolence.com and, also with reference to the learning in this case: • ensure that fathers are always spoken with in domestic violence/abuse cases (where safe to do so, and in those cases where it is not, to document it) • ensure that perpetrators are held accountable for domestic violence/abuse, and that non-abusive parents are therefore fully supported and not expected to stop the abuse themselves • For this to be regularly reviewed in	Local	Safeguarding Operational Managers to cascade information regarding new working practices to all officers.	Manager, LSCB & SAPB	New working practices to be implemented. Audit practices 6 months into implementation. Progress tracked through SCR subgroup of LSCB/SAPB.	Q4 2016/17	New working practices implemented and being adhered to by officers, confirmed via audit.

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
supervision, and for a dip sample audit to take place six months after changes have been made, with the results reported to the Safer Hillingdon Partnership						
10. For the school to ensure that domestic violence/abuse policies, procedures and training for staff include the need to see parents alone when there has been a disclosure or suspicion of domestic violence/abuse.	Local	Designated Safeguarding Lead (DSL) and 2 deputy DSLs review DV procedures and training for school staff and update accordingly	Head Teacher	DSL attends domestic awareness training and cascades to deputy DSLs DSL leads staff training for all members of staff DSL & Deputy DSLs complete DV awareness policy for all staff and publish to all staff and governors	Jan 2016 Jan 2016 April 2016	Safeguarding review meetings between DSL and deputy DSLs review all cases where disclosure of DV (or suspicion of DV) have been made to school and keep in regular contact with any possible victims
11. CNWL to review their domestic abuse policy in light of the learning from this case, and in particular to ensure that it contains adequate information and guidance on warning signs/triggers in relation to domestic violence/abuse perpetrators	Local	Review current procedure and update to contain perpetrator profiles warning triggers	CNWL	Review of current practice Policy updated accordingly Dissemination via the care Quality structure in Hillingdon and	August 2016	New policy in place

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				CNWL governance structures		
12. Hillingdon Hospital to ensure that Hospital database systems link family members together so that they can be identified when an individual attends.	Local	Explore capability of existing patient administration system (PAS) to link family group members Domestic violence pathway to include mandatory questioning to identify immediate family members. DVA flag to be attached to records of persons identified to be affected	Lead Nurse for Safeguarding Children, Hillingdon Hospital	Consider extending scope of Child Protection Information System (CPIS) project to include DVA Review MARAC list monthly to identify perpetrators/victims and associated children of DA and update PAS with Domestic Violence and Abuse (DVA) alerts for family group Update DVA Pathway Update and undertake staff training Audit process compliance	December 2016 February 2016 May 2016 June 2016 July 2016	
13. Safer Hillingdon Partnership to carry out a review to establish service users' and partner agencies' views on the IDVA service being located in a statutory service. The	Local	Domestic abuse to be reviewed as part of the Council's Transformation Programme	LBH Transformation Team	Proposed plan of work presented and approved by senior leadership team.	Q1 2016/17	Outcome subject to findings of the review

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
experiences of other boroughs to be sought, and the findings to be acted on accordingly in relation to service delivery.				Phase 2 of transformation programme to follow	Q4 2016/17	
14. The Safer Hillingdon Partnership (or a delegated short term working group) to review the use of the DASH risk identification checklist in Hillingdon agencies, covering (other issues may also be identified): • the purpose of DASH completion • the use of DASH as an ongoing risk identification tool (rather than as a one off threshold tool) • the sharing of risk identification outcomes between agencies involved with the same client	Local	Domestic abuse to be reviewed as part of the Council's Transformation Programme	Community Safety Team, London Borough of Hillingdon	Identify which DV Forum sub group is best placed to lead on development of protocol. Draft protocol produced and discussed at Forum Protocol adopted by domestic abuse agencies	Q2 2016/17 Q3 2016/17 Q4 2016/17	Outcome subject to findings of the review
15. Metropolitan Police Service to review the ongoing contact by Officers in the Case with victims as investigations and trials progress, in light of the learning from this case	Local	Victims to be kept regularly updated with regard to their investigation and trial	Met Police (Hillingdon) - Superintendent	Domestic abuse 'car' to be utilised for victim updates and welfare visits Additional Victim Support IDVAs to work alongside Community Safety Unit	May 2016	Victims are kept regularly updated
16. The Specialist Domestic Violence Court (SDVC) Steering Group to review, with the IDVA service and other relevant services, the support	Local	Conduct a review of the SDVC.	SDVC Steering Group	Conduct review of all 11 core components of an SDVC to ensure	Q4 2016/17	Review completed and all core components working well.

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
provided at the SDVC to victims of domestic abuse/violence, with particular reference to victims in cases that are transferred from the Magistrate's Court to the Crown Court. To report to the Safer Hillingdon Partnership on the Review and any actions taken as a result.				they are in place and working effectively		
17. Safer Hillingdon Partnership to carry out a review of existing domestic abuse specialist support services, that includes all services operating in Hillingdon (not just those based in Hillingdon), to establish how the needs of minority ethnic victims are met. To also include consultation with minority ethnic women in the borough on whether they feel their needs are met, and their opinion on how services should operate. For the learning from the review to be acted upon and progress reported back to the Safer Hillingdon Partnership.	Local	Domestic abuse to be reviewed as part of the Council's Transformation Programme	LBH Transformation Team	Proposed plan of work presented and approved by senior leadership team. Phase 2 of transformation programme to commence	Q1 2016/17 Q4 2016/17	Outcome subject to findings of the review
18. Metropolitan Police Service to review their processes (and conduct a dip sample audit) in relation to arrest, and withdrawal statements, with reference to the learning in this case, and to report back to the	Local	Dip sample to be conducted for performance year commencing April 2016	Met Police (Hillingdon) - Superintendent	Interim report to SHP Thereafter, monthly review of figures	Q3 2016/17	Learning indentified and acted upon

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Safer Hillingdon Partnership addressing these learning points						
19. All members of the DHR Panel and Safer Hillingdon Partnership to conduct internal reviews of their domestic violence/abuse policies and procedures in relation to how they identify, risk assess, refer and respond appropriately to perpetrators (including alleged), to make changes as appropriate and report to the Safer Hillingdon Partnership	Local	Domestic Abuse Partnership to include this recommendation as an action for all members within their annual strategy/action plan.	Community Safety Team, London Borough of Hillingdon	Annual strategy updated Panel members conduct own internal audit Results collated and report presented initially to Domestic Abuse Forum/Executive for consideration	Q4 2017/18	Report presented to SHP for consideration
20. The Safer Hillingdon Partnership to review the structure, governance, membership and Terms of Reference of the partnership responsible for domestic violence/abuse, to address the points made in this review, including but not limited to: • The need to provide governance of the MARAC and MARAC Steering Group; including the necessity of different partner agencies chairing the MARAC and the MARAC Steering Group. The MARAC	Local	Domestic abuse to be reviewed as part of the Council's Transformation Programme	LBH Transformation Team	Proposed plan of work presented and approved by senior leadership team. Detailed action plan to follow Work plan completed	Q1 2016/17 Q2 2016/17 Q3 2016/17	Outcome subject to findings of the review

Recommendation	Scope	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Steering Group to report into an appropriate partnership group; • The need for the Partnership to be inclusive of the voluntary sector • Ensuring that all organisations in Hillingdon understand the purpose and role of the partnership responsible for domestic abuse/violence; their role within it and their ability to present issues and potential to effect change						
21. The Safer Hillingdon Partnership and MARAC Steering Group to establish a procedure for all agencies and the MARAC to respond appropriately to situations in which a known perpetrator poses a risk to someone not known to agencies, including those out of area.	Local	Develop a protocol across all domestic abuse agencies which includes a procedure and referral pathway when risk from a known perpetrator has been identified	Community Safety Team, London Borough of Hillingdon	Identify which DV Forum sub group is best placed to lead on development of protocol. Draft protocol produced and discussed at Forum Protocol adopted by domestic abuse agencies	Q2 2016/17 Q4 2016/17 Q1 2017/18	Protocol in place and adopted by all agencies