Domestic Homicide Review

The London Borough of Lewisham

Anthony Wills
April 2013

Index

Lewisham

Domestic Homicide Review – AB

1. Executive summary

2. On 19 November 2011 police were called to an address in Lewisham where the subject of this review, AB, a 22 year old female had been staying with her boyfriend CD. AB had been stabbed and CD was arrested. A murder investigation was launched and CD was charged with the offence of murder. He was found guilty of the offence of manslaughter on the grounds of diminished responsibility and sentenced to a hospital order under S37 Mental Health Act 1980 without restriction of term.

3. These circumstances led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the Community Safety Partnership (CSP) in Lewisham. The initial meeting was held on the 2nd February 2012 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death.

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

5. The purpose of these reviews is to:

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

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

7. Terms of Reference

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

9. Methodology

10. The approach adopted was to seek Individual Management Reviews (IMRs) from all organisations and agencies that had contact with AB or CD. 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.

11. Contact has been attempted with the families of parties involved but they have, in the main, declined direct contact with panel members. The mother of AB has been spoken to by the Chair on three occasions but with no useful conversation being possible. Attempts are continuing to discuss this review with her but this report cannot be delayed further.

12. It was possible to speak with the foster carer of AB who looked after her as AB moved towards independence. This was not considered possible until the conclusion of the case. Following a lengthy discussion she was firmly in support of the recommendations from the review, particularly those in relation to the Leaving care service. She also highlighted that vulnerable period for AB when moving from the care environment to adult life. She felt that AB was not ready for a separate existence but AB was insistent that this happened.

13. The perpetrator has not been interviewed but enquiries continue with his Consultant Psychiatrist to see if this can be arranged. It was agreed by the panel that this should not be attempted until after the case was complete.

14. Once the IMRs had been provided panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

15. Composition of the DHR panel

- Lewisham Children's Social Services
- Lewisham Healthcare NHS Trust
- Lewisham Community Services Directorate
- GP
- South London and Maudsley (SLaM) Foundation Trust
- Metropolitan Police Service – Specialist Crime Review Group and Lewisham Police (Public Protection)
- London Probation Trust
- Standing Together (Independent Chair and Administration)

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

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

18. There have been no parallel or similar reviews conducted into this case.

19. The Facts

20. The death of AB

21. AB had been a looked after child in the care of the London Borough of Lewisham from the age of six to eighteen years. She had spent that time in foster care and moved into independent accommodation when she was 19. At the time of her death AB was receiving support from the Lewisham Leaving Care Service.

22. Although AB had her own flat, her housing arrangements were often unclear and she had faced eviction. During the latter part of 2011 AB had spoken of having a boyfriend but the identity of the boyfriend was not known to authorities. This was believed to be CD.

23. CD lived in the Lewisham area with his mother. He did not have record of any significant contact with statutory agencies until early 2011. In March 2011 CD had been taken into custody having attempted to gain entry to a house and was subsequently assessed under the Mental Health Act as having had a psychotic episode. In August 2011 he was made subject of a Community order with Supervision and Mental Health requirement for 12 months.

24. AB and early contact with the statutory sector

25. AB came to notice of the statutory sector at an early age. Having been initially placed on the Child Protection Register, AB and her sister were later taken into Local Authority care when AB was aged five, due to poor parenting and neglect and remained with long-term foster parents.

26. In 2004 AB's apparent vulnerability increased as she began to abscond from her foster placement. She was known to be sexually active from the age of 13 and frequenting risky locations and had been found in the company of older men.

27. AB continued to cause concerns for her carers in relation to the risks she was facing especially in relation to contact with men. At one point she reported that she had been abducted and raped by a male.

28. When AB reached 16 years old her case was transferred to the Leaving Care Service. (She would be subject to statutory social work support and reviews until the age of 18.) Children's Social Care (CSC) considered that AB's life began to settle and she was described to be behaving in a more age appropriate way.

29. AB - The Period 2009 – 2011

30. At the start of 2009 when AB was 18 years old and still in her foster placement, plans were being made for her to move to independent living. In December 2009 AB was offered a flat.

31. AB moved away from her foster placement and into her own flat in February 2010. In July 2010 AB informed CSC that she had been staying with her boyfriend and was not seen at her own home.

32. At the start of 2011 CSC continued to try and engage with AB but this was not always successful. AB had no known source of income and was not claiming Job Seekers allowance. The source of any income for AB was never established.

33. Although CSC recorded that AB had relationships with boyfriends, their identities were not known.

34. Throughout May until the time of her death AB was known to be suffering from housing issues facing eviction. Contact with her was quite limited and it was known a boyfriend existed but no information about him was held by any of the agencies involved. On 2nd November 2011 AB attended the CSC offices attempting to resolve housing problems. This was the last statutory sector contact with AB, her death occurring on the 19th November 2011.

35. The perpetrator CD

36. In 1997, when CD was six, CD moved to live in the UK from Jamaica to stay with his mother and two sisters in Lewisham. There is no notable statutory involvement until the start of 2011.

37. In February 2011 it was reported to police that CD had recently been seen to be in possession of a knife and information was passed to the police intelligence unit, but no further investigation took place.

38. On 11th March 2011 CD attempted to gain entry to a house (possibly of a previous friend) which led to the involvement of SLaM and a later referral to London Probation Trust (LPT).

39. CD was admitted to Ladywell Mental Health Unit (Lewisham), for an assessment of his mental health including the possibility of drug induced psychosis and acute stress reaction. CD was prescribed anti-psychotic medication but he consistently refused to take this medication.

40. On 5th April 2011, after continued refusal to take medication, CD was restrained and medication administered under S.2 of the Mental Health Act. Now under the care of SLaM he was prescribed medication and discharged on 13th April 2011 to the care of the Community Mental Health team at Lewisham. CD's formal diagnosis was of "Mental Disorder" and his risk was reviewed by SLaM and defined as being high, but low in relation to 'others'.

41. CD was also assessed at Lewisham Early Intervention Service as presenting low risk to himself or others. Information was passed to CD's GP confirming clear signs of psychosis and confirming his medication. CD was seen at home in June 2011 and assessed as being asymptomatic, making good progress and looking at vocational opportunities. At this time he also appeared to be complying with his anti-psychotic medication.

42. LPT records relating to CD show that he self-reported that the offence for which he was under their supervision took place at the home of his ex-partner and he had thrown a brick through the window to gain entry when no-one answered the door. The LPT IMR indicates that this may have been a case of DV and this should have led to further actions within LPT (e.g. a spousal risk assessment and enquiries with the police) but these did not happen. The police view is clear that this incident was recorded as an attempted burglary and there is no evidence to support the classification of this offence as a domestic violence (DV) incident.

43. LPT Risk Management Plans require that enquiries should be made with police Borough Intelligence Units (BIU) but this did not happen.

44. LPT were responsible for managing the community order. There is no evidence that details of the court sentence and mental health requirement of the community order were communicated to SLaM.

45. The primary care for CD is provided by his GP. The GP has recorded occasions when CD had not been taking prescribed medication but was not aware of the existence of the mental health requirement of the court order.

46. In September 2011 CD visited his GP who recorded that he had not taken medication for three weeks. He was seen two days later during a home visit

from his community health team. He was assessed as having good insight into his illness and not reporting any side effects.

47. CD attended LPT offices on 17th November a day late for the rescheduled appointment. CD had mistaken the 17th for 16th November. This was the last contact before CD was arrested for the murder of AB on the 19th November 2011.

48. AB and CD 2011

49. It cannot be certain when AB and CD met. MPS information indicates that AB probably knew CD for 6 months prior to the murder.

50. There are no formal statutory records linking AB and CD before the events of 19th November 2011. There are acknowledgements that it was known that AB had a boyfriend during this period.

51. Analysis

52. There is considerably more information about AB and spread over a longer period than is available for CD within the records of the statutory sector. The following analysis examines the lives of the victim of this murder and the perpetrator but nothing should detract from the fact that CD took AB's life and he has been found responsible for that act. Nothing in AB's life could have ever possibly justified her murder. It may be true that had her vulnerability been approached more comprehensively, safer options could have been sought to allow her to live a life free from violence.

53. Since AB was 11 years old, statutory services knew that she had been vulnerable to sexual abuse and later to possible exploitation by males. After AB reached 16, CSC considered that she was becoming more settled. However, at this time her GP had recorded concerns about stress caused by a boyfriend and sexual health issues.

54. As AB moved away from foster care into independent living it was important that she was supported to continue to develop a safe lifestyle. Ultimately it was during this period that she came into contact with CD. Although information sharing is key to managing risk, it appears that there were gaps in the information sharing processes that would have thrown light on relationships and the place of residence of AB or CD thereby informing any risk assessment processes.

55. The panel were also clear that many of the discussions that took place between AB and CD and caring agencies were voluntary in nature. The Leaving Care Service has no power to demand contact or information.

Similarly much of CD's care was based around what he chose to tell his workers.

56. Individual agencies reviewed their interactions with AB and CD and failure to fully meet guidelines on pathway planning and risk assessment were found. Individual agencies did not feel that the evidence available to them would have predicted the outcome in this case. However if parties had been asked appropriate questions there is a possibility that the relationship between AB and CD could have been identified. When all information from statutory agencies is shared it does create a picture of risk to AB's personal safety.

57. Information Sharing

58. Information sharing is a crucial element essential to the prevention and management of DV. There was a lack of information sharing in both inter and intra-agency working. Sharing of information may have enhanced the quality of pre-sentence reports and management of CD's post sentence care.

59. LPT do not consider that the mental health requirement of CD's order was fulfilled (through non-compliance with drug medication regime). With increased contact between SLaM and LPT the latter could have been in a position to enforce a breach of his order.

60. Risk Assessment

61. There was a failure to complete a spousal risk assessment by the one agency that at least had information to suspect DV. Where there were more generic processes it appears that the importance of relationships and the prevalence of DV were not sufficiently considered.

62. Understanding of the existence of DV with AB

63. Statutory agencies were not aware of DV being present whilst AB was in the process of leaving care. She was a vulnerable young woman and violence from males had previously been present in her life and her subsequent relationships do not appear to have been explored in depth by statutory agencies.

64. It was recorded in LPT records that CD was involved in a crime of violence towards property belonging to an ex-partner. This is not supported by police reports that remain of the view that this was an attempted burglary, but LPT took no steps to explore CD's background and conduct the appropriate risk assessment.

65. It is apparent that agencies working with AB and CD were not sufficiently aware of the personal circumstances of either party to assess, respond or refer any potential DV issues.

66. Mental Health

67. The issue of mental health is common within many incidents of DV. This is clearly apparent in relation to CD. This case has highlighted the need for a multi-agency approach to managing mental health.

68. It also appears that AB received no support for mental health issues from which she may have been suffering. This points to a clear gap between CSC and ASC into which it appears AB fell.

69. There also appears to be a lack of understanding about the roles of SLaM and LPT in relation to the assessment and administration of a community order with a mental health requirement.

70. Children's Social Care

71. AB had been a looked after child and in the care of CSC since the age of six. She had had very difficult teenage age years although she was considered more settled as she prepared for independent living. The effective management and support of young adults into independent living should be considered as essential. AB may have needed more proactive and targeted intervention specifically designed for her circumstances.

72. Substance Misuse

73. There is comment about substance misuse within IMRs. There was a considered link between CD's psychosis and cannabis use but there appears to be no referral to substance misuse services or this being addressed by the mental health team.

74. Awareness and understanding of DV

75. There were no reported incidents of DV in relation to AB. It is clear that she had been subject to violence from men and considered it part of her life but she never reported DV to the police. AB had shown the confidence to report previous incidents of sexual violence but the pressures to avoid reporting can increase when the victim is in an intimate relationship. AB had expressed concerns of stress with boyfriends and needing time out, but it is unclear whether these statements were further explored, or related to her relationship with CD.

76. Culture of questioning

77. There are a number of occasions when both AB and CD were in contact with agencies and the circumstances were such that questions should have been asked about domestic circumstances.

78. The self-reporting of CD to LPT about the circumstances of his arrest should have generated questions by LPT about CD's risks to current or future partners.

79. In 2008 GP records note AB reporting stress related to her boyfriend and her foster carer had concerns about her behaviour and safety. This, and subsequent opportunities to discover the level of her safety or risk do not appear to have been explored.

80. AB may not have been forthcoming about her relationships and questioning could have been considered intrusive. The need for privacy should be balanced against the need to ensure AB's safety. Although she was no longer "looked after" by CSC, the Leaving Care Service was a provision that had the role of someone "looking out" for her.

81. Policies and processes

82. It appears that existing policies are in place within agencies to support identification and prevention of DV. This review leads to concerns that these processes have not been always been followed thoroughly. CD was also potentially an individual who could have been diagnosed as suffering from both mental health and substance misuse issues (dual diagnosis) and discussions between agencies could have been helpful.

83. Equality and Diversity

84. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.) The panel did not feel that these issues had a material bearing on the circumstances of this case or the subsequent review.

85. Family Contact

86. The guidance for DHRs recommends that families and friends should be a part of the DHR. The panel gave careful consideration to the involvement of AB's foster carer in the review process. It was considered that she was an employee of CSC and should be kept informed of the process, but not directly consulted, although her role in ABs care was included in the relevant IMR. Contact was made with AB's natural mother through the MPS Family Liaison Officer (FLO). AB's mother had not had any recent contact with AB. She made it very and repeatedly clear that she did not want any contact with the DHR panel chair or to be involved in the process. The mother of AB has now been spoken to by the Chair on three occasions (after the conclusion of the case) but with no useful conversation being possible. Attempts are continuing to discuss this review with her but this report cannot be delayed further.

87. At the conclusion of the case it was possible to speak with the foster carer of AB who looked after her as AB moved towards independence. As stated above this was not considered suitable until the conclusion of the case. Following a lengthy discussion she was firmly in support of the recommendations from the review, particularly those in relation to the Leaving Care Service. She also highlighted that vulnerable period for AB when moving from the care environment to adult life. She felt that AB was not ready for a separate existence but AB was insistent that this happened.

88. The perpetrator has not been interviewed but enquiries continue with his Consultant Psychiatrist to see if this can be arranged. It was agreed by the panel that this should not be attempted until after the case was complete. It was not deemed appropriate before any criminal trial and any attempts to gain information could have been considered as evidence gathering for the crown and disclosable in criminal proceedings.

89. Conclusions

90. Was this death preventable?

91. Although agencies have generally followed policies in relation to their internal working relationships, it has demonstrated that the dynamics of intimate relationships were not effectively explored. A crucial factor in this case is the failure of agencies to effectively share information. It is not possible to determine whether AB's death could have been prevented, but the lack of communication between agencies meant that the risks apparent now were not recognised and managed.

92. Failings have been discovered but not of sufficient gravity to indicate that AB's death could have been avoided if the circumstances within the agencies had been different. However, if information was shared, in line with established policy, then the heightened risk presented by CD could have been addressed. Standard processes may also not have been enough in this case. For example the transition from foster care to independent living was a time when AB, a very vulnerable individual, may have benefited from more comprehensive support.

93. Whilst information about CD is sparse prior to his arrest in March 2011 it is he who went on to kill AB. It is clear that agencies must consider the role of the perpetrator in DV cases with a view to understanding the dynamics and the possible indicators of their future abusive behaviour.

94. This case has highlighted the challenges that face a young person entering a stage of independent living when they have been previously "looked after" by CSC. This case emphasises the need to maintain a dynamic view of potential risks to vulnerable people. The scale of DV is known to all statutory agencies and management processes are there to address the obvious risks. If

agencies can consider the dynamics of personal relationships and the increased risk for DV at times of vulnerability, then future cases could be managed towards a more positive outcome.

Recommendations

(These are brief outlines of the full recommendations which are contained within the full report.)

1. That the partnership conducts a review of its effectiveness in its response to DV in relation to risk assessment, information sharing, policies and processes and the effectiveness of support to young people leaving care
2. That a new training strategy be designed to help practitioners understand DV and deliver the most effective responses
3. That the local approach to child sexual exploitation be considered by the Local Safeguarding Children's Board
4. That a policy of transferring care, when necessary and following risk assessment, from CSC to ASC be implemented.
5. That the issue of dual or triple diagnosis (DV/mental health/substance misuse) be the subject of a local project
6. That LPT and SLaM agree a process to ensure all relevant staff within both organisations are provided with guidance on how a community order with a mental health treatment requirement is assessed and administered.

Overview Report

95. Introduction

96. On 19 November 2011 the London Ambulance Service (LAS) were called to the home address of GR in Lewisham. The subject of this review, AB, had been staying at the address with her boyfriend CD, the nephew of GR. The Metropolitan Police Service (MPS) were called to the address by the LAS, informing them that a 22 year old female had been stabbed and the man responsible was still present. At the flat police found AB suffering from multiple stab wounds and CD was arrested. Despite the efforts of emergency medical services at the scene, AB's life was pronounced extinct. A murder investigation was launched and CD was charged with the offence of murder. He was found guilty of the offence of manslaughter on the grounds of diminished responsibility and remanded for reports. On 22nd February 2013 at the Central Criminal Court he was sentenced to a hospital order under S37 Mental Health Act 1980 without restriction of term.

97. These circumstances led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the Community Safety Partnership (CSP) in Lewisham. The initial meeting was held on 2nd February 2012 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death.

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

99. The purpose of these reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- 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
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100. This review process does not take the place of the criminal or coroners courts nor does it take the form of any disciplinary process.

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111. The independent chair of the DHR is Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic Violence an organisation dedicate to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the Borough of Lewisham or any of the agencies involved in this case.

112. There have been no parallel or similar reviews conducted into this case

113. The Facts

114. The death of AB

115. The victim, AB, was living temporarily in a flat in Lewisham where she died from stab wounds on 11th November 2011. She was 20 years old at the time of her death. The circumstances leading up to her death are as follows.

116. AB had been a looked after child in the care of the London Borough of Lewisham from the age of six to eighteen years. She had spent that time in foster care and moved into independent accommodation when she was 19. At the time of her death AB was receiving support from the Lewisham Leaving Care Service.

117. Although AB had her own flat, there were a number of reports showing that from July 2010 she was not living there on a regular basis. In October 2010 AB was in rent arrears and under threat of eviction. There were concerns over AB's tenancy and it is not known when she left her flat. An eviction notice was finally issued on 26th September 2011.

118. During 2011 AB had spoken of having a boyfriend but the identity of the boyfriend was not known to authorities. It is believed that a few months before her death AB stayed on a temporary basis at the home of a 45-year-old man, GR. The nature of the relationship between AB and GR is not known. It is believed that whilst staying with GR, AB started an intimate relationship with GR's nephew CD. The police homicide investigation indicates that this relationship had been on-going for approximately 6 months.

119. CD lived in the Lewisham area with his mother. He did not have record of any significant contact with statutory agencies until early 2011. In March 2011

CD had been taken into custody having attempted to gain entry to a house and was pursued by police. CD had climbed a roof and threw objects at police and was later arrested after a long negotiation. CD was assessed under the Mental Health Act as having had a psychotic episode. In August 2011 he was made subject of a Community order with Supervision and Mental Health requirement for 12 months. CD was generally compliant with probation and healthcare, but there were reported episodes when he had failed to take prescribed medication.

120. On 19th November 2011 GR called the LAS to his flat. He reported that a 22 year old woman in the flat had been stabbed. The LAS requested police assistance and upon arrival the police were told that the man responsible for the attack was inside the premises with a knife. Police entered the premises and found CD and arrested him. AB was found lying on a mattress in the front room suffering from multiple stab wounds. Helicopter Emergency Medical Services (HEMS) supported the LAS. Despite the efforts of the medical staff, AB was pronounced dead at the scene.

121. The MPS undertook the homicide investigation. A post mortem examination was carried out on AB, the cause of death being recorded as haemorrhage and multiple stab wounds. CD was charged with the murder of AB and remanded in custody. He has been found guilty of manslaughter by reason of diminished responsibility and awaits sentence.

122. AB and early contact with the statutory sector

123. The majority of information in this section comes from Lewisham Children Social Care (CSC) and General Practitioner (GP) Health records. AB came to notice of the statutory sector at an early age. Having been initially placed on the Child Protection Register, AB and her sister were later taken into Local Authority care when AB was aged five, due to poor parenting and neglect. In 1998 AB became subject to a full care order and remained with long-term foster parents. In 2002 when AB was 11 years old she disclosed that an older brother had sexually abused her (in 1998), when she had been living with a previous foster carer. Police were consulted but there was no criminal investigation into AB's disclosure following inter-agency consideration of the best approach to AB's wellbeing. It was agreed that prosecution was not in AB's interest and the crime report was noted as requiring no further action. AB was referred to Child and Adolescent Psychiatric Services for counselling.

124. In 2004 AB's apparent vulnerability increased as she began to abscond from her foster placement. She was known to her GP as being sexually active from the age of 13 and having unprotected sex. At one point, aged 14, AB was missing for over a month. Information was provided that she was associating with adults in Soho, Central London. At one point she was found at the house of a 40-year old man. The panel expressed concerns that this

activity left AB vulnerable to sexual exploitation. In November 2004 AB attended hospital reporting an assault by an ex-boyfriend. There were no obvious injuries seen and there is no record of a formal investigation. Whilst missing from her placement in 2005, AB disclosed to a friend that her foster carer had assaulted her when he intervened in a fight between AB and her sister.

125. AB was placed with a new foster carer and her younger sister remained in the original placement. AB would live with this carer until her move to her own flat in 2010.

126. AB continued to cause concerns for her carers. Her absconding continued and her foster carer believed that AB had no regard for her own safety. In 2006 AB reported that she had been abducted and raped by a male who was known to her. Police reported conversation with AB's foster carer whereby AB considered that being assaulted by men was part of her life. AB was supported in her placement and had a good relationship with her foster carer. She was referred for therapy and her social worker worked with her to consider her safety and sexual health.

127. When AB reached 16 years old her case was transferred to the Leaving Care Service. (She would be subject to statutory social work support and reviews until the age of 18.) CSC considered that AB's life began to settle and she was described to be behaving in a more age appropriate way. However, medical records indicate that AB had a long-term boyfriend. Issues with this boyfriend caused her stress and there were concerns about her sexual health. Police records show AB being convicted for an offence of assault on police in 2008.

128. In 2008 information was held by the Health Services that AB had sexual health issues and stress concerning her boyfriend, and that her foster carer was worried about her safety. At this time AB was 17 and whilst there may have been concerns around confidentiality and "Gillick Competence"[1], there is no record that AB's foster carer reported to CSC that she was concerned about AB's safety.

129. AB - The Period 2009 – 2011

130. The majority of information for this period comes from CSC records. CSC policy is that from the age of 18 to 21 years AB would be supported by a social services pathway advisor from the Leaving Care Service. The pathway advisor has a role to support the client and this includes supporting access to

[1] Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

education, employment and accommodation. At the start of 2009 when AB was 18 years old and still in her foster placement, plans were being made for her to move to independent living. South London and Maudsley (SLaM) NHS Foundation Trust records show a referral from Croydon Youth Offending Team (YOT) to Croydon Child Adolescent Mental Health Service (CAMHS). The referral was declined by CAMHS as she was over 18 years of age. No information is recorded on what generated this referral and AB was not then referred on to adult services.

131. CSC contact with AB in 2009 shows the completion of a pathway plan for AB to attend college and move from foster care into supported lodgings. In December 2009 AB was offered a flat. At this time AB met with CSC to discuss her accommodation and benefits. AB brought her boyfriend to that meeting; this person is not believed to be CD. It appears no discussion about the relationship with this boyfriend took place.

132. AB moved away from her foster placement and into her own flat in February 2010. She was visited in her flat when she first moved in by her Leaving Care worker. During this visit AB discussed a significant relationship with a boyfriend recently ending. The CSC records do not show any further meetings taking place in AB's flat.

133. In July 2010 AB informed CSC that she had been staying with her boyfriend; she said that she had been having problems with her key at her flat. During the remainder of 2010 AB was never seen at home. AB and her friends had informed CSC that she had either been staying with a boyfriend and on occasion with her mother and brother. It is not known whether this is the same person whom AB had reported sexually abused her as a child.

134. In October 2010 a CSC visit to AB's flat found another woman staying at the flat. At the end of 2010 AB was in rent arrears and at risk of eviction. During this period CSC made a number of attempts to engage with AB, but she did not always respond.

135. At the start of 2011 CSC continued to try and engage with AB, but she still missed appointments. Contact was made in March when AB attended a careers interview and an action plan was created to support her to gain employment. In March 2011 AB reported that she was staying with her cousin, as she could not access her flat. AB had no known source of income and was not claiming Job Seekers allowance. The source of any income for AB was never established or the means by which she obtained such, if any, income.

136. Although CSC recorded that AB had relationships with boyfriends, their identities were never established. CSC did not identify where AB was living when she was away from her flat. At some point in the spring of 2011, AB had an opportunistic meeting with her care worker in the street. AB was in the company of a man she introduced as her boyfriend, it is not known if this was CD. In May 2011 a pathway plan was completed with AB. This did not examine where AB had been living or the existence of any intimate relationships.

137. Throughout May and June 2011 there was limited statutory sector contact with AB and this is a voluntary process for the care leaver. During September AB began to visit CSC offices, mainly to complete college work, but she still had unresolved housing issues. She failed to keep appointments with the housing office and an eviction order was granted on 26th September 2011. AB was advised by CSC that if she were evicted she would be supported in accessing accommodation. In October 2011 AB informed CSC that she had been staying with her boyfriend in Lewisham, she mentioned that she sometimes had "time out" and stayed in her own flat. On 2nd November 2011 AB attended the CSC offices attempting to resolve housing problems. This was the last statutory sector contact with AB her death occurring on the 19th November 2011.

138. The perpetrator CD

139. In 1997, when CD was six, CD moved to live in the UK from Jamaica to stay with his mother and two sisters in Lewisham. There is no notable statutory involvement until the start of 2011. CD had not previously presented with any significant concerns to his GP or Health services. CD had contact with the police investigating reported robberies. He was questioned as a suspect on two occasions, but there was insufficient evidence to charge him with robbery. One of the investigations resulted in CD being convicted of driving offences.

140. In February 2011 it was reported to police that CD had recently been seen to be in possession of a knife at the Job Centre, Rushey Green. The report was made to police three days after the incident. Information was passed to the police intelligence unit, but no further investigation took place.

141. On 11th March 2011 CD attempted to gain entry to a house (possibly of a previous friend). This case involved CD being chased from the premises and throwing objects at police. On 12th March 2011 CD was referred to a court diversion service who arranged an assessment under Section 2 of the Mental Health Act. This resulted in a 28 day detention as an in-patient. This incident therefore led to the involvement of SLaM and a later referral to London Probation Trust (LPT) after the crown court case on the 4th August.

142. CD was admitted to Ladywell Mental Health Unit (Lewisham), for an assessment of his mental health including the possibility of drug induced psychosis and acute stress reaction. In his initial assessment CD said that things had gone wrong from the New Year, the impression of the junior doctor dealing with CD being that this was a first episode of psychosis and there was considered to be a link to cannabis use. He was assessed as presenting a low risk to others and not suicidal. There were regular visits and support from CD's family. A consultant told CD that he may be suffering from psychosis and was prescribed anti-psychotic medication. CD consistently refused to take this medication.

143. On 5th April 2011, after continued refusal to take medication, CD was restrained and medication administered under S.2 of the Mental Health Act. Shortly after this CD threatened staff with his belt and used force to abscond. CD was found the same day by the police and subsequently transferred to the Maudsley Hospital (SLaM). It was considered that CD was presenting with first onset psychosis. He was prescribed medication and discharged on 13th April 2011 to the care of the Community Mental Health team at Lewisham. CD's formal diagnosis was of "Mental Disorder".

144. SLaM recorded that a brief review of his risk was conducted on his admission to hospital in March 2011. This documented risks to CD being high, but low in relation to 'others'. Two further risk assessments were conducted in April 2011; these relate to CD absconding from an in-patient ward and following his later discharge from hospital. No further risk assessments were recorded by SLaM until after CD's arrest in relation to the homicide of AB.

145. CD was assessed at Lewisham Early Intervention Service as presenting low risk to himself or others. Information was passed to CD's GP confirming clear signs of psychosis and confirming his medication. CD was offered vocational support. CD was seen at home in June 2011 and assessed as being asymptomatic, making good progress and looking at vocational opportunities. At this time he also appeared to be complying with his anti-psychotic medication.

146. In July 2011 CD sustained a facial injury and according to SLaM records he stated that this resulted from a fight with three boys which he did not report to the police. CD was seen at the A & E department at Lewisham Hospital and by his GP in relation to this incident. CD continued to look for employment and was considered stable.

147. On 4th August 2011 CD appeared at Woolwich Crown Court where he pleaded guilty to causing a public nuisance for the offence for which he was arrested on the 11th March. CD was interviewed by LPT and they attempted

to speak with his psychiatrist without success. There was some consultation with SLaM and a pre-sentence report was submitted to court. On 31st August CD was sentenced to a Community Order for 12 months, with a Supervision and Mental Health Requirement, also for 12 Months.

148. LPT records relating to CD and this offence show that CD self-reported that the offence which related to the community order took place at the home of his ex-partner and he had thrown a brick through the window to gain entry when no-one answered the door. The LPT IMR indicates that this may have been a case of DV and this should have led to further actions within LPT (e.g. a spousal risk assessment and enquiries with the police) but these did not happen. The police view is clear that this incident was correctly recorded as an attempted burglary and not as a DV incident. Whilst CD states this event took place at the house of an ex-partner that in itself does not provide sufficient evidence that his actions were intended to abuse this person in any way. It would only have been possible to establish a theme of DV if further enquiries and actions had been taken by LPT.

149. LPT Risk Management Plans require that enquiries should be made with police Borough Intelligence Units (BIU) but this did not happen. At the time of completion of the plan the BIU records would have informed LPT that CD was carrying a knife in public at the start of 2011 at the Job Centre. This information would have informed processes addressing risk to the public, SLaM and LPT staff. Given that gaining employment was an element of the sentence plan, the information held by police was an important element of any future action.

150. LPT were responsible for managing the community order. There is no evidence that details of the court sentence and mental health requirement of the community order were communicated to SLaM. SLaM sought information from CD on the nature of his sentence in the absence of other information. LPT records indicate one attempted contact with the Community Psychiatric Nurse after sentence. It is not known whether SLaM action on CD's failure to take medication could have been more robust if they had been made aware of the mental health element to the community order. The failure of CD to take medication is not noted on LPT records.

151. The primary care for CD is provided by his GP. The GP has recorded occasions when CD had not been taking prescribed medication. It is not clear that this information was communicated to SLaM who were providing the secondary care. The GP was the primary carer prescribing anti-psychotic medication to CD but was not aware of the existence of the mental health requirement of the court order.

152. In September 2011 CD visited his GP who recorded that he had not taken medication for three weeks. He was seen two days later during a home visit from his community health team. He was assessed as having good insight into his illness and not reporting any side effects. SLaM records do not reflect the information provided to the GP that CD was not taking medication. CD was subject to a medical review where he seemed to be functioning well. CD met with the LPT Offender Manager and discussed his sentence plan, which focused on mental health, employment and training. CD was risk assessed as presenting medium risk to public and known adults. CD attended all scheduled appointments with LPT in September and October.

153. At the start of October 2011 the Offender Manager left a message for the Community Psychiatric Nurse but there is no record of any follow up to this message. CD was seen by his mental health team on two occasions in October and he was described as feeling better, it was again noted that he had not been taking medication.

154. On 2nd November 2011 CD met with his Offender Manager and indicated that accommodation was a problem. On 9th November CD's GP noted that he had not been taking medication for a week and a new prescription was issued, on that same day CD missed an LPT appointment. CD then attended LPT offices on 17th November a day late for the rescheduled appointment. CD had mistaken the 17th for 16th November. This was the last contact before CD was arrested for the murder of AB on the 19th November 2011.

155. AB and CD 2011

156. It cannot be certain when AB and CD met. MPS information indicates that AB moved into GR's flat one or two months before her death and probably knew CD for 6 months prior to the murder. It is believed that a drug dealer was using AB's home and her heating system had been stolen. AB was apparently offered accommodation at GR's flat by a friend of GR. There is no evidence of any intimacy between AB and GR. It is not known how or when AB met CD who is the nephew of GR. It is not known if CD was ever resident at his uncle's flat. There are no records of CD's relationship to GR recorded by SLaM or LPT. In June 2011 CD was seen at his mother's address during a SLaM home visit.

157. There are no formal statutory records linking AB and CD before the events of 19th November 2011. There are acknowledgements that AB had a boyfriend during this period. On 25th October 2011 she informed CSC that she sometimes stayed with her boyfriend in Lewisham and occasionally needed to take time away from him. CD is never mentioned by name as AB's intimate partner and CSC have no records relating to him.

158. It appears that some statutory agencies (LPT and Leaving Care Service) could have taken more steps to establish the existence of the personal relationships of AB and CD. At this time AB was known to have been vulnerable and not staying at her home. She had no obvious form of income and had previously been considered as a victim of exploitation. There was some limited evidence of CD's potential propensity for violence. He was under court legal supervision and assessed as being "medium risk" to the public and known adults in September 2011(although this was not known to all agencies). It is highly likely that CD was associating with AB at that time.

159. Analysis

160. There is considerably more information about AB and spread over a longer period than is available for CD within the records of the statutory sector. The following analysis examines the lives of the victim of this murder and the perpetrator but nothing should detract from the fact that CD took AB's life and he has been found responsible for that act. Nothing in AB's life could have ever possibly justified her murder. It may be true that had her vulnerability been approached more comprehensively safer options could have been sought to allow her to live a life free from violence.

161. Since AB was 11 years old, statutory services knew that she had been vulnerable to sexual abuse and later to possible exploitation by males. There was information that her elder brother had abused her at home and she was known to be sexually active from the age of 13. She had reported to health services that she had been assaulted by an ex-boyfriend, abducted and raped by a male known to her and had been reported missing on a number of occasions subsequently being found in high risk circumstances. These events did not lead to significant action or investigation. After AB reached 16, CSC considered that she was becoming more settled. However, at this time her GP had recorded concerns about stress caused by a boyfriend and sexual health issues.

162. As AB moved away from foster care into independent living it was important that she was supported to continue to develop a safe lifestyle. Ultimately it was during this period that she came into contact with CD. By March 2011 information was available to statutory authorities that CD had been seen in possession of a knife, and subsequently found to have mental health issues. Information was available to LPT in August 2011 that CD had self-reported that he had tried to use force to enter the premises of an ex-partner. Although information sharing is key to managing risk, it appears that there were gaps in the information sharing processes that would have thrown light on any relationships and the place of residence of AB or CD thereby informing risk assessment processes. It is not clear from the information provided whether AB had refused to provide information about her current boyfriend and where she was staying, or whether she had not been asked for that information.

163. The panel were also clear that many of the discussions that took place between AB and CD and caring agencies were voluntary in nature. The Leaving Care Service has no power to demand contact or information. Similarly much of CD's care was based around what he chose to tell his workers. CD did on a number of occasions admit or state things which were relevant to his circumstances. For example he told his GP and other health professionals about not taking his medication but this did not lead to any apparent action.

164. Individual agencies reviewed their interactions with AB and CD and failure to fully meet guidelines on pathway planning and risk assessment were found. Individual agencies did not feel that the evidence available to them would have predicted the outcome in this case. However if parties had been asked appropriate questions there is a possibility that the relationship between AB and CD could have been identified. When all information from statutory agencies is shared it does create a picture of risk to AB's personal safety.

165. Before the death of AB there was no evidence within statutory agencies that she was in an intimate relationship with CD. In this case AB had not reported any violence from CD to agencies that may have provided help.

166. With all the foregoing in mind the issues raised within the panel meetings and which should lead to further consideration for the future are as follows.

167. Information Sharing

168. Information sharing is a crucial element essential to the prevention and management of DV. There was a lack of information sharing in both inter and intra-agency working.

169. Within criminal justice agencies, police possessed information about CD's possession of a knife and LPT had information about the possible domestic nature of an incident and this intelligence may have changed risk management plans. (In actuality if probation had contacted police about the "possible domestic nature" of this offence the likelihood is that it would have been assessed as not being one of domestic violence.) There are also concerns about the information sharing between LPT and SLaM. Sharing this information may have enhanced the quality of pre-sentence reports and management of CD's post sentence care.

170. In dealing with intra-agency communication it is not apparent that information held by the NHS GP on CD's adherence to prescribed medication was passed to SLaM. SLaM were reliant on their patient, CD, to provide this

information. SLaM also relied on CD to provide information on his community sentence.

171. LPT do not consider that the mental health requirement of CD's order was fulfilled (through non-compliance with drug medication regime). With increased contact between SLaM and LPT the latter could have been in a position to enforce a breach of his order.

172. Risk Assessment

173. There was a failure to complete a spousal risk assessment by the one agency that at least had information to suspect DV. Where there were more generic processes it appears that the importance of relationships and the prevalence of DV were not sufficiently considered. The consideration for inter and intra-agency information gathering is essential to identify and manage risks. Risk assessment should be considered as an on-going and dynamic process

174. Understanding of the existence of DV with AB

175. Statutory agencies were not aware of DV being present whilst AB was in the process of leaving care. She was a vulnerable young woman and violence from males had previously been present in her life. AB had expressed concerns over stress with a boyfriend and needing "time out" from a relationship. These statements and her relationships to do not appear to have been explored in depth by statutory agencies. In 2008 AB's foster carer expressed concerns about her safety to her GP but it is not apparent if she provided the same information to CSC.

176. It was recorded in LPT records that CD was involved in a crime of violence towards property belonging to an ex-partner. This is not supported by police reports that remain of the view that this was an attempted burglary, but LPT took no steps to explore CD's background and conduct the appropriate risk assessment.

177. It is apparent that agencies were not sufficiently aware of the personal circumstances of either party to assess, respond or refer any potential DV issues.

178. Police action

179. There are no concerns over the initial response to the death. MPS staff were provided with very clear evidence on the date of the incident; the responsibility for AB's care at the scene was clearly with the LAS once the risk presented by CD was removed. CD was in custody following his arrest and is now detained in secure accommodation.

180. There is an apparent lack of action in failing to fully investigate an incident where CD was seen to drop a knife in the Job Centre in January 2011. This matter was recorded for information on police officer safety, but it is not apparent what consideration was given to public safety.

181. Mental Health

182. The issue of mental health is common within many incidents of DV. This is clearly apparent in relation to CD. As a result of the circumstances of his arrest in March 2011 CD was subject to statutory involvement with Mental Health agencies within hospital and community settings. This case has highlighted the need for a multi-agency approach to managing mental health. It is clear that regular communication between NHS primary/secondary care and probation would have identified the failure of CD to comply with treatment and possible legal enforcement to support the care plan.

183. It should be noted that AB had been referred to CAMHS services but at the time of the referral she was aged 18 and was not within the service criteria. Although the referral came from a YOT there is no information as to what the concerns of the referring agency were. Having been outside CAMHS remit it appears that AB received no subsequent support for mental health issues. This points to a clear gap between CSC and ASC into which it appears AB fell.

184. There also appears to be a lack of understanding about the roles of SLaM and LPT in relation to the assessment and administration of a community order with a mental health requirement.

185. Children's Social Care

186. AB had been a looked after child and in the care of CSC since the age of six. She had had very difficult teenage age years although she was considered more settled as she prepared for independent living. The effective management and support of young adults into independent living should be considered as essential. This is a vital role for social care when the young person has spent so long being 'looked after' and where they do not have the same family support and networks that others may have. This is especially true when they have such a history as is evident in ABs case. Whilst there were activities, processes and pathway plans in place their effective implementation are crucial, and, in such cases AB may have needed more proactive and targeted intervention specifically designed for her circumstances. Whilst processes were clearly followed they may not have been thorough enough in ABs case.

187. Support Services

188. At the time of AB's death there was no identified need for her to access specialist DV support services. Support for both parties had been provided through statutory agencies to address education, employment, health and housing.

189. Substance Misuse

190. There is comment about substance misuse within IMRs. On CD's initial admission to hospital for mental health assessment in March 2011 there was a considered link between his psychosis and cannabis use. He stated he had used cannabis since the age of 17 and he tested positive for the drug on admission. During his care substance misuse was identified as an issue but there appears to be no referral to substance misuse services. It is also true that cannabis use was not identified as problematic to his mental health after his initial admission. Substance misuse services tend to deal with "high end" drug users and referral in this case may not have been appropriate but there is no evidence of this issue being actively addressed by the mental health team.

191. Awareness and understanding of DV

192. There were no reported incidents of DV in relation to AB. It is clear that she had been subject to violence from men and considered it part of her life but she never reported DV to the police. AB had shown the confidence to report previous incidents of sexual violence but the pressures to avoid reporting can increase when the victim is in an intimate relationship. AB had expressed concerns of stress with boyfriends and needing time out but it is unclear whether these statements were further explored, or related to her relationship with CD.

193. Culture of questioning

194. There are a number of occasions when both AB and CD were in contact with agencies and the circumstances were such that questions should have been asked about domestic circumstances.

195. It is not clear from LPT or SLaM IMRs whether CD was asked about his intimate relationships. It is apparent that home visits were being conducted at CD's mother's house and CD was considered to be living there. On 2nd November 2011 CD indicated to LPT that accommodation was a problem. Those problems were not explored and it is not recorded whether he was questioned about his domestic arrangements. The self-reporting of CD to LPT about the circumstances of his arrest should have generated questions by LPT about CD's risks to current or future partners.

196. In 2008 GP records note AB reporting stress related to her boyfriend and her foster carer had concerns about her behaviour and safety. This does not

appear to have been explored. On 23rd November 2010 CSC made a home visit and AB was not present, and was possibly in Liverpool with her brother. There was no recorded contact with AB until a telephone call in February 2011. Although AB was 19 years old at the time given the history of vulnerability and previous concerns about her brother it does not seem inappropriate for AB to be asked about her whereabouts, family relationships and personal safety.

197. On 25th October 2011 AB was spoken to by phone. She told CSC that she sometimes stayed with her boyfriend and sometimes took time out. At this time she had no obvious means of support. AB visited the CSC office on two occasions after this and it is not recorded that she was asked where she was staying and the nature of any relationships.

198. AB may not have been forthcoming about her relationships and questioning could have been considered intrusive. The need for privacy should be balanced against the need to ensure AB's safety. Although she was no longer "looked after" by CSC, the Leaving Care Service was a provision that had the role of someone "looking out" for her.

199. Policies and processes

200. It appears that existing policies are in place within agencies to support identification and prevention of DV. This review leads to concerns that these processes have not been always been followed thoroughly. Within LPT there are concerns that a spousal risk assessment was not conducted with CD and there was a failure to make enquiries with the police intelligence unit. CD was an individual who could have been diagnosed as suffering from both mental health and substance misuse issues (dual diagnosis) and discussions between LPT and other agencies could have been helpful.

201. Within CSC there is guidance on elements required for a pathway plan but the issues of AB's housing and social relationships were not considered in depth whilst she was living independently.

202. Family Contact

203. The guidance for DHRs recommends that families and friends should be a part of the DHR. The panel gave careful consideration to the involvement of AB's foster carer in the review process. It was considered that she was an employee of CSC and should be kept informed of the process, but not directly consulted, although her role in ABs care was included in the relevant IMR.

204. Contact was made with AB's natural mother through the MPS Family Liaison Officer (FLO). AB's mother had not had any recent contact with AB. She made it very and repeatedly clear that she did not want any contact with DHR panel chair or to be involved in the process. The mother of AB has now been

spoken to by the Chair on three occasions (after the conclusion of the case) but with no useful conversation being possible. Attempts are continuing to discuss this review with her but this report cannot be delayed further.

205. At the conclusion of the case it was possible to speak with the foster carer of AB who looked after her as AB moved towards independence. As stated above this was not considered suitable until the conclusion of the case. Following a lengthy discussion she was firmly in support of the recommendations from the review, particularly those in relation to the Leaving Care Service. She also highlighted that vulnerable period for AB when moving from the care environment to adult life. She felt that AB was not ready for a separate existence but AB was insistent that this happened.

206. The perpetrator has not been interviewed but enquiries continue with his Consultant Psychiatrist to see if this can be arranged. It was agreed by the panel that this should not be attempted until after the case was complete. It was not deemed appropriate before any criminal trial and any attempts to gain information could have been considered as evidence gathering for the crown and disclosable in criminal proceedings.

207. Equality and diversity

208. The nine protected characteristics as defined by the Equality Act of 2010 have all been considered within this review. (They are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.) The panel did not feel that these issues had a material bearing on the circumstances of this case or the subsequent review.

209. Conclusions

210. The issue of preventability

211. This case allows examination of current statutory systems and processes in relation to risk assessment, management and domestic violence. Although agencies have generally followed policies in relation to their internal working relationships, it has demonstrated that the dynamics of intimate relationships were not effectively explored. A crucial factor in this case is the failure of agencies to effectively share information. It is not possible to determine whether AB's death could have been prevented, but the lack of communication between agencies meant that the risks apparent now were not recognised and managed. Therefore better inter-agency communication may prevent future tragedies.

212. The IMRs across statutory agencies highlight failings but not of sufficient gravity to indicate that AB's death could have been avoided if the circumstances within the agencies had been different. However, if information was shared, in line with established policy, then the heightened risk presented by CD could have been addressed. Standard processes may also not have

been enough in this case. For example the transition from foster care to independent living was a time when AB, a very vulnerable individual, may have benefited from more comprehensive support.

213. For these reasons it is important to test the performance of the agencies working individually and together to satisfy the partnership that things have improved. The recommendations are designed to achieve this outcome and fall largely into the following areas:
    - Partnership effectiveness
    - Risk assessment
    - Information sharing
    - Policies and processes (including referral/care pathways)
    - Training – dynamics and practice
    - Culture of questioning

214. Whilst information about CD is sparse prior to his arrest in March 2011 it is he who went on to kill AB. It is clear that agencies must consider the role of the perpetrator in DV cases with a view to understanding the dynamics and the possible indicators of their future abusive behaviour.

215. This case has highlighted the challenges that face a young person entering a stage of independent living when they have been previously "looked after" by CSC. As she was entering that new environment AB came into contact with CD at a time that he was presenting with potential risks and the need for supervision and medical care. Whilst this case does not reveal a failure to deal with long standing issues of DV, it does highlight the need to maintain a dynamic view of potential risks to vulnerable people. The scale of DV is known to all statutory agencies and management processes are there to address the obvious risks. If agencies can consider the dynamics of personal relationships and the increased risk for DV at times of vulnerability, then the future cases could be managed towards a more positive outcome.

216. Recommendations

217. The recommendations below are, in the main, for the partnership as a whole but many organisations have internal recommendations which mirror these. It is suggested that the single agency action plans should be subject of review via the action plan hence the first recommendation.

1) That all agencies report progress on their internal action plans to the relevant task and finish group of Lewisham CSP.
2) That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the Lewisham CSP, to include an examination of:
    - The risk assessment processes across all agencies coming into contact with victims and perpetrators of DV, sexual violence or potentially unhealthy relationships
    - The effectiveness of information sharing

- The existence and application of agency polices and procedure in relation to DV
- The effectiveness of support to young people leaving care.

3) That a new training strategy be designed, following the review:
   - to allow frontline practitioners to understand the dynamics of DV and good practice, and,
   - to support an increase in questioning about DV and potential risk
   - to support an increase in questioning around healthy relationships.
4) That the Leaving Care Service examine its processes (including risk assessment) when young people move towards independent living, to include consideration of the method of making plans according to specific need and the maintenance of appropriate records, including paper and computer based.
5) That all senior managers in CSC ensure that the police are requested to investigate any crime where any looked after young person is the victim or perpetrator.
6) That the local approach to child sexual exploitation be considered by the Local Safeguarding Children's Board.
7) That a policy of transferring care, when necessary and following risk assessment, from CSC to ASC be implemented.
8) That the issue of dual or triple diagnosis (DV/mental health/substance misuse) be the subject of a local project to establish understanding and future processes.
9) That LPT and Slam agree a process to ensure all relevant staff within both organisations are provided with guidance on how a community order with a mental health treatment requirement is assessed and administered and any case where clients are being cared for by both organisations.
10) That SLaM teams in Lewisham are made aware of referral routes and criteria for the appropriate organisation where cannabis or other type of substance misuse is discovered.

Glossary of acronyms	
LAS	London Ambulance Service
MPS	Metropolitan Police Service
DHR	Domestic Homicide Review
CSP	Community Safety Partnership
IMR	Individual Management Review
SLaM	South London and Maudsley NHS Foundation Trust
LPT	London Probation Trust
HEMS	Helicopter Emergency Medical Service
CSC	Children's Social Care (Children's Social Services)
ASC	Adult Social Care
GP	General Practitioner
YOT	Youth Offending Team
CAMHS	Child and Adolescent Mental Health Service
BIU	Borough Intelligence Unit
NHS	National Health Service
DV	Domestic violence

Appendix 1.

Domestic Homicide Review Terms of Reference for AB

This Domestic Homicide Review is being completed to consider agency involvement with AB, and CD, following the murder of AB on 19th November 2011. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

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

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

3) To review the involvement of each individual agency, statutory and non-statutory, with *AB* and *CD* during the relevant period of time: 1st January 2007 – 19th November 2011.

4) To summarise agency involvement prior to 19th November 2011.

5) The contributing agencies to be as follows:
   a) South London and Maudsley (SLaM)
   b) Lewisham Healthcare NHS Trust
   c) Metropolitan Police
   d) Lewisham Children Social Care
   e) GPs
   f) London Probation Trust

6) For each contributing agency to provide a chronology of their involvement with the victim, AB and alleged perpetrator, CD during the relevant time period.

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

8)
   a) For each contributing agency to provide an Individual Management Review: identifying the facts of their involvement with *AB* and/or *CD*, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.
   b) To consider issues of activity in other boroughs and review impact in this specific case.

9) In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following five points:
      1. Analyse the communication, procedures and discussions, which took place between agencies.

2. Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
3. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
4. Analyse agency responses to any identification of domestic abuse issues.
5. Analyse organisations access to specialist domestic abuse agencies.
6. Analyse the training available to the agencies involved on domestic abuse issues.

   And therefore:
   i) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
   ii) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
   iii) To improve inter-agency working and better safeguard adults experiencing domestic abuse.

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

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

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

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

14) To establish a clear action plan for individual agency implementation as a consequence of any recommendations.

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

16) To provide an executive summary.

17) To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Safer Lewisham Partnership, with subsequent learning disseminated to the Domestic Violence Forum and the local MARAC, where appropriate.

Appendix 2

Panel Members and agencies represented

Agency	Panel Member
Children's Social Care	Jo Cross / Amy Weir
Health – GP	Dr Nicola Payne
Healthcare NHS Trust	Dr Teresa Sealy
Local authority – Community services	Aileen Buckton
Local authority – Crime reduction	Geeta Subramaniam-Mooney
Local authority – DV lead	Ade Solarin
Local authority – Joint commissioning	Dee Carlin
London Probation Trust	Becky Canning
Mental Health	Jo Lawrence
Metropolitan Police – Specialist Crime Review Group SC&O	Natalie Cowland
	Phil Fitzgerald
Metropolitan Police – Lewisham Public Protection Desk	Greg Pople
Standing Together Against Domestic Violence	Anthony Wills (Chair)
	Annie Poland
SLaM	Wanda Palmer, Abigail Fox-Jaeger

Appendix 3
DHR
Action Plan

All recommendations will be overseen by the Lewisham Community Safety Partnership supported by a task and finish sub group of that partnership.

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 1 – Local partnership					
That all agencies report progress on their internal action plans to the relevant task and finish group of Lewisham CSP.	Agencies to bring regular updates on actions to the T&F Group meetings	All agencies	Task and Finish Group meetings are now held quarterly.	On going	On going
That the partnership conducts a review of its effectiveness to establish its strengths and weaknesses. This review, which should be completed by a task and finish sub-group of the Lewisham CSP, to include an examination of: • The risk assessment processes across all agencies coming into contact with victims and perpetrators of DV, sexual violence or potentially unhealthy relationships.	<u>Action for CSC</u> DV policy for CSC to be completed and circulated to reflect effective risk assessment procedures regarding victims	All agencies CSC – Ian Smith	 Confirmation to be sent by senior managers	 July 2013	 July 2013

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
	and perpetrators of DV, sexual violence or potentially unhealthy relationships.		ASC, SCAIT have embedded a safeguarding process that considers domestic, sexual violence. Training has been implemented.		DV training provided November 2012
• The effectiveness of information sharing	Action for CSC, as above. .	CSC – Ian Smith	Confirmation to be sent by senior managers.	July 2013	July 2013
			Lewisham Healthcare NHS Trust has updated policies in place that advise on confidentiality issues when an individual discloses that are they are being harmed or abused.	February 2013	February 2013
• The existence and application	Action for CSC	CSC – Ian Smith		July 2013	July 2013

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
of agency polices and procedure in relation to DV	DV policy for CSC to be completed and circulated to reflect effective risk assessment procedures regarding victims and perpetrators of DV, sexual violence or potentially unhealthy relationships.				
			<u>Lewisham Health Actions</u> Telephone meeting between Health and the borough Domestic Violence Lead in regards to accuracy of reporting and how this can be improved completed.	February 2013	February 2013
			Domestic Violence Policy completed.	February 2013	March 2013
			Domestic Violence Policy has	February 2013	February 2013

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
• The effectiveness of support to young people leaving care		CSC – Ian Smith	been reviewed by the Borough Lead for Domestic Violence to ensure the policy works with multi-agency process.		
	Audits		Domestic Violence risk assessment tool on intranet.	January 2013	January 2013
			Increase in MARAC referrals has been noted.	February 2013	February 2013
			Reference to Domestic Violence within the Safeguarding Adults at Risk Policy.	February 2013	
			Lewisham Healthcare Staff can also use the adult safeguarding procedure to escalate concerns.	February 2013	
			Attendance to information sharing groups – MARAC, Safeguarding Board, Safeguarding Sub group.	Ongoing	Complete – ongoing
			Lewisham Healthcare NHS Trust Governance systems. Reporting structure up to Board level.	Ongoing	Complete – ongoing
			<u>Adult Social Care Actions</u>		ASC timescale

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
			ASC are updating their local pan-London safeguarding process to reflect DV within the safeguarding process. An audit has been completed and proposals for targeting help to care leavers have been agreed and are in the process of being implemented by Service Manager for Leaving Care.	 Ongoing	September 2013 September 2013
Theme 2 – Processes					
That the Leaving Care Service examine its processes (including risk assessment) when young people move towards independent living, to include consideration of the method of making plans according to specific need and the maintenance of appropriate records, including paper and computer based.	Audit	CSC – Ian Smith	Audit completed which led to proposals for developing a targeted service.	Ongoing	October 2013
That all senior managers in CSC ensure that the police are requested to investigate any crime where any looked after young person is the victim or perpetrator.	Correspondence to be sent to SMT.	CSC – Ian Smith	Briefing sent to all CSC staff regarding this.	June 2013	June 2013

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
That a policy of transferring care, when necessary and following risk assessment, from CSC to ASC be implemented.	CSC will highlight cases that require on-going support from ASC as part of transition planning	ASC – Joan Hutton CSC – Ian Smith	On-going		On-going
That LPT and Slam agree a process to ensure all relevant staff within both organisations are provided with guidance on how a community order with a mental health treatment requirement is assessed and administered and any case where clients are being cared for by both organisations.	LPT and SLAM to ensure that all relevant staff are given guidance on how a Community Order with a Mental Health Treatment Requirement should be assessed for, and administered.	LPT Louise Hubbard SLaM – Wanda Palmer			
That SLaM teams in Lewisham are made aware of referral routes and criteria for the appropriate organisation where cannabis, or other type of substance misuse is discovered.		SLaM – Wanda Palmer CCG – Dee Carlin			
Theme 3 – Local Safeguarding Children's Board					
That the local approach to child sexual exploitation be considered by the Local	That CSE should be a priority for the LSCB	CSC – Ian Smith	The LSCB has considered CSE and an annual report has been submitted to the LSCB for	June 2013	June 2013

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Safeguarding Children's Board			information in June 2013		
Theme 4 – Training					
That a new training strategy be designed, following the review: • to allow frontline practitioners to understand the dynamics of DV and good practice, and, • to support an increase in questioning about DV and potential risk • to support an increase in questioning around healthy relationships	<u>Lewisham Health actions</u> To plan domestic violence into new training programme The partnership to undertake a comprehensive assessment and exploration of options for learning i.e. e-learning packages for borough-wide staff	All agencies Lewisham Healthcare CRS – Ade Solarin LSCB – Marinda Beaton SAB – Brian Scouler	ASC have implemented training for SCAIT. This will be audited	April 2013 November 2012	November 2012
Theme 5 – Further projects					
That the issue of dual or triple diagnosis (DV/mental health/substance misuse) be the subject of a local project to establish understanding and future processes.	Research to be conducted in the area of the aforementioned to determine effective usage in the borough	Crime Reduction Service / CRI / SLaM		August 2013	