Version number 3

Executive Summary

Domestic Homicide Review

The London Borough of Croydon

Case of Janice

Independent Chair: Anthony Wills and Victoria Hill

November 2014

Introduction

1.1 This executive summary outlines the process and findings of a domestic homicide review undertaken by the London Borough of Croydon into the murder of Janice. The identity of those involved in this review have been anonymised for the purposes of confidentiality and pseudonyms have been used.

1.2 The perpetrator Jacob, Janice's ex-partner, has been sentenced to eight years custody. The judge stated in his sentencing comments that this was not a case of domestic abuse; therefore, did not increase the sentence which that criteria, if present, would attract. The Domestic Homicide Review panel believe that the judge's views show a lack of understanding of domestic violence and the nature of abusive relationships. The panel are clear that this is a domestic homicide and the review has proceeded on that basis.

1.3 Following his conviction, Jacob was written to about the review; however, he declined to engage with the process.

Facts

2.1 Janice had been out with her friends in the evening and returned to a friend's address in the early hours (at around 04:00hrs) to collect her car and then left. She was due to collect her children (a friend was looking after the children) to take them to nursery at approximately 08:00hrs that same morning. Shortly after she had collected her car, the Police were called to an argument at the address of Janice's ex-partner (Jacob) by his current partner, stating that Janice was knocking on the door.

2.2 Police attended and spoke with Janice and Jacob. They were having a verbal argument and no criminal allegations were made to the Police. Janice told the officers she went to his address to speak to him as he had been ignoring her and had not seen their son (Ethan) for five months since he had started a new relationship.

2.3 The Police advised Jacob to back to his home (as they were out in the street). He returned home and following an argument with his current girlfriend, she then left his address. The Police officers at the scene offered Janice a lift, which she refused. She stated she was going to her friend's and then left the area. The Police officers remained at the scene for about ten minutes whilst they completed their paperwork before leaving.

2.4 This was the last time Police saw Janice alive.

2.5 Janice failed to collect her sons at 08:00hrs (from a friend who was looking after the children overnight). As this was out of character for Janice, and after the friend had made several unsuccessful attempts to contact her, they contacted the Police and reported Janice missing. As part of the missing person enquiries, Jacob was spoken to as a witness the following day.

2.6 As concerns about Janice's whereabouts increased, Jacob was interviewed as a potential suspect by the Police. This led to his arrest and further interview.

2.7 Jacob made admissions in the Police interview to killing Janice. He stated that she had picked up a claw hammer from the kitchen worktop and hit him, causing two minor abrasions on his forearm. A struggle ensued resulting in him pushing her backwards away from him using open palms. He stated that Janice hit her head when she fell to the ground. Janice was unconscious but breathing. Jacob tried to rouse her but she had stopped breathing. Jacob stated it was an accident. He placed Janice's body in a bag, wrapped it in a sheet, and placed it in the boot of his car where it remained until he declared its location in Police interview.

2.8 Jacob was subsequently arrested for Janice's murder. When cautioned, he replied "I didn't murder her". As a result of disclosures made in interview, his car was located. Janice's body was discovered by police officers in the boot of his vehicle. Janice's life was pronounced extinct by the London Ambulance Service at 14.52hrs.

2.9 **The relationship between Janice and Jacob**

2.9.1 The couple had been separated for a year following a long-term relationship. Janice and Jacob had one child together (Ethan). Janice had another child (Aiden) from a previous relationship with David. At the time of Janice's death, Jacob was in a new relationship and no domestic violence has been disclosed or reported in this new relationship.

2.9.2 A family genogram is included to assist the reader (see Appendix 2).

2.10 **The perpetrator - Jacob**

2.10.1 Jacob is of Black British Caribbean origin. There was limited involvement with his GP from first registering as a child. He had an early history of road traffic accidents and alleged confrontation with the Police as a teenager. There are three contacts with health services which may be relevant to the issues being considered by the review:

2.10.2 Early in 2000, Jacob attended his GP regarding swelling to his left hand allegedly having assaulted a policeman.

2.10.3 In August 2005, Jacob was seen with a fracture to his right hand, but there is no record of how this injury was caused.

2.10.4 In the Autumn of 2011, Jacob attended A&E accompanied by the Police after he had sustained a laceration near his left eye caused by a fight with another driver.

2.10.5 It is noted that Jacob had a different GP than Janice. He was known to the Probation Service.

The Domestic Homicide Review Process

3.1 Following the death of Janice, a Domestic Homicide Review (DHR), established under Section 9(3), Domestic Violence, Crime and Victims Act 2004, was implemented by the London Borough of Croydon Community Safety Partnership.

3.2 The purpose of the Domestic Homicide Review is to:

3.2.1 Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

3.2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

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

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

3.3 The Independent Chair

3.3.1 Throughout the review until November 2013, the independent chair of the DHR was Anthony Wills. Anthony Wills was an ex-Borough Commander in the Metropolitan Police, and was previously the Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing effective, coordinated

responses to domestic violence. Anthony Wills retired from Standing Together in November 2013 and also from his position as independent chair of this review.

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

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

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

3.5 The full terms of reference are included in the overview report. 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, to help improve practice and prevent similar events happening.

3.6 The review began with an initial meeting in March 2013 of all agencies that potentially had contact with Janice and Jacob prior to her death. The time period subject to review as set out in the terms of reference were 01/01/2005 – to the date of Jacob's charge for Janice's murder.

3.7 It was also considered helpful to involve agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

3.8 Croydon Safeguarding Children's Board did not undertake a serious case review and no other parallel reviews were conducted.

3.9 Agencies participating in the review are:

- Metropolitan Police – Croydon borough and Critical Incident Advisory Team
- Croydon Council – Public Realm and Safety
- Croydon Council – Social Care and Family Support
- Croydon Council – Public Health
- Croydon Council – Croydon Council – Adult Social Services and Housing*

- Croydon Council – Safeguarding and Looked After Children Service
- NHS England (Croydon Clinical Commissioning Group)
- Croydon Health Services NHS Trust
- London Probation Trust
- South London & Maudsley NHS Foundation Trust
- Croydon Council Family Justice Centre
- Standing Together Against Domestic Violence (chair).

Individual Management Reviews

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

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

4.2 Eight of the eleven agencies involved in the panel responded as having contact with the individuals concerned. These agencies were:

- Metropolitan Police
- Croydon Council – Croydon Council – Adult Social Services and Housing
- Croydon Council – Safeguarding and Looked After Children Service
- NHS England (Croydon Clinical Commissioning Group)
- Croydon Health Services NHS Trust
- London Probation Trust
- South London & Maudsley NHS Foundation Trust
- Croydon Council Family Justice Centre.

4.3 Croydon Landlord Services provided an IMR and a chronology for the review and were represented by Croydon Council (Adult Social Services and Housing).

Contact with family and friends

5.1 Members of Janice's family were approached about contributing to the review. Janice's friends did express an interest in involvement but despite several attempts and conversations this has not taken place. Similarly, Janice's father was contacted by Anthony Wills, but has not subsequently responded to requests for further involvement. Janice's mother has contributed significantly to the review.

5.2 Janice's mother's concerns about her daughter's death centre on two particular areas.

5.2.1 First, she believes that the action of the Police when called to the incident on the night Janice disappeared should have been more effective.

a. Whilst she accepts that the officers remained at the scene, she believes that Janice was so vulnerable that they should have taken other action. She feels that their positioning did not prevent Janice from finding a different route back to Jacob's property. Apparently Janice also had no coat and no shoes and was evidently (from CCTV pictures) very cold. This was the depths of winter and in the early hours of the morning. Her actual words were that they (the Police) "failed to protect the vulnerable". She accepts that Janice may have been emotional at this time, but she felt that her needs and their skills should have led to a more pro-active approach. Her belief is that the Police should be better trained in circumstances such as these and be more empathetic.

b. Police action is based on their lawful powers. There is no evidence of any crime (and there was no evidence of drunkenness) so arrest was impossible. Whilst Janice was undoubtedly vulnerable in the sense that she was wearing little clothing on a cold night, this in itself is insufficient to take any action under other powers such as the Mental Health Act. Janice was very clear that she believed the Police had no power to detain her.

5.2.2 Secondly, Janice's mother feels that all the agencies that had contact with Janice should have recognised her needs and responded more effectively, both individually and together. If Janice had been provided with the support she needed, her situation may have been more manageable and reduced the possibility of the outcome in this case. This accords with the findings of this review.

Key findings arising from the review

6.1 **Information Sharing**

There was very little sharing of information about the family's issues between different health services (particularly the GP and Child Adolescent Mental Health Service - CAMHS). The contacts Janice had with Children's Social Care were not shared with Health Visiting, which could have prompted a Common Assessment Framework (CAF) to have been completed and an offer of early help to the family being made.

6.2 **Role of universal services**

Janice had regular and ongoing contact with her GP. Despite the issues the family were experiencing, she remained as a corporate caseload within the Health Visiting Service (she did not have an allocated named Health Visitor). A named Health Visitor, whom she may have been able to develop a relationship with and to whom she could disclose concerns, would have been beneficial.

6.3 **Early intervention and family support**

6.3.1 Exploration of a CAF and a "team around the family", (with one lead professional to coordinate support for the family) would have been appropriate, considering Janice's request for respite care, her disclosure to Children's Services about struggling to cope and her the approach to CAMHS (and subsequent disengagement from the service).

6.3.2 More should be done to attempt to positively engage people who independently approach Children's Services for help and support when they do not meet the threshold for statutory intervention.

6.4 **Risk Assessment**

Accident and Emergency (A&E) did not risk assess their contact with Janice. Identification of risk and safeguarding concerns were not explored, which was highlighted by the A&E safeguarding prompts not being utilised. Despite disclosures of past domestic violence to clinicians (both maternity and at CAMHS), issues in relation to the relationship with Janice's current partner (Jacob) were not considered or explored.

6.5 **Understanding and awareness of the dynamics of DV and its impact**

The review of the IMRs document several disclosures by Janice of domestic violence in her previous relationship with David. There was no evidence that she was ever asked about her

relationship with Jacob despite stating that they had separated. The issue of domestic violence was not explored by the clinicians Janice came into contact with even though she shared her concerns about the impact on Aiden of him previously witnessing domestic violence. When Janice was pregnant with Aiden (when she was a teenager) the reality of domestic violence was not considered.

6.6 **Role and function of the Family Justice Centre (FJC)**

The IMR process highlighted issues with record keeping and follow-up systems within the FJC. In September 2011, Janice was referred to the FJC by Housing, but there was little detail recorded about this in either of the IMRs. The one occasion of signposting Janice to the FJC was not followed-up by the originating agency. The difference between signposting to a service and a proactive referral needs to be agreed at a Borough level so that staff understand their responsibilities.

6.7 **Mental Health**

Janice was routinely screened for depression as part of her antenatal care. Early signs of depression were noted but there was no follow-up. Janice later had a high score for depression (23/27) but was never referred to a specialist service. It has not been possible to establish why this did not happen given that Croydon has an established Peri-natal Mental Health Service. Janice's Health Visiting records had no evidence of her depression.

6.8 **Role of health services**

Janice and her two children had regular contact with the GP and also had contact with CAMHS. The issues Janice was openly raising to her GP were not progressed and the disengagement from CAMHS was not followed-up. The GP could have been a more effective conduit for a system of coordinated support for the family.

6.9 **Disengagement with services**

6.9.1 The IMRs suggest that Janice was struggling with a number of difficulties. She had considerable contact with services (Health) but there was disengagement with CAMHS and she became further isolated with little support.

6.9.2 The treatment offered by CAMHS did not meet the needs of Janice nor was it particularly appropriate. Given the concerns Janice raised about her child's behaviour, the group treatment environment was one that she already stated she was struggling with and may have been too difficult for her to engage with. Janice stated she was isolated and struggling with all the demands on her. She

approached her GP for support as she was balancing a lot of competing demands on her time.

6.9.3 Janice was referred to and from agencies. No one agency or professional took responsibility for following actions up. The panel can only offer suggestions as to the reasons why Janice did not engage with CAMHS, but the ongoing pattern of being passed around services must have caused her frustration and influenced her decision to discontinue contact. All services must examine the reasons why some clients disengage, and use this information to help shape their services and systems to be more client-centred and accessible. Professionals need to be equipped to understand the parental right to refuse or disengage with a service, against the dynamics of safeguarding responsibilities and supporting vulnerable families.

6.10 **Culture of questioning**

There was a general failure to ask appropriate and sensitive questions about the circumstances of Janice's life (and also to Jacob). A&E clinicians need support and training so they are able to conduct clinical enquiry for domestic violence. The quality of general clinical enquiry for treating presenting injuries appears to be minimal. Basic factors relating to causes of injuries are not explored or recorded, along with a lack of detail on what the clinician asked as part of their investigations and the response given by the patient.

6.11 **The role of fathers**

Jacob's role as a father was apparent in the Probation account, but other than that ,he is invisible in other agency accounts (in contact with his child and with Janice). Despite the number of absences recorded on his unpaid work order due to child-care issues, there was no exploration of his family dynamics or his relationship.

6.12 **The "Think Family" approach to safeguarding**

6.12.1 Health services, particularly the GP, appear to have struggled to see the connection of the various issues facing the family. There was a lack of understanding of the family history. Incidents, presentations and consultations were all viewed in isolation.

6.12.2 GP's need to consider all aspects of the family to improve their risk assessment and safeguarding responses. They should consider both children and adults in the family concerned to make an informed holistic assessment. This would help to

improve referral practices and identifying early safeguarding concerns (the past history of unexplained injuries resulting in A&E admissions emphasises this point).

6.12.3 Janice's stress and depression was not seen as ongoing (since 2006), and the risks of self-harm were not viewed in the context of safeguarding the children or responding to a vulnerable adult. There must be an improvement in how the patient's social history is explored, including consideration of the responsibility for children in the patients care, any relationship issues with a partner, and the underlying reasons for unexplained injuries.

6.13 Policies and processes

6.13.1 The stated local priority of domestic violence is not helping to drive an effective community coordinated response. The panel has identified that there is a gap between strategic vision and the nature and quality of the operational response to domestic violence.

6.13.2 The Borough has a domestic violence strategy, but there is little evidence of how this translates into operational practice. There is no Borough domestic violence referral pathway in place, which leaves practitioners struggling to know who to refer to and what their role and responsibilities are.

6.13.3 The A&E safeguarding prompts were a local process designed in response to recommendations from a Serious Case Review (SCR) in 2011. The prompts ask A&E staff to consider if patients who arrived in the department have a dependent child and the age of the child. It also asks about any evidence of domestic violence. This review has found that these prompts are not being used. The use of the prompts is not embedded into practice and this should be urgently reviewed by the Hospital Trust in light of the SCR recommendations and findings from this review.

6.14 Signposting and referral practices

6.14.1 Referral and signposting practices have been discussed in detail by the panel. The FJC inadvertently created and supported a signposting culture which had the outcome of absolving statutory services of their responsibilities to take adequate safeguarding action. It appears (as in Janice's experience) victims were "sent" to the FJC, rather than professionals taking direct responsibility for making and following up referrals.

6.14.2 The lack of a local domestic violence referral pathway has compounded this situation, as front line practitioners are daunted and working under operational pressures to understand and navigate the different services. Professionals need to be clear of their responsibilities, know how (and whom) to make referrals to and be clear on the follow-up action they have to take. Systems and procedures should be in place to support and empower professionals respond appropriately to issues and concerns of domestic violence.

6.15 **Preventability**

6.15.1 The panel have not identified a single event or point of contact that could have prevented Janice's death. There is no "chain of causation" which would indicate agencies could have prevented Janice's death.

6.15.2 Although it is agreed that Janice's death could not have been foreseen or prevented, Janice had little support networks to utilise. A coordinated offer of early help by statutory services would have been helpful to Janice and her children. Had early help been put in place, the issues about domestic violence may have been identified and could have been appropriately responded to.

6.15.3 There is little evidence of reported domestic violence between Janice and Jacob. Police officers at the scene on the domestic incident on the night of Janice's death spoke with her and encouraged her to accept a lift home. This point of contact has been discussed in detail with the Police representatives of the DHR panel, to fully explore the limitations they faced in compelling Janice to leave the scene and the appropriateness of their response. The panel does not seek to place responsibility on Janice for her decision to remain at the scene and also understands the position the Police faced that they were powerless to legally remove her.

6.15.4 The lack of a recorded history of domestic violence may be due to an absence of domestic violence enquiry and assessment by agencies to which she turned for support. The panel agreed that statutory services should have responded better to Janice's (and her children's) needs. The panel felt that Janice was under increasing pressure and was actively seeking help and support but this was not identified or responded to.

6.15.5 Croydon has been recognised as an area of innovative practice on the issue of

domestic violence. The integrated court and the FJC were two key projects the council developed to revolutionise the response to domestic violence. Whilst this innovative practice should be celebrated, the high profile nature of these initiatives meant that little critical examination and review of the quality of the services was conducted. It is acknowledged that there is a significant change now underway to the response to domestic violence in Croydon.

Diversity

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

7.1.1 **Age**: Janice was a teenage parent and had been evicted from a YMCA hostel due to becoming pregnant. There appears to have been little consideration of the specific support Janice needed at this time and her emotional resilience. Her transition into adulthood was accompanied by experiences of domestic violence with David. Services had little understanding of the issue of relationship violence in adolescent relationships. The panel agreed that it is a positive development that the government definition of domestic violence has been changed to include sixteen and seventeen year olds.

7.1.2 **Disability**: Aiden's diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) are relevant factors in the case. Given the support Janice was seeking regarding her children and coping with their challenging behaviour.

7.1.3 **Pregnancy and maternity**: Janice was a teenage parent, and research indicates the high risk of domestic violence experienced by teenage mothers[1].

7.1.4 **Marriage and civil partnership:** Janice and Jacob had separated. There is no evidence of this being considered by agencies.

Conclusions

[1] Harrykissoon S, Rickert V, Wiemannet C (2002) Prevalence and patterns of intimate partner violence among adolescent mothers during the postpartum period. *Archives of Paediatrics and Adolescent Medicine* 156(4): 325-330

8.1 Improvements to the local coordinated community response to domestic violence need to be strengthened by policies, procedures, staff training and a referral pathway to support professionals respond effectively to concerns and disclosures of domestic violence. In order to reduce the likelihood of future domestic homicides, these improvements should be mediated and driven through the local partnership with the engagement and commitment of all agencies.

8.2 It is impossible to identify a single event or point of contact Janice had with a service or agency, which could have prevented her death. There is no "chain of causation" which would indicate agencies could have foreseen her death and acted differently to prevent it from happening. The panel have carefully considered the action of the Police officers at the scene on the domestic incident on the night of Janice's death, and agree that they dealt with the situation appropriately.

8.3 Although the panel have found that Janice's death was not preventable, there is a consensus that a coordinated offer of early help and intervention by statutory services would have certainly helped Janice and her children. Although we are unable to know for certain, the panel considered that the lack of support Janice received from her ex-partner with the children (following their separation), could have been a factor in her attempt to confront him on the night of her death.

8.4 There is little documented history of domestic violence in the agency records. The lack of information about domestic violence is an indicator of poor or non-existent enquiry processes. The panel agreed that statutory services should have responded better to the needs the panel has subsequently identified for Janice and her children.

8.5 The London Borough of Croydon has been recognised as an area of innovative practice on the issue of domestic violence. The Integrated Court and the FJC were two key projects the Council developed to revolutionise the response to domestic violence. Whilst this innovative practice should be celebrated, the high profile nature of these initiatives meant that little critical examination and review of the quality of the services was conducted. It is acknowledged that there is a significant change now underway to the response to domestic violence in Croydon.

8.6 The panel were pleased to receive assurances that since October 2012, there have been a number of positive and innovative developments to Croydon's coordinated community response to domestic violence (these are listed in the conclusion of the overview report).

8.7 Despite Janice suffering domestic violence over a long period of time with different partners, she had little contact with the Police. Her contact with Health Services was particularly significant.

8.8 The events Janice experienced as a young woman (which pre-date the time period subject to this review), bear some relevance in looking at her perception and experience of contact with services. Had those experiences been addressed more satisfactorily when she was a young woman, Janice may had led a more positive early adulthood and may have avoided the on-going victimisation she experienced.

8.9 It would seem that Jacob was her entire support network for the children (with Jacob's mother often looking after the children overnight). Janice's attendance at Jacob's address on the night before her death may indicate the stress she was under at the time and her frustration at Jacob's lack of help with the children. Janice did well to seek help and the review considers that statutory services should have done more to support her.

8.10 Many services had a number of opportunities to support Janice and her children. Health Services should have done more to help Janice with how she was feeling.

8.11 It is noted that the Borough does have a domestic violence strategy, yet there appears to be a disconnection between this vision and what happens in operational practice. In light of what we have discovered regarding the use of the A&E prompts, (introduced as a result of an earlier SCR and not being used), it will be extremely important that the partnership response to this review is able to engage and influence Health Services, including A&E.

8.12 There was evidence that the engagement of Health Services in the local partnership, particularly the community safety arena, has been limited. The scale of Janice's contact with Health Services shows how important it is that Health are engaging and fully committed to supporting the domestic violence agenda.

8.13 This case has highlighted a lack of professional responsibility to follow-up actions and necessary referrals. A Borough-wide domestic violence protocol or care pathway is required where staff are trained so that they are able to understand and respond appropriately, according to their role and responsibilities.

Recommendations

9.1 The recommendations in this report reflect the missed opportunities that existed to support Janice in her parenting role and to allow for safe and appropriate enquiry regarding domestic violence. This case has shown that the offer of early help to families in need in Croydon must be improved. It is hoped that the introduction of a Multi-Agency Safeguarding Hub (MASH) in Croydon will help enhance the sharing of information and ensuring that targeted and timely support is offered to families who come to the attention of services. The "team around the family" and CAF needs to be used by professionals and practitioners across the entire multi-agency partnership. Health Services need to be supported so that when it is appropriate they lead the CAF process.

9.2 Although not directly relevant to the circumstances of this review, the panel were concerned that the local MASH, as it is currently configured, will not necessarily help those victims who do not have children. This is included as a general observation to help further improve the response to domestic violence locally to all victims.

9.3 The recommendations will include consideration of the need to have policies and practice that supports all victims, regardless of their family composition.

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

9.5 The review identified that engagement with health partners in the Community Safety Partnership has been limited. If the recommendations of this review are to be implemented, Public Health and the Clinical Commissioning Group must engage fully with the coordinated community response to domestic violence.

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

9.7 These completed actions are shown below.

9.8 **Croydon Children's Services:**

9.8.1 The evidence clearly suggests that Aiden was a child in need and services should

have been offered regardless of any other criteria that existed. The Children With Disability Team now has permanent managers appointed, has consultants working with the team who look at the clinical decisions being made by the team and has undergone an audit of all open cases to ensure that all children referred to it receive an appropriate standard of service and are safe.

9.8.2 Allegations of domestic violence involving children are assessed according to the age of the child/children involved and the level of risk identified within the information presented. If a child younger than twelve months old is involved then a Section 47 (Child Protection) Investigation takes place.

9.8.3 Croydon Children's Services are planning to use Independent Review Officers (IROs) to review all new Child-in-Need cases. This will ensure clear planning for children, an independent view of risk and threshold for services.

9.9 **Family Justice Centre:** The referral pathways agreement for Housing and Social Care and other partners, including the requirement to records action and outcomes, is being re-written.

Panel recommendations

10.1 The panel recommendations are shown below:

10.2 All recommendations will be overseen by the Croydon Community Safety Partnership, and will be delivered by the Croydon Domestic Violence Strategic Group. The recommendations also have been translated into an action plan (Appendix 4 of the overview report).

10.3 **Croydon Community Safety Partnership:**

Recommendation 1
Conduct a rigorous borough wide review of the response to domestic violence. This review must address the gap between the strategy and delivery of the strategic aims in operational practice of partner agencies.

Recommendation 2
In conjunction with other strategic boards, produce a domestic violence protocol, policy and care pathway, across the partnership and for each organisation. This should include domestic violence enquiry and provision for safeguarding children and vulnerable young people.

. **Recommendation 3**

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

Recommendation 4

Commission a borough multi-agency domestic violence training programme. This should be done with support of other strategic boards and take up of training should be audited and monitored per agency by the Croydon Domestic Violence Strategy Group. It is recommended that the training covers awareness and dynamics of domestic violence, specific skills training on enquiry and completion of MARAC risk assessment, safeguarding responsibilities and referrals pathways.

Recommendation 5

Develop an early intervention approach to domestic violence through local schools (that ties in with the existing programme on gangs and sexual exploitation) and is age appropriate.

10.4 **Metropolitan Police (within all London boroughs):**

Recommendation 6

Review the policy of restricting intelligence checks to five years.

Recommendation 7

Use this case as a briefing aid and learning tool for Croydon Police to support an enhanced response to potential victims of domestic violence.

10.5 **London Probation Trust:**

Recommendation 8

Ensure specific and open questions are asked to the Police as part of intelligence checks so that more accurate information is obtained to inform risk assessments.

Recommendation 9

When subject to an order, when there are a sustained number of absences in relation to children of the offender (e.g. child care) a risk assessment should be completed, supported by a line manager.

10.6 **Metropolitan Police and London Probation Trust:**

Recommendation 10

Ensure that probation officers have quick access to the Police national computer to inform their reports and risk assessments.

10.7 **SLaM:**

Recommendation 11

Complete an audit on Did Not Attend (DNAs) who were discharged from CAMHS to check that risk assessments have been or are now completed before decision to discharge as outlined in the policy and provide a new offer of support (where appropriate).

Recommendation 12

Provide those referring to SLaM Child ADHD Services information to help them signpost families to other support networks at the time of the referral as it is recognised that there are at times delays from date of referral to date of first appointment, and the family may require more speedy support.

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

Recommendation 13

Review its prioritisation of and response to the issue of domestic violence. This should include recognition of the possibility of domestic violence within each referral and policies which address routine and/or selective enquiry about the existence of domestic violence.

Recommendation 14

Review corporate policy for responding to families who fail to engage with services (and make amendments) in light of the findings of this review.

Recommendation 15

Audit safeguarding children's training (and take up across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.

Recommendation 16

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

Recommendation 17

Review the process of the early offer of help to examine its effectiveness with particular reference to CAF implementation within health services and how domestic violence is included in this assessment.

Recommendation 18

Review and update the local Safeguarding Children's Board Domestic Violence Policy and ensure it is widely circulated to all relevant professionals.

10.9 **Croydon Council Family Justice Centre:**

Recommendation 19

Rewrite the Multi-Agency Borough Referral Pathway agreement which should include action taken by agencies and the outcomes of referral.

10.10 **Croydon Council Public Health:**

Recommendation 20

The Joint Strategic Needs Assessment on domestic violence should reference the findings of the two Croydon Domestic Homicide Reviews.

10.11 **NHS England (Croydon Clinical Commissioning Group) and Croydon Council Public Health:**

Recommendation 21

Look to pilot and/or commission a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.

10.12 **Croydon Clinical Commissioning Group:**

Recommendation 22

Ensure engagement in Croydon's coordinated community response to domestic violence through regular and appropriately senior representation at the Croydon Domestic Violence and Sexual Violence Strategy Board.

10.13 **Croydon Children's Services:**

Recommendation 23

Develop a system where independent approaches to Children's Social Care from individuals and families requesting help and support which then do not meet the threshold for statutory intervention are reviewed and shared with universal family support services.

10.14 **NHS England:**

Recommendation 24

As NHS England have provided funding within GP budgets to deliver safeguarding training (adults and children), a local review of this training should be instituted to ensure domestic violence is included in this training and to an appropriate level.

Recommendation 25

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

Recommendation 26

Develop a depression screening and care pathway for GP's, and review the tools that are used to include psychological/social aspects on the dynamic of mental health and domestic violence.

Recommendation 27

Safeguarding adult training to be implemented to raise awareness of the issues identified.

Recommendation 28

Include learning points in the Croydon CCG Newsletter.

Recommendation 29

Include these learning points in case reflection session with GP Practices once organised.

Recommendation 30

Data relating to family members and dependents should be gathered at the time of registration and/or the initial health check.

Recommendation 31

Consideration should be given to flagging cases where there is high-risk or potentially high-risk.

Recommendation 32

Consideration needs to be given as to how information can be shared with other practices if parents have re-registered at separate practices.

Recommendation 33

Meet with staff to provide a briefing on the initial review findings to enable opportunities to learn from them and develop their confidence and competence re managing such cases.

Recommendation 34

Support staff through case reflection as needed.

10.15 **Croydon Health Services NHS Trust:**

Recommendation 35

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

a. Specific reference to the use of the A&E prompts for the emergency department.

b. Inclusion of routine enquiry within the service specification of any new commissioning processes, particularly for health visiting and school nurses.

c. An organisational stance on providing "private time" at the antenatal booking appointment, and then throughout all antenatal care appointments to enable midwives to ask about sensitive issues such as domestic violence.

Recommendation 36

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

Recommendation 37

Develop and distribute a universal resource on help and support available for all new parents, to support routine enquiry for domestic violence during ante natal and post natal care.

Recommendation 38

Conduct a systematic review of the processes within A&E so that staff are aware of their role and responsibilities in relation to responding to domestic violence and any safeguarding concerns. This should include a mandatory training programme for all A&E staff and

provision of information on local domestic violence support services and how to refer to them.

Recommendation 39

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

Recommendation 40

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

Recommendation 41

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

10.16 **National recommendation** – (included for information only and not for Croydon Community Safety Partnership to progress).

Recommendation 42

Implement a new specific separate category of domestic violence on the children social care system for registration within child protection plans for cases where domestic violence is the reason for registration[2].

[2] This was recognised as a gap within Croydon but categorisation is determined by "Working Together" and this problem appears to be one for all children's services. The panel felt it vital that the extent and scale of domestic violence is accurately recorded rather than potentially hidden within emotional or physical categories on the current system.

Appendix One

Key

ADHD	Attention Deficit Hyperactivity Disorder
A&E	Accident and Emergency
Aiden	Son of Janice and David
ASD	Autistic Spectrum Disorder
CAMHS	Child Adolescent Mental Health Service
CSC	Children Social Care
CSP	Community Safety Partnership
CSU	Community Safety Unit
CUH	Croydon University Hospital (formally Mayday Healthcare)
CWD	Children With Disability Team
David	Janice's ex partner and father of Aiden
DHR	Domestic Homicide Review
DV/A	Domestic violence and abuse
Ethan	Son of Janice and Jacob
GPs	General Practitioners
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety (GP practice scheme)
Jacob	Perpetrator
Janice	Victim
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MPS	Metropolitan Police Service
SLaM	South London & Maudsley NHS Foundation Trust

Appendix 2

Janice's Family Tree