Enfield Community Safety Partnership

Domestic Homicide Review

Overview Report

Elizabeth (March 2016)

10 January 2019

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CONTENTS

1. INTRODUCTION

The key purpose for undertaking domestic homicide reviews (DHR) is to enable lessons to be learned from homicides in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

This domestic homicide review was commissioned by Enfield Community Safety Partnership following the death of Elizabeth, a white British woman. Her partner was found guilty of her murder and in January 2017 he was sentenced to life imprisonment and ordered to serve a minimum prison term of 20 years.

This report examines the contact and involvement that agencies had with Elizabeth and her partner between January 2013 and her death in March 2016. In addition to the agency involvement, this report also examines any relevant past history of abuse and incorporates the views, thoughts and questions raised by Elizabeth's family, friends and neighbours.

The panel wishes to express their condolences to Elizabeth's family and friends following her death. The panel also would like to thank all those who have contributed to the review.

1.1. Timescales

Enfield Community Safety Unit was notified of Elizabeth's death on 6 April 2016. The Unit reviewed the circumstances against the criteria set out in the Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2013) and recommended to the Chair of the Enfield Safer and Stronger Communities Board that a domestic homicide review should be undertaken. The Chair ratified the decision to commission a domestic homicide review on 7 April 2016 and the Home Office was notified on 22 August 2016.

An independent chair/author was commissioned in October 2016 to manage the process and compile the overview report.

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until after the report was approved by the Home Office Quality Assurance Panel.

To protect the identity of the family members, the following anonymised terms and pseudonyms have been used throughout this review:

Elizabeth – victim (deceased) aged 42

Perpetrator (partner) aged 41

} Age at the time of Elizabeth's death

2. THE REVIEW PROCESS AND TERMS OF REFERENCE

The review was conducted in accordance with the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) under s.9(3) Domestic Violence, Crime and Victims Act (2004).

2.1. Time period

The panel decided that the review should focus on the contact that agencies had with both Elizabeth and the perpetrator between January 2013 and the time of Elizabeth's death in March 2016. This ensured that information was captured about Elizabeth's relationship with the perpetrator; the history of abuse and violence within their relationship; his recall to prison following an assault on Elizabeth; and his subsequent release from prison in November 2015. The panel agreed, however, if any agency had relevant information outside of this period, this information should be included in the individual management review.

2.2. Contributors to the review

The Chair wrote to Elizabeth's mother via the police family liaison officer to explain that a domestic homicide review was taking place. The family was provided with information leaflets from the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA). Nevertheless, because of the on-going investigation and the impending criminal proceedings, the Chair was unable to make direct contact with Elizabeth's mother until after the conclusion of the trial in January 2017. At this point, Elizabeth's mother, her cousin, two neighbours and the family's AAFDA (Advocacy After Fatal Domestic Abuse) worker all kindly agreed to meet with the Chair.

2.2.1. The thoughts and feelings of Elizabeth's family, friends and neighbours

Elizabeth's mother wanted to be involved with this review, as did one of Elizabeth's cousins and two of Elizabeth's neighbours. At first, Elizabeth's mother felt Elizabeth's children should not be involved, as they continued to struggle with her death. Nevertheless, with time her elder daughter also agreed to meet with the Chair and she provided information for the review. The family had the opportunity to read and agree the report before it was

published. The invaluable insight the family provided into Elizabeth's life is included in this section and throughout the report.

Elizabeth had had a number of traumatic life experiences. When she was 16 years old she was involved in a road traffic accident in which a number of young people died, including her boyfriend. Elizabeth was the sole survivor. Her mother described how he was the "*love of her life*", she twice tried to kill herself afterwards and for a long-time Elizabeth felt that he was "*calling her*". Her mother felt that Elizabeth carried this pain through the rest of her life and throughout her life "*men crushed her*". She wanted to be loved but "*she didn't love herself and didn't think she deserved any better*".

In the 1990s Elizabeth woke up to find her then partner had died of a methadone overdose during the night. She later had to go to court to prove she was not involved in his death. Elizabeth had a number of abusive relationships and moved to Enfield for her own safety in November 2009.

From discussions with her family, it was clear that Elizabeth "*gave up*" her children because she knew she could not look after them because of her mental health difficulties. She doted on her children and always bought them presents at Christmas and for their birthdays. She enjoyed taking them shopping for clothes. She clearly had a good relationship with her daughters and her mother, and her daughters would often stay with her.

Elizabeth's friends and family described her as kind and generous. They said she was almost too generous as she would give away her money to those around her. This meant that people often took advantage of Elizabeth. Her family described how she wanted to be loved and men saw her vulnerability and preyed on her – despite this, "*Elizabeth always thought she was in control*" and she came across as "*strong and capable*". Elizabeth was very proud of her house and she always kept it spotless. She was also smart, very well-kempt and loved to have shoes for every occasion.

Elizabeth's family and friends described the perpetrator as manipulative. He would phone her from prison and threaten her. He would ask her who was the man walking her dog. He would get people to make "*marks*" outside her home and then tell her to look for them. This meant Elizabeth knew he had someone watching her. Then to confuse her, he would write her lovely letters and phone her to say he loved her, and tell her that they should get married. Her family and friends said that just as she was happy, he would "*beat her down again*". The perpetrator was seeing another woman but always denied it and said it was in Elizabeth's head. On one occasion, they argued about it and she told her family that he had pulled her hair out.

Elizabeth had a dog that she was devoted to and loved dearly. She told her family and friends that the perpetrator would try to control her dog and separate it from her. On occasion, he made threats about the dog and once took it away to upset Elizabeth. When Elizabeth died, her dog was distressed and confused and had to be "*put down*".

The perpetrator frequently told Elizabeth that he would harm her mother and children. Elizabeth clearly believed he would and tried not to antagonise him. The last time he was

released from prison, Elizabeth refused to move in with her mother and her children because she thought he would find them all. She was scared that as he was a burglar, he could break into any house. At this time, Elizabeth's mother was in the process of having an extension built so Elizabeth could live with her and Elizabeth's children. Her family described how she was always very protective of others (especially her children), but could not protect herself. Elizabeth's neighbour explained that she telephoned services at least three or four times to get help for Elizabeth, particularly mental health services; but help was not forthcoming.

Elizabeth's family provided insight into how vulnerable Elizabeth was even when the perpetrator was in prison. They described how he used members of his family to threaten and intimidate Elizabeth whilst he was in prison. This information did not appear to be known by the agencies working with Elizabeth.

There were a number of issues that Elizabeth's family and friends wanted raised. Her mother wanted to understand why (as Elizabeth's next of kin) she was not informed first about Elizabeth's death. Her elder daughter was angry that she found out about her mother's death on Facebook and wanted to understand how this was possible. Both Elizabeth's mother and her elder daughter wanted to understand why they had not been able to see Elizabeth after her death to say "goodbye".

2.2.2. Agencies and other contributors to the review

Individual management reviews and chronologies were requested from:

- Barnet, Enfield and Haringey Mental Health NHS Trust (BEH-MHT)
- Compass Drug and Alcohol Service Enfield
- Enfield Strategic Safeguarding Adults Service
- Enable Drug and Alcohol Service (BEH-MHT)
- General Practitioner (GP)
- Hertfordshire Community Rehabilitation Company (CRC)
- London Community Rehabilitation Company (CRC)
- Metropolitan Police Service
- North Middlesex University Hospital NHS Trust (A&E)
- One Support
- Royal Free London NHS Foundation Trust
- Solace Women's Aid – Independent Domestic Violence Advisor Service
- Westminster Drug Project

Information report reports and chronologies were requested from:

- Essex Children's Social Care
- London Ambulance Service

- Multi-Agency Risk Assessment Conference (MARAC)[1]

All the authors of the individual management reviews and the information reports were independent of the case i.e. they were not involved in the case and had no management responsibility for any of the professionals involved.

2.3. Key lines of enquiry

The individual management reviews and information reports addressed both the "generic issues" set out on pages 31-32 of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) and the following specific issues identified in this particular case:

- What knowledge or information did your agency have that indicated Elizabeth might be at risk of abuse, harm or domestic violence and how did your agency respond to this information?

- If your agency had information that indicated that Elizabeth might be at risk of abuse, harm or domestic violence was this information shared? If so, with which agencies or professionals?

- In what way did your agency's knowledge of Elizabeth's history influence professionals' decision making?

- How did your agency assess whether Elizabeth was able to articulate what was happening in her life (on those occasions when she accessed services whilst under the influence of drugs or alcohol)?

- What knowledge or information did your agency have that indicated the perpetrator was violent, abusive or might cause harm to someone and how did your agency respond to this information.

- If your agency had information that indicated that the perpetrator was violent, abusive or might cause harm to someone, was this information shared? If so, with which agencies or professionals?

- What opportunities and services did your agency offer and provide to meet the needs of Elizabeth and the perpetrator? Were they accessible, appropriate, empowering and empathetic to their needs and the risks they faced?

- Were there issues of capacity or resources within your agency that had an impact on your agency's ability to provide services to Elizabeth or the perpetrator? Did capacity

[1] This is a multi-agency risk assessment conference at which local agencies meet to discuss confidentially high-risk victims of domestic abuse. The aim is to identify what safety measures and support mechanisms could be put in place for Elizabeth and her family. MARAC was introduced in Enfield in August 2005.

or resources have an impact on your agency's ability to work effectively with other agencies?

- Identify any lessons learnt and implemented during the review process.

2.4. Review panel

The panel met five times. All members were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved at the time. The review panel comprised:

- Eleanor Stobart, Independent Chair and Author
- Alan Brown, Associate Head of Mental Health, One Support
- Andrea Clemons, Head of the Community Safety Unit, London Borough of Enfield (LBE)
- Andy Bishop, Substance Misuse & IOM Development Manager, Drug and Alcohol Team, London Borough of Enfield
- Aveen Gardiner, Area Manager, London Community Rehabilitation Company (CRC)
- Candice Donn, Enable (Drug and Alcohol Service in BEH-MHT)
- Carole Bruce-Gordon, Acting Director of Quality and Governance, Enfield Clinical Commissioning Group
- Craig Emmerson, Acting Detective Inspector, Enfield Metropolitan Police
- Deirdre Blaikie, Adult Safeguarding Lead, Royal Free NHS Trust
- Helen Rendell, Detective Sergeant, Metropolitan Police Service
- Joanna Stronach-Lenz, Public Health Strategist, Public Health, London Borough of Enfield
- Julie Dalphinis, Interim Adult Safeguarding Lead, Enfield Clinical Commissioning Group
- Ruth Vines, Head of Safeguarding, Barnet Enfield & Haringey Mental Health NHS Trust
- Sandjea Green, Senior Manager, Solace Women's Aid
- Sarah Pope, Safeguarding Adults Lead, North Middlesex Hospital NHS Trust
- Shan Kilby, Domestic Violence Coordinator, Community Safety Unit, London Borough of Enfield
- Sharon Burgess, Head of Safeguarding Adults, London Borough of Enfield

2.5. Author of the overview report

The chair and author of this review has been a freelance consultant for 17 years. She specialises in violence against women and girls, safeguarding children and vulnerable adults with a particular focus on domestic abuse and working with minority ethnic families. During this time, Eleanor has been appointed to undertake projects for a wide range of organisations including (amongst others) the Department of Health, The National Police Chiefs Council (formerly the Association of Chief Police Officers), Interpol, Forensic Science Service, Amnesty International, National School of Government, Home Office Immigration Enforcement (formerly UK Border Agency), ECPAT UK and the British Medical Association.

Examples of her work include being commissioned (2000 – 2011) to research, develop and write the national statutory and multi-agency guidelines for practitioners handling cases of forced marriage for the Forced Marriage Unit (Foreign & Commonwealth Office and Home Office Unit). The NSPCC appointed Eleanor to develop a service model and accompanying manual to assist NSPCC practitioners working with South Asian children and families. Following the death of Victoria Climbié, the Department of Education commissioned Eleanor to investigate the scale and extent of child abuse linked to a belief in 'spirit possession' and 'djinns' in the United Kingdom.

Eleanor has also undertaken research on domestic abuse for Community Safety Partnerships and conducted audits and practice reviews for Local Safeguarding Children Boards. She has chaired and authored over 15 serious case reviews/domestic homicide reviews. Eleanor has a Master of Business and Administration (MBA) from Bradford University School of Management (2000) and a Master of Laws (LLM) in Child Law from Northumbria University (2011).

Prior to her work as an independent consultant, Eleanor managed services within the NHS caring for people with life limiting illnesses. She has extensive experience of working with bereaved families.

She is independent of, and has no connection with any agency in Enfield; she has never been employed by any agency in Enfield.

2.6. Parallel reviews

In addition to the criminal investigation, a serious untoward incident review was carried out by Barnet, Enfield and Haringey Mental Health NHS Trust. The resulting report was made available to the domestic homicide review panel. The content of the report has been included (where appropriate) in this review.

2.7. Equality and diversity

Both the victim and perpetrator were of white British origin as were Elizabeth's friends and family who participated in the review. All aspects of equality and diversity were considered throughout the review process including age, disability, race, gender and religion. To ensure

the review process considered issues around mental health and drug and alcohol use, the panel included representatives from services that specialise in supporting individuals living with mental health problems as well as drug and alcohol dependence.

2.8. Dissemination

In addition to the organisations contributing to this review (listed in 2.2.2), the following will receive copies of this report for learning within their organisations.

- Barnet, Enfield and Haringey Mental Health NHS Trust Integrated Safeguarding Adult and Children Committee
- Enfield Safer and Stronger Communities Board (Community Safety Partnership)
- Enfield Health and Wellbeing Board
- Police and Crime Commissioner (Mayor's Office)
- Drug and Alcohol Board
- Enfield Safeguarding Adult Board
- Health Integrated Safeguarding Committee
- Enfield Safeguarding Children's Board
- Enfield Mental Health Partnership Board
- London Community Rehabilitation Company
- Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire (BeNCH) Community Rehabilitation Company.

3. BACKGROUND

Early one March morning in 2016 police were called to an address in Enfield. Elizabeth had been stabbed in the abdomen and had sustained severe facial injuries. London Ambulance Service was at the scene and pronounced Elizabeth dead 30 minutes later. Elizabeth was 42 years old.

Elizabeth's partner was arrested at the scene and subsequently charged with her murder. He was found guilty in January 2017 and sentenced to life imprisonment with a minimum term of 20 years.

Elizabeth lived in Enfield. She had two children who were both subject to residence orders and lived with Elizabeth's mother outside London. Elizabeth continued to have contact with them. Elizabeth was known to mental health services. She had a diagnosis of bi-polar disorder and she had a history of self-harm. She was dependent on alcohol as well as a

number of prescription drugs, including temazepam (sleeping tablet), diazepam (valium) and dihydrocodeine (painkiller). Over the years, she worked hard to reduce her dependence on them and by 2015 she only drank one glass of wine or a can of cider a day.

Both Elizabeth and the perpetrator were known to police. Elizabeth had ten previous convictions for 18 offences. These mostly concerned offences such as shoplifting and drink driving. During the period under review, she was charged with theft, possession of cannabis and common assault for which she received a 12-month supervision order, a six-month alcohol treatment order and a restraining order.

The perpetrator had 29 convictions for 84 offences. These included criminal damage, burglary, arson, drink driving and actual bodily harm. He had been given prison sentences on numerous occasions. Most notably in 1995 for arson (18 months), 1997 for actual bodily harm (18 months), 1999 for burglary and theft (5 years), 2009 for burglary (876 days), 2011 for burglary (4 years) and in 2013 for burglary (2 years). Whilst under the supervision of London Community Rehabilitation Company (CRC), he was registered as a persistent and prolific offender (PPO).

It appeared that the perpetrator met Elizabeth sometime around the beginning of 2013. Between 2013 and the time of Elizabeth's death in 2016, police were called to five incidents when the perpetrator had assaulted Elizabeth. In April 2015, the perpetrator was recalled to prison following an assault on Elizabeth. He was released in November 2015.

4. CHRONOLOGY OF SIGNIFICANT EVENTS

In May 2011, the perpetrator was sentenced to four years' imprisonment for burglary and theft. The conditions of his release required him to report to Hertfordshire Probation Trust. The perpetrator's mother was reluctant for him to stay with her. Hertfordshire Probation Trust therefore agreed to find him alternative accommodation. Nevertheless, he was released in January 2013 with no fixed abode.

During this period, Elizabeth was seen every couple of weeks by her GP, as she was reducing both her diazepam and dihydrocodeine prescriptions. She was supported by One Support[2] from 2011 to 2013.

4.1. Assault one

On 16 May 2013, Elizabeth called the police. She told officers that she and her partner had argued, during which he punched her in the face and then punched the wall. Officers noted

[2] One Support is the care and support branch of One Housing. One Housing is a housing association that helps support 11,000 individuals to live independently by offering a range of care and support services around mental ill health and homelessness.

that she "*had no visible injuries*". She was assessed as at standard risk of harm and the case was passed to the police Community Safety Unit for further investigation.

Her partner was arrested on suspicion of common assault and criminal damage. Elizabeth provided a statement. Her partner was interviewed and he denied any offences. The case was referred to the Crown Prosecution Service (CPS) who authorised a charge of common assault and criminal damage. He was granted bail until the end of July 2013 with conditions not to go within 100 metres of Elizabeth's home nor have any direct or indirect contact with her. Elizabeth's details were passed to the independent domestic violence advisor (IDVA).

A referral was sent to Enfield Adult Social Care on 24 May 2013 by Victim Support. The social worker telephoned Elizabeth who said that she had already told Victim Support that she did not require any support. Elizabeth terminated the call before the social worker had finished speaking. The records stated that the social worker informed the senior practitioner and they agreed to close the alert. There were no detailed recordings of what was considered and the rationale for closing the case.

Elizabeth told her One Support worker about the assault in a face-to-face meeting on 17 May 2013. She described self-harming and informed the worker that she had stopped going to the drug and alcohol service (Compass).

In June 2013, the perpetrator informed Hertfordshire Probation Trust that he was staying with a friend. No address was given. Elizabeth's One Support worker tried to contact her a number of times during June 2013 and then sent her a letter. They finally met on 10 July 2013. At this meeting, her One Support worker discussed closing the case as Elizabeth had no "*tenancy issues*". Elizabeth said that she was seeing her children and she wanted a "*fresh start*". One Support closed Elizabeth's case on 17 July 2013.

Despite the perpetrator having bail conditions not to have any contact with Elizabeth, they twice visited his GP. He presented with a history of increased anxiety and depression, he was "*snappy and abrupt*" and was having difficulty sleeping. On the second occasion, he had a laceration to his hand from "*punching the stereo*". During these consultations, Elizabeth was described as his carer; the perpetrator stated that he lived with his mother and had no girlfriend.

The perpetrator registered twice with the GP Practice. First using his real name and also under a false name. He appeared to mostly visit using his real name and he did not acquire additional prescription drugs using his false identity. Clearly, he may have registered at other local GP Practices using false names. He certainly used a different alias for mental health services.

During the course of this review it became apparent that the perpetrator had 13 separate aliases that he used at various times with different services.

On 19 July 2013, the perpetrator informed his probation officer that he was spending five nights a week at his mother's house and two nights at his girlfriend's. Both addresses were in Enfield. There does not appear to be any liaison between probation/police in

Hertfordshire and Enfield to establish the identity of his girlfriend or the appropriateness of her address.

4.2. Assault two

In late July 2013, police were called by a friend of Elizabeth's. Her friend had seen Elizabeth earlier that day with reddening to her cheek and was concerned she had been assaulted by the perpetrator. When police went to Elizabeth's home, she was initially reluctant to open the door. Eventually, she agreed and the officers noted that she had bruising under both eyes. Elizabeth indicated to the officers that the perpetrator was upstairs and they found him in an upstairs room, hiding under a bed. Intelligence checks identified that there had been a previous domestic abuse incident and that the perpetrator had bail conditions prohibiting him from going to Elizabeth's home. He was arrested on suspicion of assault and for breaching his bail conditions.

Elizabeth refused to provide a statement and told the officer she was unwilling to support a prosecution. She declined a referral to domestic abuse support services. The police assessed her as at standard risk of harm (DASH)[3] (the rationale being that the police did not consider him a risk to Elizabeth at that moment in time because he had been arrested).

The perpetrator denied assaulting Elizabeth. The case was referred to the Crown Prosecution Service (CPS) who took the decision that no further action should be taken, as there was no realistic prospect of conviction because the perpetrator had denied the assault and Elizabeth was "*unwilling*" to provide a statement. The perpetrator was remanded in police custody to appear at court at the end of July 2013 in relation to breaching his bail conditions. The closing risk assessment remained standard risk.

Throughout this period, there was nothing documented within the Hertfordshire Probation Trust records to suggest they were aware of this assault; nor was there any information to evidence that the perpetrator was being supervised regularly by his probation officer.

On 4 August 2013, the perpetrator called the police, reporting that Elizabeth had possibly taken an overdose. When the police arrived, Elizabeth was asleep so they woke her up and she told them that she had taken four anti-depressants. It was not classified as a domestic incident and the case was closed.

[3] Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Assessment – for further information see www.safelives.org.uk/practice-support/resources-identifying-risk-victims-face - accessed online 10 Aug 2017

At this point the Metropolitan Police Service (MPS) had started training officers on the Vulnerable Adult Framework and the creation of "Adult come to Notice". Therefore, an "Adult come to Notice" should have been created for this incident and shared with Adult Social Care

On 13 August 2013, the perpetrator went to his GP accompanied by a "*friend*". He was low in mood and said that he had already asked his probation officer about counselling. The GP records noted that he smelt of alcohol and a referral was made to Barnet, Enfield and Haringey Mental Health NHS Trust. The Trust was unable to contact the perpetrator by telephone and sent him an appointment letter for 6 September 2013.

On 14 August 2013, his probation officer was informed by Enfield police about the assault on Elizabeth in May 2013. Elizabeth's name was not documented and there was no indication that enquiries were made or whether the Trust considered whether the perpetrator should be charged or arrested. The same day, Hertfordshire Probation Trust records noted that the case was to be transferred the London Probation Trust but there was no documented record of any discussion, handover or meeting; and records showed that Hertfordshire continued to monitor the perpetrator.

On 27 August 2013, the perpetrator gave his probation officer a "sick note" covering his previous absence. The sick note exempted him from attending his probation meetings between 13 August 2013 and 24 September 2013. Records showed that the perpetrator was still living at both his mother's and girlfriend's house.

On 30 August 2013, Elizabeth was taken to Chase Farm Hospital Accident & Emergency Department. She had sustained a head injury after taking an overdose of paracetamol and alcohol. London Ambulance Service staff recorded that her "*husband*" said that she had fallen and hit her head in the front room of their home. However, on the carbon copy of the ambulance report was a hand-written note that "*neighbours stated that it looked like her husband hit her head on the pavement*".

This allegation did not appear to have been seen by the nursing or medical staff at the hospital, or verbally handed over to them; nor were the police were informed.

Elizabeth was described as alert but very agitated and "*uncooperative*". She complained of a head injury which she stated was alcohol-related. Elizabeth's history was taken three times; first by a doctor in the emergency department; second by a nurse in the emergency department; and third by an emergency department registrar. In each case, her history stated that she fell and hit her head. Records indicated that the perpetrator "*helped*" to provide the background information and both he and Elizabeth told staff that Elizabeth had been drinking all day, had a fall, hit her head on the ground, and later became unresponsive and agitated.

Elizabeth was admitted to the ward for assessment and the perpetrator stayed with her. The following morning, she had a seizure. Her seizure was considered to be as a result of the overdose. Following her seizure, her "*husband*" was observed to be upset and he was crying whilst Elizabeth tried to comfort him. Following a scan of her head, the perpetrator had a discussion with doctors as he was unhappy with her care; he wanted her to have more medication to prevent further seizures. Later that afternoon, Elizabeth self-discharged against medical advice. It was noted that the perpetrator was present throughout her admission and during all conversations. Throughout Elizabeth's admission, he used a false name.

On 3 September 2013, the police received information from a friend of Elizabeth's stating that the perpetrator was controlling and physically abusive towards Elizabeth. The informant wished to remain anonymous and told police that Elizabeth was too scared to substantiate any allegations. The police records stated that an intelligence report was completed (although it was unclear how this information informed police practice during other incidents of assault).

The perpetrator did not attend his mental health appointment on 6 September 2013. Another appointment was sent to him for 3 October 2013. The same day, the perpetrator failed to meet his Hertfordshire probation officer.

On 7 September 2013, Elizabeth and the perpetrator were arrested on suspicion of burglary. They had been witnessed attempting to enter a property. They were both interviewed and denied any wrongdoing. They were granted police bail. The case was submitted to the Crown Prosecution Service (CPS). The perpetrator was charged with burglary on 4 October 2013[4]. No further action was taken against Elizabeth.

At this time, Hertfordshire Probation Service received information that the perpetrator was staying full time with his girlfriend. The records documented her address. Again, it appeared that no enquiries were made. On 12 September 2013, the perpetrator reported to Hertfordshire Probation Trust but as he had a dog with him, he was seen outside. An appointment was made to see him the following week.

4.3. Assault three

On 15 September 2013, Elizabeth went with her "*sister*"[5] to Enfield police station. She told officers that she had been assaulted by the perpetrator. She said that the perpetrator had grabbed her face and head-butted her. The officer noted that Elizabeth had bruising and swelling to her face and "smelt strongly of alcohol". Elizabeth was advised to seek medical attention, but she refused. Elizabeth's injuries were photographed and a statement was taken. A Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) was completed and she was assessed as at high risk of harm. Elizabeth was advised not to return home and

[4] On 1 November 2013, the perpetrator was sentenced to two years' imprisonment for this offence

[5] Elizabeth did not have a sister – all references to a "*sister*" are thought to be her neighbour

arrangements were made for her to stay with her "*sister*". The case was allocated to the police Community Safety Unit for further investigation.

The perpetrator was arrested and denied assaulting Elizabeth. He told officers that Elizabeth was an alcoholic, who suffered with bi-polar disorder and schizophrenia. He said he assumed her injuries were as a result of her suffering a seizure. The investigating officer contacted Elizabeth to inform her of the perpetrator's arrest. She immediately stated she was no longer willing to support a prosecution and wished to withdraw her statement. The Crown Prosecution Service (CPS) decided that no further action should be taken as there was no realistic prospect of conviction. A referral was made to the National Centre for Domestic Violence (NCDV)[6]. The closing risk assessment was marked as standard and the case was closed.

On 24 September 2013, the perpetrator saw his GP, as he was experiencing paranoia and anger. He told his GP that he was "*sofa surfing*" and he had not attended his mental health appointment earlier that month; although he had another appointment for early in October 2013. It was recorded that he had been drinking non-stop for six days and he was described as having "*good insight*".

The perpetrator failed to attend his mental health appointment on 4 October 2013. A call was made to his landline and mobile but there was no answer. His GP Practice was contacted. His GP was not available and therefore the secretary was informed that as the perpetrator had not attended his appointments, they assumed he did not wish to be seen and thus he would be discharged back into the care of his GP. The Practice was advised to re-refer again if appropriate.

> The mental health services should have considered discussing the case with the GP to understand any potential risks; referring him to the Home Treatment Team and undertaking a home visit to establish whether he was living alone or with anyone else

On 22 October 2013 Elizabeth went to her GP because she was having difficulty sleeping, she felt depressed and wanted to have counselling. A referral was made to a psychologist.

4.4. October 2013 – perpetrator recalled to prison

On 18 October 2013, the perpetrator was arrested and recalled to prison for burglary. On 1 November 2013, the perpetrator was sentenced to two years' imprisonment. He provided

[6] The National Centre for Domestic Violence provides a free, fast emergency injunction service to survivors of domestic violence regardless of their financial circumstances, race, gender or sexual orientation. For further information see www.ncdv.org.uk - accessed online 10 August 2017

his mother's address in Enfield, but the case was allocated to Hertfordshire Probation Trust because they were supervising him at the time of the offence.[7]

In December 2013, Elizabeth saw her GP and was advised to contact mental health team as soon as possible. She returned to her GP again in January 2014 as her symptoms of poor sleep and anxiety when leaving the house continued. She was noted to be waiting to see a psychologist and was prescribed sleeping tablets. Elizabeth saw her GP a further three times during February 2014 for insomnia, seizures and to request diazepam and more sleeping tablets.

Elizabeth was referred back to One Support in October 2013 and support commenced in January 2014. Between January 2014 and March 2014, Elizabeth was offered practical support around her housing options. Then on 4 March 2014, Elizabeth went to the GP with her One Support worker. She asked to see a psychiatrist but instead she was referred to 'Improving Access to Psychological Therapies' (IAPT),[8] which did not have a psychiatrist.

Elizabeth went to the emergency department at North Middlesex Hospital on 7 March 2014. She had taken an overdose of two types of antidepressant having had an argument with the perpetrator over the telephone. Her notes recorded that she lived alone, had a key worker who supported her and that her GP had referred her to the local mental health team. As she said that she did not feel suicidal, it was decided that she could be discharged home. The plan was to refer her to mental health triage team in Enfield so they could "*signpost*" her to the most appropriate service. She was also advised to contact Improving Access to Psychological Therapies (IAPT) for anxiety and panic attacks.

On 22 April 2014, Elizabeth's referral to Improving Access to Psychological Therapies (IAPT) was declined because her needs were too complex. The service instead referred her to the Mental Health Trust's triage team.

Elizabeth took a significant overdose (86 sleeping tablets and 10mg of diazepam with alcohol) on 28 April 2014 and was taken to the emergency department at North Middlesex Hospital. She had received an abusive telephone call from her brother telling her to "*take her life*". She was admitted to a ward, where she remained until she was assessed as medically fit for discharge. She was seen by the mental health liaison team. Elizabeth told staff that she had been contacted by a psychiatrist the previous week (which the team assumed was from Improving Access to Psychological Therapies). She also said she had a further appointment with the psychiatrist on 6 May 2014.

[7] Subsequently, on his release in January 2015, Hertfordshire Probation Trust requested to transfer the perpetrator's case to Enfield Probation.

[8] Improving Access to Psychological Therapies (IAPT) is a free and confidential talking service to anyone over the age of 16 years in Enfield or Haringey who is experiencing mental health problems

There was no evidence in Elizabeth's records that she had an appointment with a psychiatrist the following week. The liaison team should have established with the psychiatrist whether or not she actually had an appointment. Equally the liaison team could have contacted Improving Accessing to Psychological Therapies (IAPT) to confirm she was engaging with them.

On 1 May 2014, Elizabeth told her One Support worker that she was in hospital following a suicide attempt. She said that the hospital was "*looking to put in a care package before they discharged her*".

On 6 May 2014, Elizabeth's "*sister*" telephoned the mental health Crisis Resolution Home Treatment Team (CRHTT). She explained that Elizabeth had been discharged from the North Middlesex Hospital the previous week but she had not received any care package. Her "*sister*" felt Elizabeth needed social work input because she was "*in crisis*". The team contacted the mental health triage team who noted that Improving Access to Psychological Therapies (IAPT) had assessed Elizabeth but the outcome was that she was not suitable for their service. The referral was discussed and deemed suitable for the Enfield Complex Care Team (ECCT).[9]

The Crisis Resolution Home Treatment Team (CRHTT) failed to act on the information provided by Elizabeth's "*sister*" i.e. that Elizabeth was in crisis. Instead, the team made contact with the triage team and the deterioration in her mental health was still not acknowledged or assessed. She was again sent to a different team.

Elizabeth had still not been seen or assessed since her GP referred her in October 2013

Elizabeth was seen by her One Support worker on 23 May 2014 and was offered practical support around "*housing repairs*". Her worker also "*chased the triage team*" about the extra support that was "*meant to be in place*" following Elizabeth's hospital admission. Elizabeth went to see her GP on 14 and 29 May 2014. She informed the GP of her overdose. She was advised to engage with the drug and alcohol service (Compass).

On 17 June 2014, an allegation was made against Elizabeth of robbery. She was arrested and charged with racially aggravated burglary. She was bailed to appear at court on 19 June 2014. Elizabeth asked her One Support worker for assistance around her pending court case.

[9] Note: The Improving Access to Psychological Therapies (IAPT), the Crisis Resolution Home Treatment Team (CRHTT) and the Enfield Complex Care Team (ECCT) are all part of Barnet, Enfield and Haringey Mental Health NHS Trust

On 23 June 2014, the mental health Enfield Complex Care Team (ECCT) received a call from Elizabeth's One Support worker to enquire whether Elizabeth had a care coordinator. The worker was concerned as Elizabeth condition appeared to be deteriorating and the worker cited anti-social behaviour. The discussion was reported to the senior manager in the Enfield Complex Care Team (ECCT). Nevertheless, Elizabeth had still not been seen by the Crisis Team.

Elizabeth's case was discussed in the team meeting on 2 July 2014. The discussion concluded that Elizabeth had significant alcohol issues. The team decided that Elizabeth required a psychological assessment and a care coordinator. A letter was then sent from Barnet, Enfield and Haringey Mental Health NHS Trust to Elizabeth's GP on 3 July 2014 requesting that she contact them to make an appointment.

On 9 July 2014, Elizabeth's One Support worker contacted the mental health Complex Care Team. The worker asked for an update from their last phone call on 23 June 2014. The worker was advised to ask Elizabeth to contact the team for an appointment.

In the course of this review, the team manager confirmed that it was (and remains) normal practice to ask the individual to self-refer. The rationale being that it not only allows an assessment of the type of intervention/appointment required but also indicates a motivation to seek help, which is seen as a positive factor.

Nevertheless, in this case it appeared inappropriate to ask Elizabeth who was in a mental health crisis to make her own appointment, particularly as her GP had referred her to mental health services in October 2013 (some nine months earlier).

On 14 July 2014, Elizabeth's "*sister*" called mental health triage team. Again, she expressed her concerns about the deterioration in Elizabeth's mental health over the past weeks. Elizabeth was described as having "*acute thoughts of self-harm and ending her own life*". Her "*sister*" described how Elizabeth had attempted to "*cut her own throat*" but someone had intervened. At the time of the call, Elizabeth was staying with her "*sister*" but her "*sister*" was concerned that if she left Elizabeth alone, Elizabeth might take her own life. Elizabeth's "*sister*" had been attempting to get Elizabeth seen by the mental health services for the past two weeks but had been passed from one team to another. Her "*sister*" was frustrated with the time that Elizabeth had to wait to get support from the mental health services. The Hub triage team spoke to Elizabeth who was tearful with "*pressured speech*". Elizabeth said she was low in mood with "*poor sleep, poor appetite, on-going negative thoughts with thoughts of self-harm and suicide all the time*". She had self-harmed a few days before and felt that she could not guarantee her safety if mental health services did not offer her support. Elizabeth's records noted that she had started to use alcohol to manage her symptoms as her medication was no longer helping.

The triage team took the phone numbers for both Elizabeth and her "*sister*". They concluded that Elizabeth would benefit from an assessment with Enfield Crisis Resolution Home Treatment Team (CRHTT). A request was forwarded to the team to see Elizabeth as soon as possible. The Enfield Crisis Resolution Home Treatment Team (CRHTT) acknowledged the referral, however, they closed the case and referred Elizabeth on to the Enfield Complex Care Team (ECCT). This team was unable to offer Elizabeth an appointment, as "*their system was down*". Thus, the duty worker was asked to make urgent contact with Elizabeth.

Enfield Crisis Resolution Home Treatment Team (CRHTT) should work with people at a time of crisis but they failed to see Elizabeth or assess her. Instead, her case was transferred to Enfield Complex Care Team (a longer-term team) for assessment.

Enfield Complex Care Team (ECCT) made contact with Elizabeth by telephone the same day (14 July 2014) to inform her that she would be given an appointment for a psychological assessment. She was asked to contact the team if she needed to be seen. Elizabeth was subsequently sent an appointment letter for a psychiatric assessment for 26 August 2014.

Elizabeth saw her One Support worker on 16 July 2014 and was offered support around her mental health as her mood was low. She saw her worker again on 5 August (GP appointment) and 22 August 2014 (appointment with the solicitor). Then on 26 August 2014, Elizabeth's One Support worker telephoned Enfield Complex Care Team (ECCT) to say that Elizabeth was in a "Disability Allowance" appointment and would not be able to attend her appointment with the psychologist.

On 27 August 2014, Elizabeth was seen for a psychological assessment at which her One Support worker was also present. The original referral had been made by her GP on 22 October 2013, some ten months earlier. The assessment of Elizabeth did not take into account issues around safeguarding children or domestic abuse. Her case was not discussed at the weekly clinical presentation meeting. Furthermore, as she had an impending court case, staff should have liaised with other agencies. This may have highlighted Elizabeth's need for a care coordinator.

To clarify her diagnosis and review her medication, she was given an appointment to see a psychiatrist on 19 September 2014. Elizabeth's One Support worker was also present at this appointment. Her medication was changed and she was to be reviewed in 2-3 months (5 December 2014).

On 1 October 2014, the perpetrator gave BeNCH Community Rehabilitation Company (CRC)[10] Elizabeth's address as his release address. There was no indication that any checks

[10] The National Probation Service was set up on 1 June 2014, along with 21 Community Rehabilitation Companies (CRCs). The Nation Probation Service and the Community Rehabilitation Companies replaced the former 35 Probation Trusts. Thus, Hertfordshire Probation Trust divided into the National Probation Service, and Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company (BeNCH CRC).

were undertaken or that the London Community Rehabilitation Company (CRC) was contacted.

Elizabeth was seen again by her GP on 7 October because she was feeling stressed. She felt the new anti-depressant was not working and she could not reduce the diazepam. The following week she saw her GP as she had a chest infection. She thought this had been caused by smoke inhalation because there had been a fire at her home and she was too sedated to wake up. She also told her One Support worker about the fire but there was no evidence that this information was shared.

The GP did not appear to recognise Elizabeth's vulnerability – Elizabeth should have been referred to Adults Social Care as a vulnerable adult. Equally, Elizabeth's One Support worker should have liaised with other services concerning Elizabeth's vulnerability

On 16 October, she called her GP to say that she could not "*cope*" without her sleeping tablets but by 28 October, the GP described her mood as "*improved*" and she was sleeping better. Her condition appeared to improve and stabilise throughout November 2014.

Elizabeth was reviewed by the psychiatrist on 5 December 2014. Her One Support worker accompanied her. It was noted that her mental health had improved and she had had contact with her children. Nevertheless, again this was a lost opportunity to undertake a fuller assessment and review issues around safeguarding and domestic abuse by exploring her relationships. Ideally her case should have been discussed at the clinical presentation meeting.

4.5. January 2015 – perpetrator released from prison

On 27 January 2015, BeNCH Community Rehabilitation Company (CRC) contacted London Community Rehabilitation Company (CRC) to arrange for the perpetrator's case to be transferred. A senior probation officer accepted the case and instructed the allocated officer to complete a home visit. The perpetrator was released on 29 January 2015 and attended the Enfield Community Rehabilitation Company (CRC) office. He was accompanied by Elizabeth, who remained present during the appointment.

On 30 January 2015, the perpetrator had an appointment with his GP, as his prison psychiatrist wanted the GP to increase the perpetrator's medication to "*stabilise his mood*". The perpetrator visited his GP again on 6 February 2015 but his patient documentation from the prison still had not arrived.[11] The same day (6 February 2015), Elizabeth missed her psychiatric appointment. Another appointment was sent to her by post for 6 May 2015.

[11] Ultimately it took a year from the perpetrator's release from prison for the GP to receive his prison medical records.

The perpetrator reported to the London Community Rehabilitation Company (CRC) on 11 February 2015. On 13 February 2015, the perpetrator saw his GP with symptoms of low mood, anxiety, irritability, poor concentration and poor sleep. He said he was experiencing "*fleeting thoughts of self-harm but he would not act on it because of his partner*". The GP told the perpetrator that he would not be prescribed buprenorphine [12] until the GP had received his records from prison. The perpetrator was given the contact details for the drug and alcohol service (Compass) and an urgent referral was made to mental health services.

On 18 February 2015, the perpetrator failed to report to the London Community Rehabilitation Company (CRC). Then on 20 February 2015, his GP referred him to mental health services. The referral noted that he had recently been released from prison and had worsening symptoms of post-traumatic stress disorder, which had been started in 2012 after witnessing a fellow prisoner self-harm. The referral also noted that his "*partner*" was supportive and a protective factor; although it did not detail who his partner was or their living arrangements. The perpetrator was sent an appointment for 17 March 2015.

On 25 February 2015, a telephone call was made to the perpetrator informing him that the Integrated Offender Management (IOM) team would conduct a home visit the following day. There was no record of the visit, the outcome or the assessment.

As part of Elizabeth's pre-sentence report (PSR), her probation officer contacted her One Support worker for information on 26 February 2015.

On 1 March 2015, police neighbourhood officers (on behalf of the Community Rehabilitation Company) visited the perpetrator at his mother's house. His mother explained that he did not live there but visited occasionally.

On 10 March 2015, the perpetrator met with the Integrated Offender Management (IOM) officer.[13] He was described as being "*obstructive*" and he refused to take a drugs test.[14] The records stated that although there had been previous domestic incidents between them, Elizabeth (who was present) stated that she was "*happy for the perpetrator to reside*" at her address.

It was completely inappropriate for Elizabeth to be at this meeting and she had no choice but to say she was "*happy*" to have the perpetrator living at her house.

The officer also noted that the perpetrator was "*gaunt and had the appearance of a regular user of controlled drugs*". The officer informed the perpetrator's probation officer that the perpetrator's address was unsuitable, as there had been domestic abuse call outs. There

[12] A narcotic analgesic (painkiller)

[13] The Integrated Offender Management (IOM) officers include drug and alcohol practitioners, police and probation officers. Officers are assigned to IOM nominals based on risk and need.

[14] Although the perpetrator refused a drug test, this could not be enforced as it was not a condition on his licence

was no indication that his probation officer discussed this with the perpetrator or instructed him to find alternative accommodation. The perpetrator also gave his probation officer a medical certificate that excluded him from attending for 31 days (dated 6 March 2015). A further home visit was scheduled to take place on 19 March 2015 (there was no record of it taking place).

On 13 March 2015, the perpetrator failed to attend his appointment with his GP. The GP phoned him and the perpetrator explained that he had attended an appointment with drug and alcohol services (Compass). The GP however contacted the service who informed the GP that the perpetrator had not attended his appointment. The GP made another referral for the perpetrator to attend the following week. On 17 March 2015, the perpetrator called mental health services to cancel his appointment as he had to attend a court appearance. He was offered another appointment for 31 March 2015.

4.6. Assault four

On 17 March 2015, police received a call with sounds of an argument in the background. The line was cut off, but it was identified as Elizabeth's phone. When officers arrived, she told them that the perpetrator had tried to force his way into her home. She had opened the door slightly and he pushed it open, knocking her arm and damaging the electronic tablet she was holding. The allegation was recorded on a body worn video.

The perpetrator was arrested nearby on suspicion of common assault and criminal damage. When Elizabeth was told of his arrest, she immediately refused to provide a statement. A Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) was undertaken but Elizabeth declined to answer any questions. As the perpetrator had been arrested, Elizabeth was assessed as standard risk of harm.

The case was allocated to the police Community Safety Unit for further investigation. On 18 March 2015, the investigating officer contacted Elizabeth who reiterated that she was still unwilling to support a prosecution and refused to provide a statement. Elizabeth was given advice about how to seek a non-molestation order and was again referred to the National Centre for Domestic Abuse (NCDV).

Again, the perpetrator denied assaulting Elizabeth. He stated that he had argued with Elizabeth, during which she assaulted him by hitting him with the tablet. Officers noted a cut and bruising to his nose. An Evidential Review Officer assessed the evidence and concluded without a statement from Elizabeth, an admission from the perpetrator or any other supporting evidence, there was no realistic prospect of conviction in this case. The case was closed.

On 18 March 2015, the perpetrator's probation officer discussed the case with a senior probation officer. The probation officer was instructed to have a drug testing condition added to the perpetrator's licence; to inform him that he could not stay at Elizabeth's address; and to engage him in 1:1 domestic abuse work.

The perpetrator saw his probation officer on 20 March 2015 – Elizabeth was in the meeting with him. He told the officer that the domestic "*incident was sorted out as they had had a chat*". Elizabeth indicated that she wanted the perpetrator to remain living at her house. The officer did not challenge this. On 26 March 2015, the perpetrator again took Elizabeth into the meeting with his probation officer. Elizabeth told the officer that it was her fault that the perpetrator was arrested and she did not want him to be recalled to prison. Again, the officer did not challenge this.

On 31 March 2015, the perpetrator called mental health services. He said he would be late for his appointment because he was with his probation officer. The practitioner spoke to the perpetrator's probation officer (with his consent) and discussed cognitive behaviour therapy and other group therapies that Westminster Drug Project (WDP) might offer the perpetrator. The probation officer agreed to make a referral to the Westminster Drug Project (WDP).

On 8 April 2015, the perpetrator reported to the London Community Rehabilitation Company (CRC) to complete the first session of one-to-one domestic abuse programme.

On 9 April 2015, Elizabeth appeared at court and was sentenced to a suspended sentence supervision order for the offence of assault, possession of cannabis and theft. The requirement of the order was for her to attend for alcohol treatment and supervision. She was allocated a probation officer on 14 April, and a home visit was undertaken by the 'supported compliance team' team on 15 April 2015. An OASys risk assessment[15] was completed on 16 April that indicated domestic abuse (the information however was basic and this should have been explored more fully).

On 16 April 2015, Elizabeth had an assessment with Westminster Drug Project (WDP). Elizabeth told her key worker that since the perpetrator had been released from prison, he had abstained from alcohol and stopped being violent. Her key worker told her that if the perpetrator became "*abusive again*", Elizabeth was to inform them and a referral would be made so she could access support.

The perpetrator failed to attend his second domestic violence programme one-to-one session on 24 April 2015; he said this was due to an incident where his daughter was "*held at knifepoint*". The same day, Elizabeth failed to attend Westminster Drug Project (WDP).

On 23 April 2015, the perpetrator was discussed at mental health triage team meeting. A request was made for his GP to review his mental state. The team contacted his probation officer, who explained that the perpetrator was having one-to-one sessions on a domestic

[15] The Offender Assessment System (OASys) is the assessment tool used by the Prison Service and Probation Trust to assess and record the likelihood of reoffending and risk of serious harm. It plays a pivotal role in assessment, case management, targeting of treatment programmes, referrals to partnerships, resource allocation and risk management for offenders aged 18 and over. OASys is the tool that allows the National Offender Management Service (NOMS) practitioners to assess an offender's likelihood of reoffending by systematically examining a number of offending-related factors, including offending history; education, training and employability; relationships; drug misuse; alcohol misuse; emotional well-being; thinking and behaviour; and accommodation, lifestyle, and associated thinking, behaviour and attitudes – for further information see www.mappa.justice.gov.uk – accessed online 10 August 2017.

violence course. His probation officer described the perpetrator as presenting well and attending his appointments on time. His mood and concentration were normal. His probation officer had no concern about his mental health. As his offence was "*burglary of a dwelling, there was no significant risk to the public or staff*". The officer appeared to discount the fact that the perpetrator was attending a domestic abuse perpetrator programme.

This was a missed opportunity to consider the risk the perpetrator posed to Elizabeth and establish which other agencies were involved in supporting them. His probation officer appeared to focus on his offending behaviour as a burglar and minimise his history of domestic abuse.

Clearly the mental health team was unable to "*triangulate*" the information, as Elizabeth's details were unknown.

4.7. Assault five

On 25 April 2015, Elizabeth called the police to report that the perpetrator had assaulted her by punching her on the nose. The officers noted Elizabeth's nose was bruised and bleeding. Elizabeth provided a statement. Her injuries were photographed and Elizabeth was advised to seek medical treatment, which she refused. The allegation was recorded on a body worn video. A Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) was undertaken to which Elizabeth answered that she was afraid of the perpetrator and the abuse was getting worse. She was assessed as at medium risk of harm.

When the perpetrator could not be located, his details were circulated on the Police National Computer (PNC) as wanted for assault. The case was passed to the police Community Safety Unit and intelligence checks identified the previous domestic abuse incidents. An investigation plan was set recommending that Elizabeth should be referred to the multi-agency risk assessment conference (MARAC).[16] There was however no information to suggest that police made this referral.

The perpetrator was recalled to prison on 27 April 2015 as a result of the assault but was not arrested until 18 May 2015.

On 27 April 2015, the perpetrator's case was 'risk escalated' to the London division of the National Probation Service. The escalation was refused, although there is no documentation of the reason. The same day a telephone call was received by Westminster Drug Project (WDP) from Elizabeth to say that she was scared to leave the house as the perpetrator had

[16] This is a multi-agency risk assessment conference at which local agencies meet to discuss confidentially high-risk victims of domestic abuse. The aim is to identify what safety measures and support mechanisms could be put in place for Elizabeth and her family. MARAC was introduced in Enfield in August 2005.

assaulted her; he was wanted by the police and she would not feel safe until he was arrested.

On 30 April 2015, Elizabeth had a face-to-face meeting with her One Support worker and informed her of the assault. The perpetrator had still not been located by the police and therefore, her support worker cancelled her appointment with the drug and alcohol service. The worker also contacted the London Community Rehabilitation Company (CRC) to arrange for her probation officer to visit Elizabeth at home that day.

Elizabeth attended an appointment at the Community Rehabilitation Company (CRC) on 6 May 2015 with her Westminster Drug Project (WDP) worker. She disclosed that she had been drinking a bottle of vodka a day with cider and not taking her antidepressants. The same day, she was seen by a psychiatrist with her One Support worker. Elizabeth was referred to a 'mindfulness' therapy group. She described how she was working on her addiction with one-to-one support from the Westminster Drug Project (WDP), seeing the Community Rehabilitation Company (CRC) weekly and also had support from One Support. She was given a follow-up appointment for 5 August 2015.

On 12 May 2015, Elizabeth was seen by the Westminster Drug Project (WDP). She was accompanied by her One Support worker. She was drinking wine and cider daily but had managed to abstain from drinking vodka.

4.8. May 2015 – perpetrator recalled to prison

The perpetrator was arrested on 18 May 2015 and interviewed. He denied assaulting Elizabeth. The investigating officer contacted Elizabeth to update her and she immediately told the officer that she wanted to withdraw her allegation. She stated that she was drunk and had sustained the injuries whilst suffering a seizure. The officer tried to engage with Elizabeth to complete a risk assessment, but she refused. The case was submitted to the Crown Prosecution Service (CPS). They directed that no further action should be taken as there was no realistic prospect of conviction in the circumstances of the suspect's denial and the victim's withdrawal. The case was closed; although the perpetrator was recalled to prison as a result of the assault on Elizabeth.

This is the second time that CPS closed the case, despite there being photos and body worn video available

On 20 May 2015, Elizabeth reported to London Community Rehabilitation Company (CRC). It should have been a three-way meeting but her worker from Westminster Drug Project (WDP) cancelled. A Multi-Agency Risk Assessment Conference (MARAC) referral was discussed but Elizabeth felt it was unnecessary at the time. She told her probation officer that she felt safer with him in prison (despite the fact that he had called her from prison and

blamed her for his situation). She said that she did not want him to be allowed back to her home when he was released.

By mid-June 2015, Elizabeth told her GP that she was down to one sleeping tablet every three days and would stop them by the end of the month. After this she was to start reducing her diazepam. By the end of June, Elizabeth told her Westminster Drug Project (WDP) worker that she had stopped drinking vodka and only had wine and cider on some days. On 8 July 2015, there was a three-way meeting between Elizabeth, Westminster Drug Project (WDP) and London Community Rehabilitation Company (CRC). Elizabeth said that she had had telephone contact with the perpetrator whilst he was in prison. He told her that "*he didn't care who was listening*", he would be going to her house on his release. Elizabeth told her probation officer that she was concerned about the perpetrator's release. A Multi-Agency Risk Assessment Conference (MARAC) referral was made by London Community Rehabilitation Company (CRC) on 16 July 2015.

Between 23 July 2015 and 31 July 2015, the independent domestic violence advisor (IDVA) attempted to contact Elizabeth's Community Rehabilitation Company (CRC) worker but to no avail. On 30 July 2015, Elizabeth's Community Westminster Drug Project (WDP) worker left and her case was re-allocated to another worker.

On 5 August 2015, the multi-agency risk assessment conference (MARAC) meeting was held. The records stated that:

> *The perpetrator was staying with Elizabeth and assaulted her in April 2015. He was recalled to prison and currently waits for an assessment for his release. If released early he will be on licence but if released in November, there will be no conditions.* [*The perpetrator*] *says he will return to Elizabeth's address, she is not strong enough to say no. Property not secure low garden fence* [*the perpetrator*] *climbs over and gains entry through the window.* [Probation officer] *worried that Elizabeth will not report or press charges. Victim has bi-polar, she does not want to move has good support network.*[17]

The police agreed to flag Elizabeth's address when the perpetrator was released from prison. Thus, any calls from her home would be treated as urgent. It was agreed that a non-molestation order should be considered if he was not released on license. The Community Safety Unit was tasked to arrange further security for the alley outside Elizabeth's property. The independent domestic violence advisor (IDVA) organised repairs to Elizabeth's front door with additional security for her windows.

Also on 5 August 2015, Elizabeth cancelled her appointment with the Enfield Complex Care Team (ECCT). Elizabeth did not attend her mindfulness group assessment on 13 August 2015, although she did report to the Community Rehabilitation Company (CRC) that day. The Complex Care Team (ECCT) staff contacted her and arranged for another appointment

[17] Elizabeth's mother explained that Elizabeth's housing association offered her alternative accommodation but they could not guarantee that it would be nearer to her mother and children. Elizabeth therefore decided to remain where she was, as she had a good support network there.

on 20 August 2015. However, Elizabeth phoned that day to cancel her appointment as she had someone from the "*domestic violence team*" at her home assessing how to make it safe. The appointment was re-arranged for the evening.

This was a missed opportunity for mental health services to explore the reasons why her house was being secured and for her case to be either discussed at a clinical meeting or with the safeguarding lead. It was an opportunity to gather further information from Elizabeth 's One Support worker, Community Rehabilitation Company (CRC) officer, the independent domestic violence advisor (IDVA) and the multi-agency risk assessment conference (MARAC).

Indeed, consideration should have been given to appointing a care coordinator.

Elizabeth was seen by her One Support worker on 29 September 2015 and her worker discussed closing the case. No reason was documented. During the month, the independent domestic violence advisor (IDVA) worked hard to have Elizabeth's property secured. On 9 October 2015 Elizabeth's independent domestic violence advisor (IDVA) informed her that she would be closing her case as all the new security measures were in place. The independent domestic abuse advisor (IDVA) suggested that Elizabeth might benefit from counselling but Elizabeth declined any further support.

On 15 October 2015, Elizabeth was discharged from Barnet, Enfield and Haringey Mental Health NHS Trust Complex Care Team (ECCT) as her mental health had improved and she had reduced her substance misuse. She was considered to be engaging well with the Westminster Drug Project (WDP) and the Community Rehabilitation Company (CRC). Elizabeth declined any psychology input. A full assessment of her current and future risk from the perpetrator was not undertaken as no one recognised the implications of her having her locks changed and door strengthened.

On 16 October 2015, the independent domestic violence advisor (IDVA) called the Community Rehabilitation Company (CRC). The perpetrator was due to be released on 20 November 2015 at the end of his sentence without bail conditions.

Elizabeth completed her Alcohol Treatment Requirement (ATR) order and at the meeting with her probation officer on 20 October 2015, the officer explained about changes to the service. Elizabeth would have a different probation officer but this officer had not yet been allocated.

On 23 October Elizabeth failed to attend her three-way appointment with Westminster Drug Project (WDP) and the Community Rehabilitation Company (CRC). She had phoned to say she was feeling unwell. Elizabeth's second worker from Westminster Drug Project (WDP) left and her case was again re-allocated.

Elizabeth's second worker from Westminster Drug Project (WDP) had been allocated to her in July 2015 but had never met with her and then left the organisation in October 2015.

Elizabeth missed her appointment with the Community Rehabilitation Company (CRC) on 27 October 2015. Her independent domestic violence advisor (IDVA) called her and Elizabeth explained that there had been an incident in the street when the perpetrator's sister drove past and verbally abused her. The car mounted the pavement and Elizabeth felt very intimidated. She also said that the perpetrator had called her from prison and she told him she did not want to see him anymore.

Elizabeth's family described how she was threatened by not only the perpetrator but his family. It was not clear whether Elizabeth shared this information widely with the practitioners trying to support her. Nevertheless, she did share it with her independent domestic violence advisor (IDVA) but the information was not passed on to police, probation or the multi-agency risk assessment conference (MARAC). So, there was no wider discussion about how these threats might impact on her life.

On 28 October 2015, Elizabeth received a letter from the perpetrator. He wanted to arrange to collect his possessions from a police station. The independent domestic violence advisor (IDVA) explained that she should close the case; but she was worried that the risk might escalate when the perpetrator came out of prison. Ultimately, she closed the case and referred Elizabeth to Victim Support on the understanding that if "*anything happened*" Elizabeth would be referred back to the independent domestic violence advisor (IDVA).

A non-molestation order was not pursued despite it being decided at the multi-agency risk assessment conference (MARAC) that one should be sought if the perpetrator was released without licence conditions.

On 29 October 2015, the independent domestic violence advisor (IDVA) called Elizabeth to complete a "service user exit form" but her mobile appeared to have been disconnected. The independent domestic violence advisor (IDVA) contacted Elizabeth the following day but Elizabeth declined to complete the form. On 6 November 2015, Elizabeth completed the exit form and told the independent domestic violence advisor that she would like to continue to work with the advisor, if she was referred back again.

On 10 November 2015 Elizabeth had a face-to-face meeting with her One Support worker and her worker again discussed closing her case as "there were no outstanding support needs".

By this time, Elizabeth had reduced her alcohol intake to about one glass of wine a day and had resumed her relationship with her family. Her mental health had improved. Yet, professionals did not appear to recognise that this improvement coincided with the perpetrator being in prison.

4.9. November 2015 – perpetrator released from prison

On 20 November 2015, the perpetrator was released from prison to his mother's home. Even though he had been recalled for an assault on Elizabeth, as he had completed his sentence for burglary, he was not subject to any post custodial licence. Records showed that he would be monitored as part of Enfield's Integrated Offender Management Team.

After the perpetrator's release, the independent domestic violence advisor (IDVA) called Elizabeth (date unclear from the records). Elizabeth stated that the perpetrator had been calling and texting her repeatedly even though she asked him to "*leave her alone*". The independent domestic violence advisor (IDVA) told Elizabeth not to return his calls and texts, and advised her to contact Solace Women's Aid advice services or to call 999 if he came to her home or made threats. The records noted that Elizabeth sounded drunk and the independent domestic violence advisor (IDVA) was "*unable to make much sense of Elizabeth's current situation*".

On 23 November 2015, Enfield Integrated Offender Management (IOM) officers conducted an unannounced visit to the perpetrator's mother's address. He was present together with his mother. The records described that he appeared to be in good health. The plan was for the Integrated Offender Management (IOM) to continue with home visits.

On 4 December 2015, Elizabeth's independent domestic violence advisor (IDVA) called Elizabeth. She said that she had heard nothing from the perpetrator (this was a sudden turnaround as previously the perpetrator had been phoning and texting Elizabeth regularly). He had not been to her home and Elizabeth felt she no longer required support. It was agreed that her case should be closed.

On 30 November 2015, Elizabeth met her One Support worker and her case was officially closed. Then on 4 December 2015, her probation officer passed her case to a new officer. Elizabeth went to the Community Rehabilitation Company (CRC) office on 10 December 2015 but her new officer was not available. She was seen by her original officer and disclosed that the perpetrator had called her since his release and that she had seen him in the street "*a couple of times and said hello*". She said that she did not feel scared and thought he would not go to her home.

On 16 December 2015, Enfield Integrated Offender Management (IOM) officers visited the perpetrator at Elizabeth's address. The records stated that he had "*recently moved back in with Elizabeth*" and they will "*keep a watch on the address as both parties are known to have a tempestuous relationship*" and they are alcohol dependent.

There was no information sharing between the Westminster Drug Project (WDP) worker, the London Community Rehabilitation Company (CRC) officer, Enfield Integrated Offender Management (IOM) officers, the One Support worker and the independent domestic violence advisor (IDVA). Therefore, professionals did not recognise or consider the discrepancies in the details that Elizabeth and the perpetrator were telling professionals.

On 17 December 2015, Elizabeth's Westminster Drug Project (WDP) worker phoned and Elizabeth said that she had an appointment for 7 January 2016. Therefore, her appointment on 18 December 2015 was cancelled.

By this time, Elizabeth has not been seen by the Westminster Drug Project (WDP) since July 2015

On 18 December 2015, the perpetrator was seen by his GP. He was still experiencing flashbacks and had poor sleep but no suicidal thoughts. His GP referred him to a neurologist and mental health services.

The perpetrator called the police on Christmas Eve 2015 to report that Elizabeth had cut her wrists. Initially, the sound of a man and woman could be heard arguing in the background. When officers arrived, the perpetrator told them that this was the third time in a week that Elizabeth had harmed herself. He told police that he was concerned that Elizabeth's self-harming behaviour had become an attempt to end her life. During the course of this review, Elizabeth's cousin said that Elizabeth had told her that the perpetrator had "*encouraged*" Elizabeth to cut her wrists".

Elizabeth was taken to North Middlesex Hospital by London Ambulance Service. An 'Adult come to Notice' was created to highlight Elizabeth's vulnerabilities and the information was shared via email with Adult Social Care. The referral to Adult Social Care included a comprehensive record of Elizabeth's contact with the police, her history of domestic abuse and the previous assaults sustained from the perpetrator.

The police did not classify this incident as a domestic abuse incident despite there being a known history of domestic abuse between the couple. The incident should have been reported as a non-crime domestic incident and a Domestic Abuse, Stalking and Harassment Risk Assessment (DASH) completed.

Both Elizabeth and the perpetrator were seen together in the emergency department by the mental health liaison team. No immediate risk was identified and it was agreed that Elizabeth could go home when she was medically cleared for discharge.

The perpetrator saw his GP on 4 January 2016 with a deep cut to his finger. He told the GP that his "*ex-girlfriend*" had tried to cut her throat and he sustained the injury when he tried to stop her. The GP made a call to orthopaedics for an urgent appointment. Despite the

available information, there was no documentation to suggest that a vulnerable adult referral was made concerning Elizabeth.

The same day the perpetrator failed to attend his mental health appointment. No reason was given and his case was discussed at the team meeting. He was then discharged from the service. A letter to his GP explained that he could still be re-referred if he wished to access cognitive behavioural therapy via the Westminster Drug Project (WDP).

On 6 January 2016, the perpetrator's mother contacted police and asked them to check on his welfare. She told officers that he had arrived at her home the previous evening and told her that Elizabeth had assaulted him with a knife. He had then left and she was now unable to contact him. She told the police that that she was concerned because the level of violence between Elizabeth and the perpetrator was increasing. Officers contacted the perpetrator via telephone. He told them he was with Elizabeth and he was safe and well. He confirmed that he remained in a relationship with Elizabeth and that he did not wish to make any allegation.

This was a third-party allegation of assault. Given the history of previous domestic abuse, it should have been viewed as a domestic abuse incident and recorded on police systems as a crime but there was no explanation why this was not done. Therefore, the Community Safety Unit was not informed and opportunities were missed to follow up the perpetrator and see both him and Elizabeth in person. A referral should have been made to the multi-agency risk assessment conference (MARAC) and information shared between agencies. This may have raised awareness between agencies about how vulnerable Elizabeth was at this point.

On 7 January 2016, Elizabeth's new worker from the Westminster Drug Project (WDP) contacted the Community Rehabilitation Company (CRC). Elizabeth's probation officer explained that she was no longer managing Elizabeth's case. The Westminster Drug Project (WDP) worker contacted Elizabeth who said she was doing "okay" and that she did not want to engage with services. Her drug and alcohol worker said she would send her a discharge letter.

On 8 January 2016, Elizabeth telephoned the Community Rehabilitation Company (CRC) to say she was unwell and could not attend her appointment. There was no further contact documented in the Community Rehabilitation Company (CRC)records.

It was evident that the violence towards Elizabeth escalated during this period. As the police failed to visit either the perpetrator or Elizabeth on 6 January, it is impossible to know whether Elizabeth cancelled her appointment because of injuries that she had sustained – however, this may have been the case.

On 22 January 2016, the police notification (dated 24 December 2015) was sent to the Barnet, Enfield and Haringey Mental Health NHS Trust Assessment Centre by the Multi Agency Safeguarding Hub. It recorded that the information had been forwarded to the

Enfield Complex Care Team (ECCT) via email on 29 December 2015 for them to follow up. The notification contained a list of Elizabeth's past history of abuse from the perpetrator and detailed Elizabeth's self-harm which was becoming "*more serious and frequent*". As Elizabeth's case had been passed to mental health services, Enfield Adult Social Care closed it. There was, however, no record on the system that the Enfield Complex Care Team (ECCT) took any action.[18]

The perpetrator called Enfield Integrated Offender Management (IOM) officers on 27 January 2016 and requested a home visit. He told officers that his relationship with Elizabeth had broken down since Christmas because of her "*excessive alcohol consumption and general behaviour*". He told officers that he was "*fearful that she would make malicious allegations against him*" so he had moved back to his mother's. He said he wanted to address his alcohol dependency. The officers arranged to accompany him to Elizabeth's home on 29 January 2016 to collect his property.

The Enfield Integrated Offender Management (IOM) officers should have liaised with other agencies to gain an understanding of the situation. This may have highlighted the incident the perpetrator's mother reported on 6 January 2017 and again was an opportunity to establish Elizabeth's vulnerability.

On 8 February 2016, Elizabeth visited her GP because she had self-harmed and had a piece of glass under her skin. She was advised to go to A&E as soon as possible. There was no record that she attended A&E although there were three phone calls between Elizabeth and the mental health service that day. She told them that she was self-harming. It was noted that her telephone number had changed due to the threat of domestic abuse. The records stated that she was "*currently living alone and still is experiencing domestic violence issues*". Elizabeth told mental health staff that she had tried to cut her throat and had smashed a glass into her face. Elizabeth stated she felt "*worthless since her partner had been released from prison*". She claimed the police knew her partner was physically abusive and that he had kicked her door down. Elizabeth was referred to Enfield Crisis Resolution Home Treatment Team (CRHTT) and was advised to contact the Crisis Team at night.

COMMENT
An alert should have been raised as per the domestic violence and abuse policy, which should have led to a referral to the multi-agency risk assessment conference (MARAC). This was also a missed opportunity to consider that her injuries may <u>not</u> have been self-inflicted.

On 9 February 2016, Enfield Crisis Resolution Home Treatment Team (CRHTT) carried out a home visit and a full mental state examination. There was a clear account of domestic abuse

[18] Since this event there has been a change in practice and now all alerts are reviewed by the team manager. The team manager then documents all decisions on the individual's record

and the current risk to Elizabeth, as she indicated that the perpetrator had recently been released from prison and he had stayed with her the previous week. He was reported to use drugs, was possessive of her and paranoid; she was scared when she left the house; and she had self- harmed recently. Elizabeth said she felt anxious, worthless and could not understand why she self–harmed. She disclosed that the perpetrator had hit her in the past. She also indicated that she intended to end the relationship. She was assessed to be at medium risk of self–harm (her children were her protective factor) and low risk of harm from others. Elizabeth was encouraged to self-refer to Improving Access to Psychological Therapies (IAPT) and a referral was made to Enfield Complex Care Team (ECCT) for longer term follow up. This referral was not received as it was sent to an incorrect email box.

The risk from the perpetrator was clearly stated and Elizabeth should have been viewed as at high risk (of being seriously harmed or murdered by her partner). Her circumstances should have been proactively investigated and escalated. Practitioners should have recognised the increased risk to Elizabeth when she said she intended to end the relationship. Signposting Elizabeth to Improving Access to Psychological Therapies (IAPT) was inappropriate in the circumstances

Ultimately, Enfield Crisis Resolution Home Treatment Team (CRHTT) should have accepted Elizabeth's case. Instead, it was an unsafe discharge with no follow up to check either on Elizabeth's safety or on the referral to Enfield Complex Care Team (ECCT).

The perpetrator saw his GP on 12 February 2016. He had stopped his anti-depressant which had made his mood erratic and low, and he was not sleeping well. He declined to engage with drug and alcohol services. His GP advised him to take his medication as prescribed.

On 22 February 2016, Elizabeth saw her GP because she had been self-harming. She described cutting her wrist and smashing a bottle in her face. Her records noted that she was under the Crisis Resolution Home Treatment Team (CRHTT). The same day, the Crisis Resolution Home Treatment Team (CRHTT) followed up Elizabeth's referral (made on 9 February) to the Enfield Complex Care Team (ECCT) and her case was opened. Subsequently, screening took place on 1 March 2016 and Elizabeth was offered an appointment for 13 May 2016.

Elizabeth died on 12 March 2016.

5. OVERVIEW AND ANALYSIS

5.1. Metropolitan Police Service

On each occasion that the perpetrator assaulted Elizabeth, he was arrested. On only one occasion was he charged. On four occasions, Elizabeth provided a statement, but later withdrew her allegation. Each time Elizabeth withdrew her statement, the police referred

her case to the Crown Prosecution Service (CPS) but on each occasion the Crown Prosecution Service (CPS) decided that no further action should be taken.[19]

In early 2015, body worn video (BWV) was introduced in Enfield by the Metropolitan Police Service as a pilot scheme. In cases of domestic abuse, this has helped capture significant supporting information such as the victim and the suspect's demeanour, any injuries that have been sustained or any damage which has occurred. This information can help to support an evidence-based prosecution when victims may be unwilling to support such a course of action.

On two occasions Elizabeth came to notice for incidents of self-harm. Despite there being a history of domestic abuse and assaults on Elizabeth, neither incident was considered, or documented, as a domestic incident. Thus, no risk assessment was undertaken. These were missed opportunities to offer Elizabeth support or refer her to local organisations that specialise in supporting victims of domestic abuse.

On 6 January 2016, the perpetrator's mother contacted police to report that he had been assaulted by Elizabeth and she feared the level of violence in the relationship was increasing. This also was not classified as a domestic abuse incident and neither the perpetrator nor Elizabeth were seen by officers. The information was not recorded on the Crime Reporting Information System (CRIS). A local recommendation has been made to address this issue. Nevertheless, this was a crucial incident that had it been investigated properly may have led officers to appreciate the risk that Elizabeth faced at that time. Instead it appeared that after this incident, Elizabeth disengaged from all services (for which the perpetrator may have been responsible).

There was no evidence that the police ever sought information from other agencies to establish the risk that the perpetrator posed to Elizabeth, nor did the police proactively refer Elizabeth to the multi-agency risk assessment conference (MARAC). In fact, the police appeared to minimise the risk that Elizabeth faced by assessing her as standard risk simply on the ground that the perpetrator had been arrested and thus at that point of time he was not a risk to her. There was no information to suggest that Elizabeth's risk was re-assessed following his release from custody.

5.2. Hertfordshire Probation Trust

Hertfordshire Probation Trust supervised the perpetrator between January 2013 and October 2013 (when he was recalled to prison).

The perpetrator provided his mother's address for his release in January 2013 (although she stated that she did not want him to live with her). His mother then moved to Enfield and thus when he was released, he was homeless. Although, the perpetrator consistently told his probation officer that he was living with his girlfriend, no attempt was made to establish

[19] The Crown Prosecution Service (CPS) was invited to sit on the domestic homicide review panel, but declined

who she was or whether it was appropriate that he lived there. In fact, Hertfordshire Probation Trust only became aware of the domestic abuse between the perpetrator and Elizabeth in August 2013 – by this time the perpetrator had assaulted Elizabeth twice. Despite these two assaults, there was no evidence to suggest that the perpetrator's probation officer took any action i.e. recalling him to prison.

He appeared to manipulate his probation officer. He focussed attention on his homelessness, thereby distracting the officer from the incidents of domestic abuse and his drug and alcohol use. He missed appointments; on one occasion, he turned up with a dog so he could not be seen; he also produced medical certificates exempting him from being seen for significant periods. This was never challenged and thus, there was a period between 25 September to his recall on 21 October 2013 when he was not seen and was not offered an appointment. This was a serious oversight because he was classified a prolific burglar and opportunistic thief with a high probability of re-offending, who carried out offences in order to pay for a significant dependency on alcohol, cocaine and cannabis.

The probation officer failed to take an investigative and pro-active approach to domestic abuse. A SARA risk assessment[20] should have been completed and the probation officer should have liaised with the Enfield police. The discussion that the probation officer had with the perpetrator about assaulting Elizabeth was inadequate and only concerned the implications for the perpetrator's living arrangements. Following the incidents of domestic abuse, the perpetrator's sentence plan should have been updated and re-focused.

The lack of information sharing between Hertfordshire Probation Trust, London Probation Trust and the police in Enfield had an impact on this case. Had information been shared, the perpetrator could have been recalled to prison sooner – yet this was not considered.

The details of the transfer of the perpetrator's case from Hertfordshire to Enfield were confusing because of a sparsity of the records. It even appeared that the probation officer in Hertfordshire changed but there were no details recorded.

5.3. London Community Rehabilitation Company (CRC)

Following the perpetrator's allocation to the London Community Rehabilitation Company (CRC), Elizabeth's address was checked by officers from the Integrated Offender Management (IOM) team. It was found to be unsuitable because of the incidents of domestic abuse. The perpetrator's probation officer should have made it clear to him that he had to find alternative accommodation. In addition, the probation officer should have liaised with the Community Safety Unit to identify any specific risks and any previous incidents or call outs.

[20] A Spousal Assault Risk Assessment (SARA) should be carried out by probation officers in all cases where offending is linked to domestic abuse – for further information see www.mappa.justice.gov.uk – accessed online 10 August 2017

The perpetrator should have been seen weekly, however, he used medical certificates from his GP to avoid appointments (as he had with Hertfordshire Probation Trust) and this was never challenged by his probation officer. The perpetrator obviously "*knew the system*" and he manipulated his probation officer by bringing Elizabeth to his appointments. By allowing this, the domestic abuse could not be explored and Elizabeth was made even more vulnerable. For example, she had to agree to let him live at her house. This accommodation was unsuitable and he should have been directed to stay elsewhere. Following the assault in March 2015, there is no indication that a further risk assessment was undertaken or that the OASys risk assessment was updated. Indeed, the perpetrator brought Elizabeth to his next two appointments. This was clearly a tactic to avoid the matter being discussed which could have led to the perpetrator being recalled to prison. His officer failed to see the signs of manipulation and subsequently decided that rather than recall him, the perpetrator should complete a one-to-one domestic abuse programme.

There was limited communication between the London Community Rehabilitation Company (CRC), the Metropolitan Police Service, Enfield Integrated Offender Management (IOM) and mental health services. Despite the London Community Rehabilitation Company (CRC) working with both the perpetrator and Elizabeth, there was no evidence that their workers exchanged information. All in all, the London Community Rehabilitation Company (CRC) did not appear to comprehend the risk that the perpetrator posed to Elizabeth, and her worker did not appear to recognise her vulnerability. This was in spite of the Community Rehabilitation Company (CRC) making a referral to the multi-agency risk assessment conference (MARAC) in advance of the perpetrator's release from prison in November 2015. As the perpetrator was supervised by the Integrated Offender Management (IOM) team, there should have been a higher degree of information sharing.

Elizabeth's contact with the London Community Rehabilitation Company (CRC) concerned an Alcohol Treatment Requirement (ATR) order. The conditions of this order were uncertain but she only had three appointments with the Westminster Drug Project (WDP).

Case records indicated that Elizabeth's probation officer was aware that the perpetrator presented a threat of violence to Elizabeth and a referral was made to the multi-agency risk assessment conference (MARAC). However, the supervision sessions focused mainly on Elizabeth's use of alcohol and her need to reduce it. Additionally, Elizabeth attended all her appointments, but as the perpetrator's release date approached, she cancelled some and rang in sick. This decline in her reporting should have been explored, as it was a change from her usual behaviour.

In December 2015 London Community Rehabilitation Company (CRC) moved to a new operating model and approximately 17,000 cases changed officers. Elizabeth was allocated a new probation officer. Her new probation officer did not make contact and consequently Elizabeth was not seen again by the London Community Rehabilitation Company (CRC).

The implementation of the new operating model in December 2015 meant that Elizabeth's new probation officer picked up a number of cases and had to familiarise herself with those new cases. During the four-month period she held Elizabeth’s case, the new probation

officer's manager was off for two months and there was no evidence to suggest that the new probation officer received supervision or that a team meeting was held.[21]

5.4. Barnet, Enfield And Haringey Mental Health NHS Trust

Elizabeth's GP referred her to a psychologist on 22 October 2013 and despite being in "*crisis*", she was not seen nor assessed for some ten months (27 August 2014). During this period, the perpetrator was in prison. It would have been an ideal time to help support Elizabeth to exit the relationship.

It was apparent from the records that Elizabeth's history of domestic abuse, self-harm and substance misuse was well-known to mental health services. The notification from the Metropolitan Police Service dated 24 December 2015 detailed Elizabeth's history of domestic abuse from the perpetrator.

There were a number of opportunities for mental health services to liaise with the London Community Rehabilitation Company (CRC), Children's Social Care, the independent domestic violence advisor (IDVA), Metropolitan Police Service and Westminster Drug Project (WDP); there were also opportunities for her case to be discussed at clinical meetings. Nevertheless, these did not take place and thus an opportunity was missed to appoint a care coordinator. Had Elizabeth been allocated a care coordinator, a health care professional would have made contact with her sooner. A care coordinator could also have liaised and coordinated the interventions being offered to Elizabeth. In fact, the appointment of a care coordinator was discussed in June 2014 and then again in August 2014 but then failed to materialise. Equally, a care coordinator may have initiated a professionals' meeting. Normally such a meeting would involve all professionals working with both parties and identify how best to support them i.e. a referral to the multi-agency risk assessment conference (MARAC) and close monitoring. This may have also identified that the perpetrator was using a number of aliases.

At the time of the incident the decision to appoint a care coordinator was based on the care planning approach (CPA). This approach required three criteria to be met and (as Elizabeth was not seen by professionals) there was not enough information to know whether she met three criteria. Currently, the care planning approach (CPA) policy is being reviewed. Up until now, domestic abuse alone does not warrant an individual having a care coordinator. In future, the policy will no longer require three criteria to be met, rather it will be based on professional clinical judgement. Barnet, Enfield and Haringey Mental Health NHS Trust now has a dual diagnosis worker with the Crisis Team. There are regular clinical team meetings where cases are discussed. All cases now have an allocated health care professional as well as a psychiatrist

[21] The probation officer who supervised the perpetrator has since left the service. Nevertheless, a disciplinary investigation has been launched into the management of Elizabeth's case in the four months prior to her death

On 9 February 2016 Elizabeth disclosed during a home visit that she was frightened of the perpetrator. She told staff that she intended to leave him. The clinical entry described his very "*possessive controlling behaviour*" and his paranoia. However, information about domestic abuse was not shared with any other agency nor was it explored further. Elizabeth was assessed as at medium risk of harming herself or attempting suicide – yet, the information she provided showed that she was at high risk of domestic abuse. [22]

Safeguarding training is provided as part of staff induction and domestic abuse is included for all new Barnet, Enfield and Haringey Mental Health NHS Trust staff (1.5 hours). Since Elizabeth's death, additional training has been given to the Enfield Complex Care Team (ECCT). In future, mental health services will be delivering level 3 safeguarding adult training over a whole day and domestic abuse will be a core subject. The trust is piloting a domestic abuse project (LINKS) which shows clearly the need for an independent domestic violence advisor (IDVA) to be based within the mental health trust.

The Team manager of the Enfield Complex Care Team (ECCT) now attends the Enfield multi-agency risk assessment conference (MARAC) to ensure that information is shared appropriately.

5.5. North Middlesex University Hospital NHS Trust (A&E)

Elizabeth went to the emergency department at North Middlesex University Hospital on four occasions. The first visit was not relevant to this review. All the three subsequent attendances at the emergency department concerned self-harm or overdose. However, on no occasion was a detailed assessment of her circumstances undertaken. Had it been, it would have highlighted her psychiatric history, her history of substance misuse, that her children were not living with her and her history of self-harm. She may also have disclosed her history of domestic abuse. This information should have led to a "safeguarding of vulnerable adults" (SOVA) referral.

On two occasions, the perpetrator was present and it did not appear that Elizabeth was seen on her own.

5.6. Royal Free London NHS Foundation Trust

Elizabeth was taken by ambulance to the Chase Farm Hospital on 30 August 2013, following a drug overdose and having fallen down the stairs. It was on this occasion that the carbon copy of the London Ambulance Service report documented "*neighbours stated that it looked like her husband hit her head on the pavement*". There was a missed opportunity to piece

[22] 'High risk' is defined as at risk of being seriously harmed or murdered by a partner – for further information, see www.caada.org.uk/policy-evidence/helping-high-risk-victims-fast - accessed online 10 August 2017

together this information and the very different account that the perpetrator (using a false name) provided to the emergency department doctor.

Throughout Elizabeth's stay in hospital, the perpetrator stayed with her. On reflection, the individual management review author thought his over-protective and seemingly loving approach could be viewed as controlling.

5.7. General Practitioners

Both Elizabeth and the perpetrator were registered at the same GP Practice. Elizabeth registered in August 2011 and the perpetrator registered in February 2013 (although he also registered in a false name). Both, particularly Elizabeth, were seen multiple times by many different GPs. Elizabeth was mainly treated for her dependence on diazepam and other prescription drugs. She had a diagnosis of bi-polar affective disorder, and a history of anxiety and self-harming behaviour. As the chronology demonstrated, she was repeatedly referred to Barnet, Enfield and Haringey Mental Health NHS Trust and Improving Access to Psychological Therapies (IAPT) as well as drug and alcohol services (Compass). However, she was referred from one team to another which made it difficult (if not impossible) for her to engage.

Elizabeth's GP records made no mention of domestic abuse and therefore her presentation following episodes of self-harm was not explored. There was no consideration that these injuries might not have been self-inflicted. This is particularly concerning considering the perpetrator attended the same GP Practice and on one occasion presented with an injury that he claimed was caused when he prevented Elizabeth from cutting her throat (January 2016). The cut to his finger was sufficiently deep that it required an urgent orthopaedic referral. The records did not outline the circumstances surrounding the event or indeed whether his "*ex-girlfriend*" sustained an injury.

Despite her history of drug dependency and mental health problems Elizabeth was not questioned about domestic abuse. Patients who present with multiple problems should be routinely questioned about domestic abuse. Furthermore, patients who have problems with mental health, substance misuse and domestic abuse (the toxic trio) should always be considered at risk of harm and vulnerable and thus, have an alert placed on their records.

5.8. London Ambulance Service

According to London Ambulance Service records, there were two contacts with Elizabeth at her address before her death. The first incident was in April 2015, following an assault by the perpetrator. Elizabeth had a laceration to her face which needed gluing but she did not want to be taken to the hospital. Then on 24 December 2015, she was taken to the North Middlesex Hospital following a request by the police. She had cut her wrist.

The information from the London Ambulance Service did not contain an account of the incident when neighbours thought the perpetrator had hit Elizabeth's head on the pavement. It is not clear why (although this information was documented) the police were not informed. London Ambulance Service was contacted via its Safeguarding Hub a number of times so that this incident could be reviewed. However, the panel never received further information about this incident.

5.9. Westminster Drug Project (WDP)

Elizabeth was referred to the Westminster Drug Project (WDP) by the courts for an Alcohol Treatment Requirement (ATR) order. Between her full assessment in April 2015 and the time she disengaged from the service in January 2016, she was only seen three times. During this period, she had three different workers; two of whom do not appear to have met with her. Furthermore, there was no evidence of a documented handover. Thus, although a risk assessment was carried out in which domestic abuse was identified, this was never reviewed.

In May 2015, Elizabeth's case was discussed at a team meeting and the line manager requested that a joint referral with the Community Rehabilitation Company (CRC) should be made to the multi-agency risk assessment conference (MARAC). The line manager also requested that a referral was made to domestic abuse services. There was, however, no documented evidence that this took place. In addition, a care plan should have been completed within 6 to 12 weeks but this was not undertaken.

Throughout Elizabeth's engagement with the Westminster Drug Project (WDP) there was no liaison with mental health services or her GP, despite her history of mental ill health. Furthermore, although Elizabeth had an Alcohol Treatment Requirement (ATR) order, she did not attend her statutory appointments. Her non-attendances were not fully explored and she did not appear to be supported to attend.

In April 2015, Elizabeth did not attend her appointment because she was scared to leave the house as the perpetrator had assaulted her and the police had not found him to arrest him. At this time, her case should have been discussed with the local management team to consider whether a welfare check should be undertaken, a referral made to the multi-agency risk assessment conference (MARAC) and the case discussed with Elizabeth's Community Rehabilitation Company (CRC) worker and the police.

5.10. Enfield Strategic Safeguarding Adults Service

In May 2013, after the perpetrator's first reported assault on Elizabeth, a safeguarding alert was made to Enfield Adults Social Care (although from records it was unclear which agency or professional made the referral). The social worker, who screened the alert, made a call to Victim Support but did not document the conversation. This social worker also made a telephone call to Elizabeth but again, no details were recorded. The records then stated that

the social worker informed the senior social work practitioner (but it did not state what she was informed of).

On 29 December 2015, the Metropolitan Police Service sent an "incident of concern" form to Adult's Social Care which indicated that Elizabeth had complex needs that required intervention from a specialist or statutory service. This was acknowledged by Adult's Social Care on 22 January 2016; it was forwarded to mental health services and Adult's Social Care closed the case.

5.11. One Support

Elizabeth received support from One Housing[23] on two occasions:

- Enfield Connect between January 2011 and July 2013
- Enfield Mental Health Floating Support Service between January 2014 and November 2015

For consistency, Elizabeth was allocated the same keyworker. For both services, the frequency of visits was not fully met; Elizabeth should have been seen every two weeks. It was also evident that Elizabeth's key worker did not actively engage with the other agencies supporting Elizabeth. Furthermore, a number of additional measures should have been considered. For example, in 2014 when the history of domestic abuse was identified, it should have been explored further; her risk management plan should have been updated following the assault in April 2015; and a safeguarding alert should have been made at that time. A safeguarding alert may have led to a multi-agency discussion.

Elizabeth's One Support worker clearly had a good relationship with her and offered her good support. Her worker however did not recognise the risk Elizabeth faced and had limited knowledge of domestic abuse.

As a result of this case, One Support now attends the multi-agency risk assessment conference (MARAC). This has led to an improvement in partnership working and information sharing.

5.12. Multi Agency Risk Assessment Conference (MARAC)

The multi-agency risk assessment conference (MARAC) took place on 5 August 2015. There were representatives present from the relevant agencies.

The referral form explicitly stated that Elizabeth was scared of the perpetrator when "*he's out of prison*". She described how (when he was out of prison) he would constantly text her, hang around outside her house and get into her garden. This time, he told her when he was

[23] One Housing provides the One Support service. Enfield Connect and Enfield Mental Health Floating Support are branches of the support services offered by this organisation

released he would go straight to her house "*whether he was allowed to or not*". The referral form stated Elizabeth "*is not strong enough to say no to this*". Elizabeth also said she thought he had "*people watching her whilst he's in prison, as he would ask her who the man was walking her dog*". She was concerned about what he might do to her and her family, including her children.[24] Elizabeth also described how he threatened to hurt, or take, her dog. She said that he had taken her dog in the past but had brought it back. It was also stated on the referral form how the perpetrator would disrupt her friendships and "*she would do something wrong every time they went out and he would make accusations*". She described how his paranoia was getting worse and he was becoming more jealous and suspicious. During the course of this review, Elizabeth's family and friends confirmed his paranoia and described how he would not ever eat anything Elizabeth made – not even drink a cup of tea – because he thought she was poisoning him.

The state of Elizabeth's mental health was unclear from the multi-agency risk assessment conference (MARAC) minutes. It was also unclear in the referral (and in the subsequent notes from the meeting) who was working with Elizabeth to support her mental health needs. The outcome of the multi-agency risk assessment conference (MARAC) was that a "*treat all calls as urgent*" (TACAU) note was placed on Elizabeth's address; and arrangements were made to secure her property and garden gate.

From the records, it was evident that 38 cases were heard at the meeting which averaged approximately 11 minutes per case. This is in line with national multi-agency risk assessment conference (MARAC) guidelines,[25] which suggest 10 – 12 minutes per case. Minutes of the meeting were taken but these were brief and did not include the discussion that took place and why specific decisions were reached. Furthermore, it appeared that the Chair of the meeting did not check minutes before they were circulated and moreover, there was no mechanism to check whether actions by agencies had been completed.

5.13. Solace Women's Aid

Elizabeth was referred to Solace Women's Aid by the Community Rehabilitation Company (CRC) on 8 July 2015. At the same time, a multi-agency risk assessment conference (MARAC) referral was received by the independent domestic violence advisor (IDVA). Between July and October 2015, the independent domestic violence advisor (IDVA) worked hard to ensure that Elizabeth's property was secure.

Then in October 2015, the independent domestic violence advisor (IDVA) called Elizabeth as it had been confirmed that the perpetrator was coming out of prison on 20 November 2015. Elizabeth told the independent domestic violence advisor (IDVA) that her relationship with the perpetrator was over.

[24] This is in line with what Elizabeth's mother's account - The perpetrator would often threaten to harm Elizabeth's mother or children and Elizabeth believed he would do this.
[25] For further information see http://safelives.org.uk/practice-support/resources-marac-meetings - accessed online 10 August 2017

After the perpetrator was released from prison, the independent domestic violence advisor (IDVA) called Elizabeth who stated that the perpetrator had been repeatedly texting and calling her. Elizabeth was advised not to return his calls or texts and to close down the lines of communication and call 999 if he went to her address or made threats towards her. Records stated that Elizabeth sounded drunk during this conversation and the independent domestic violence advisor (IDVA) found it hard to make sense of Elizabeth's situation. Little thought was given to the fact that up to the perpetrator's release from prison, Elizabeth had reduced her alcohol intake to one glass of wine a day.

On the 4 December 2015, the independent domestic violence advisor (IDVA) again made contact with Elizabeth. This time Elizabeth said that she had not had any contact with the perpetrator and he had not been to her home. Therefore, the independent domestic violence advisor (IDVA) closed the case on 4 December 2015 (just two weeks after the perpetrator was released from prison) and informed the multi-agency risk assessment conference (MARAC) coordinator and the London Community Rehabilitation Company (CRC).

With hindsight, the independent domestic violence advisor (IDVA) should have shown more professional curiosity and had a better understanding of the increased threat to Elizabeth when the perpetrator was released from prison. There appeared to be a lack of consideration in terms of closing the case during that critically sensitive period. The advisor appeared to accept everything that Elizabeth told her without questioning its validity or seeking information from other professionals supporting Elizabeth or indeed those supporting the perpetrator. Ultimately, when Elizabeth ceased to engage, her worker should have considered alternative ways to support her rather than closing the case.

Nevertheless, at the time of the perpetrator's release from prison, Elizabeth had already received five months of support, despite Solace Women's Aid only being commissioned to provide three months of intervention. Furthermore, Solace Women's Aid was significantly over capacity and the independent domestic abuse advisors were supporting approximately three times more victims than was recommended. Since this time, the number of independent domestic abuse advisors in Enfield has doubled (from two to four) and advisors are in a better position to meet the needs of women with complex needs.

Solace Women's Aid is now working with Southwark and Enfield on a three-year project. The project aims to work with women who have multiple needs but have not engaged with support. A specialist worker will join the Enfield independent domestic abuse advisor (IDVA) team and the project is to be externally evaluated. One of the central elements of the project is to work across agencies, ensuring that professionals understand why a woman is not engaging with services; then working with her to secure her engagement. [26] This project should improve interagency working and assist the sharing of learning across the partnership.

[26] This project builds on the learning from "My Sisters Place" in Middlesbrough where the major reason for non-engagement was fear of perpetrators and that agencies would be unable to protect women from perpetrators.

6. EMERGING THEMES

6.1. Co-ordination of cases and sharing information

Alcohol Concern's Blue Light Project[27] asserts that because 'change resistant drinkers' are in contact with a number of agencies, "*a multi-agency care planning or care coordination role will be essential".* The research also emphasises the importance of consistency and a care coordinator should ensure that the work of all agencies is integrated into a single multi-agency plan. The multi-agency approach enables each agency to identify who is involved and who is meant to do what, when and why. This helps professionals to recognise risk and facilitate information sharing. Failure to provide this coordinated response can lead people to "*pinball around the system*". Unsurprisingly, this is what happened to Elizabeth.

The chronology of this case demonstrated that there were many agencies and practitioners working to support Elizabeth and to a lesser degree, the perpetrator. It was also evident that there was some positive contact between Elizabeth and some of those supporting her; particularly her probation officer and One Support worker. Nevertheless, the co-ordination and information-sharing around Elizabeth was ineffective. There was no evidence of professional discussions or a professionals' meeting being called, even after the multi-agency risk assessment conference (MARAC) referral. There were missed opportunities from all agencies (especially mental health services, Solace Women's Aid, London Community Rehabilitation Company (CRC), Integrated Offender Management (IOM) team, One Support and the drug and alcohol service) to come together to understand Elizabeth's experience and the effect the perpetrator's violence was having on her mental health and the impact his presence had on her use of prescription drugs and alcohol.

The lack of co-ordination and information sharing also led to confusion about the identity of the practitioners working with her. Numerous terms were used in her records including:

- Liaison worker
- Duty worker
- Support worker
- Floating support worker
- Key worker
- One support worker
- Social worker
- Drugs worker
- Alcohol liaison
- Dual diagnosis worker
- Domestic violence case worker
- Care worker

The majority of these titles appeared to refer to Elizabeth's One Support worker. Nevertheless, this confusion may have led professionals to think that Elizabeth was receiving more support than was the case. There is no doubt that Elizabeth received a disjointed service because of the lack of co-ordination. This meant that no agency/professional appeared to be accountable and she was frequently referred on to another service (e.g. mental health services) with no individual/agency being responsible for the outcome.

[27] Alcohol Concern (2014), Working with Change Resistant Drinkers: The Project Manual, London: Alcohol Concern – for further information see www.alcoholconcern.org.uk - accessed online 10 August 2017

Even the handovers within agencies were insufficient. For example, Elizabeth's drug and alcohol worker at the Westminster Drug Project (WDP) changed three times. Two of the workers never met with her and there was no evidence of a detailed handover.

6.2. Inaccurate spelling of names and the use of aliases

Another concern raised by this review was the spelling of names and the use of aliases. It was apparent from the agency records that the perpetrator used up to 13 different aliases. He used a false name when he breached his bail conditions and contacted Elizabeth. He used different names at his GP Practice and another one for his interactions with mental health services. He often gave false names when attending hospital with Elizabeth. This made it hard for agencies to identify him, to follow his movement and collate his actions. There was no doubt that the perpetrator used aliases to prevent agencies gaining a clear picture of his movements.

To compound matters, Elizabeth's name was spelt in six different ways in her records (e.g. Elizabeth, Ellizabeth, Lizbeth, Liz, Lizzy and Lizzie); and distressingly for her family, it was even spelt incorrectly on her death certificate.

6.3. Drugs and alcohol, mental health and domestic abuse

Elizabeth had a long history of mental health problems, her life-style was often described as "*chaotic*" and she frequently self-harmed. These issues along with her drug and alcohol use may have influenced professionals' response to her injuries i.e. they appeared to accept that they were either due to self-harm (as Elizabeth never indicated otherwise) or as a result of being under the influence of drugs or alcohol; therefore, the possibility that the perpetrator may have inflicted them was never considered.

There were times when professionals appeared to blame her lifestyle for her circumstances and there were occasions when the language used appeared to blame her. For example, their relationship was described as "*tempestuous*", Elizabeth was described as "*uncooperative*" in hospital, and police described her as "*unwilling*" to support a prosecution.

Both Elizabeth and the perpetrator were heavy drinkers and research shows that when both parties misuse alcohol the level of risk increases and frequently agencies focus on the alcohol and do not recognise that the victim is drinking to cope with the abuse. [28]

It is also important that drug and alcohol services screen for domestic abuse and vice versa. Neither issue can be wholly addressed unless the accompanying abuse or alcohol misuse is

[28] Hester, M. (2009) Who Does What to Whom? Gender and Domestic Violence Perpetrators, Bristol: University of Bristol in association with the Northern Rock Foundation – accessed online 10 August 2017 @ www.nr-foundation.org.uk/downloads/Who-Does-What-to-Whom.pdf

taken into consideration.[29] In cases such as this, where there is clear evidence of drug and alcohol misuse, domestic abuse and mental health problems, the professionals involved should have had a better understanding of the impact these issues had on both Elizabeth's and the perpetrator's ability to engage with services and the professionals should have sought various approaches to help them engage.

6.4. Non-engagement with services

In Elizabeth's case, she was frequently asked to self-refer to services (i.e. mental health services and the drug and alcohol service). While signposting can be useful, it was not an adequate response to Elizabeth who was vulnerable and at risk. The Blue Light Project research considered that a more "*assertive response is required*" – for example, following up referrals and identifying someone to accompany Elizabeth.

Research[30] shows there are a large number of factors that might act as a barrier to people engaging with alcohol services (although it could apply to any service). Examples include a lack of belief in the ability to change or victims may have anxiety or depression which can affect their ability to attend appointments.

Another barrier can be perpetrators subverting efforts to change. Elizabeth clearly worked hard to reduce her use of drugs and alcohol. In fact, she achieved this while the perpetrator was in prison but on release there was an increase in her drug and alcohol use. Often perpetrators may simply not allow the victim to attend appointments. This was apparent in this case i.e. when the perpetrator was released from prison, Elizabeth's engagement became more sporadic – this was not picked up by those working with her. In fact, professionals began to exit when he was released, just as she was becoming increasingly vulnerable.

6.4. Coercive control

Throughout this review professionals underestimated the level of coercive control in the relationship. Elizabeth's family and friends described how the perpetrator would not eat or drink anything she made – not even a cup of tea. We know that he was violent towards and tried to control Elizabeth's dog. There appeared to be a correlation between Elizabeth decreasing engagement with services and the perpetrator's release from prison. It is likely that he prevented her (or at least hampered her) from attending appointments. It was also evident that he "*coached her*" when providing explanations of her injuries – for example,

[29] Domestic abuse and change resistant drinkers: Learning lessons from domestic homicide reviews (June 2016) Alcohol Concern's Blue Light Project in partnership with AVA's Stella Project – www.avaproject.org.uk/guidance-domestic-abuse-change-resistant-drinkers/ - accessed online 10 August 2017

[30] Domestic abuse and change resistant drinkers: Learning lessons from domestic homicide reviews (June 2016) Alcohol Concern's Blue Light Project in partnership with AVA's Stella Project – www.avaproject.org.uk/guidance-domestic-abuse-change-resistant-drinkers/ - accessed online 10 August 2017

when she was admitted to hospital for a head injury following a fall, but records noted that her neighbours thought the perpetrator had hit her head on the pavement.

Had the police focussed more on coercive control, it may have prevented them taking a 'incident-by-incident' approach to the domestic abuse. In-depth work with victim-survivors[31] has shown that many take a long time to name what they are experiencing as abuse, and that they frequently deploy coping strategies of minimising the actions of the perpetrator whilst modifying their own lifestyle and behaviour.

The perpetrator appeared to control and manipulate the professionals around him. He certainly managed to evade scrutiny from his probation officers. He used similar tactics in Hertfordshire and London e.g. using medical certificates to avoid appointments. The fact that he was able to take Elizabeth into all his appointments and to use her to minimise the incidents of domestic abuse, shows an incredible level of manipulation of the system and control of Elizabeth.

Throughout the period under review, Elizabeth had contact with her children. They visited her regularly while they were in the care of their maternal grandmother. No agency appeared to consider the potential risk the perpetrator might pose to them. Although we know that he made threats against Elizabeth, her children and their maternal grandmother.

7. CONCLUSION

This domestic homicide review has been complex and upsetting. Elizabeth was a vulnerable woman who was open to seeking help and changing her life. When the perpetrator was in prison, she came close to realising her goals. However, the lack of systems in place actually thwarted her attempts not only to change, but to extricate herself from her relationship. Some panel members thought that stretched budgets may have played a role in the way Elizabeth was "pin balled" between services, whilst others thought that it was incompetence. Whatever the case, the lack of a coordinated response had an impact on every aspect of her life – it meant that no one realised that the perpetrator was using false names, it meant that no one noticed her name was being spelt incorrectly; it meant that the domestic abuse, the use of drugs and alcohol and Elizabeth's mental ill health were all viewed in isolation; it meant that no one considered her mother and her children and the risk they faced; it meant that no one addressed her difficulties engaging with services; and ultimately it led to a total lack of information sharing between agencies.

[31] Myhill, A. & Hohl, K.(2016) The "Golden Thread": Coercive Control and Risk Assessment for Domestic Violence. Journal of Interpersonal Violence, doi: 10.1177/0886260516675464

8. RECOMMENDATIONS

1. The key agencies within this review must consider how complex cases are managed and report back to the Community Safety Partnership and other senior level Boards by March 2018

2. Within 18 months, the Community Safety Partnership should evaluate whether complex cases are being managed more effectively

3. The multi-agency risk assessment conference (MARAC) meeting should consider how to share any pertinent information with the relevant GPs

4. The individual management reviews in this case were particularly poor. The Violence Against Women and Girls Group should consider providing multi-agency training to improve agency's understanding of the process

5. Staff in Accident and Emergency Departments should receive training about self-harm and self-harm should be included in all local domestic abuse training. (This should ensure that staff have an understanding of unusual self-inflicted injuries (e.g. Elizabeth's facial injury or 'accidental' injuries)

6. The Community Safety Partnership should consider funding a domestic abuse advocate/educator for the Accident and Emergency Department at North Middlesex Hospital

7. Elizabeth's mother and daughter had a number of questions they wanted answered about the chain of events following Elizabeth's death (see section 2.2.1.). The Metropolitan Police Service should consider how best to address those questions

8. Enfield Community Safety Partnership should ask each agency involved in this review to provide feedback on their single agency recommendations.

Agencies identified a number of opportunities for areas of improvement and 23 single agency recommendations arose from this domestic homicide review.

These single agency recommendations addressed a wide range of issues including (amongst other things) fostering closer liaison between professionals working with perpetrators and those supporting victims, improving responses to disclosures of domestic abuse, offering timely assessment appointments, further developing training on domestic abuse and flagging records where domestic abuse, mental health and/or substance misuse are a feature. There were also recommendations about improving handovers between professionals when workers leave and highlighting the importance of maintaining consistent and meaningful working partnerships between key agencies.

Work has already started to improve practice in some of these areas. Nonetheless, Enfield Community Safety Partnership will ensure that agencies implement all the recommendations, which are set out in full in the attached action plan.