CROYDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the Death of Jasmine

March 2017

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Associate, Standing Together Against Domestic Violence

Date of Final Version: July 2018

Permission has been granted by the Home Office to publish this final report

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1. Preface

1.1. Introduction

1.1.1. Domestic Homicide Reviews were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2. This report of a Domestic Homicide Review (Review) examines agency responses and support given to Jasmine, a resident of Croydon, prior to the point of her homicide (for which Eric was convicted) at home in March 2017.

1.1.3. The Review will consider agencies contact/involvement with Jasmine and Eric from 1 January 2013 to the date of Jasmine's death.

1.1.4. In addition to agency involvement, the Review also aims to examine Jasmine's and Eric's past to identify any relevant background or trail of abuse before the homicide. This may include whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the Review seeks to identify appropriate solutions to make the future safer for people.

1.1.5. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. The Review Panel have approached this Review openly to seek those lessons and to act on them.

1.1.6. This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.7. The Review Panel expresses its sympathy to the family of Jasmine for their loss and thanks them for their contributions and support for this process.

1.2. Timescales

1.2.1. The Croydon Community Safety Partnership, in accordance with the December 2016 *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*, commissioned this Domestic Homicide Review. The Home Office were notified of the decision in writing.

1.2.2. Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR in May 2017. The completed report was handed to the Croydon Community Safety Partnership in July 2018.

1.2.3. Home Office guidance states that the review should be completed within six months of the initial decision to establish one. This Review took longer than that due to the need for Croydon Community Safety Partnership to commission a number of DHRs at the same time, the need to ensure scoping information was completed comprehensively, and to arrange meeting dates so as to allow maximum attendance by agencies who were having to cover multiple reviews. These factors impacted panel capacity and thus more time was

allowed to ensure a through and effective review. Once established, the Review was completed as quickly as possible.

1.3. Confidentiality

1.3.1. The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is available only to participating professionals and their line managers.

1.3.2. This Review has been suitably anonymised in accordance with the 2016 guidance. The specific date of death has been removed and only the independent chair and Review Panel members are named.

1.3.3. To protect the identity of the victim, the perpetrator and family members the following anonymised terms have been used throughout this Review:

1.3.4. The victim: Jasmine

1.3.5. The perpetrator: Eric

1.3.6. As family members had not been fully involved in the Review (see 1.9), these pseudonyms were checked with the police Review Panel representative to ensure they did not match with any family members.

1.4. Equality and Diversity

1.4.1. The Chair of the Review and the Review Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process.

1.4.2. Given what was known about Jasmine and Eric at the start and throughout the Review, the following characteristics / additional vulnerabilities were also considered relevant to understand and analyse:

- Sex / gender
- Race
- Religion and belief

1.4.3. The Review Panel agreed that the existing members of the panel are sufficient to address the particular characteristics and issues in this Review.

1.4.4. The following issues have also been identified as particularly pertinent to this homicide:

- Mental health of Jasmine
- Substance use by Jasmine and Eric
- Eric as a former Looked After Child
- Issues relating to rent, housing and homelessness for Jasmine and Eric
- Serial perpetration of domestic abuse by Eric

- Possible issues of isolation for Jasmine and Eric

1.4.5. Consideration was given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk'. The Review Panel concluded that this would be a key line of enquiry for the Review.

1.5. Terms of Reference

1.5.1. The full Terms of Reference are included at Appendix 1. This Review aims to identify the learning from Jasmine's and Eric's case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2. The Review Panel comprised agencies from Croydon, as the victim and perpetrator were living in that area at the time of the homicide, and had only lived in that borough. Agencies were contacted as soon as possible after the Review was established to inform them of the Review, their participation and the need to secure their records.

1.5.3. At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1 January 2013 to the date of the homicide. This date was chosen as it covered the period of Jasmine's and Eric's most significant contact with agencies.

1.5.4. *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in the 2016 Guidance and identified and considered the following case specific lines of inquiry:

- Analyse the communication, procedures and discussions, and co-operation and joint working, which took place within and between agencies in relation to Jasmine and/or Eric.
- Analyse the opportunities to identify, assess and respond to individuals with the following issues:
  - Domestic abuse perpetration (Eric)
  - Mental health (Jasmine)
  - Substance misuse (Jasmine & Eric)
  - Rent / housing issues or homelessness (Jasmine & Eric)
  - Looked after child / leaving care (Eric)
- Analyse agency responses in relation to the characteristics of Jasmine and Eric, including how they intersected:
  - Race (Jasmine & Eric)
  - Religion / faith (Jasmine & Eric)
  - Mental health (Jasmine)

- Substance misuse (Jasmine & Eric)
- Looked after children / leaving care (Eric)

- Analyse what policies, procedures and training are in place for the agency to address the issues identified in the above two points.
- Analyse organisations' access to: specialist domestic abuse agencies for victims or perpetrators; mental health services; substance misuse services.

1.5.5. The Review Panel felt that the membership of the following would adequately address the expertise required on the above issues: Family Justice Centre (domestic abuse service); Turning Point (drug and alcohol agency) and South London and Maudsley NHS Foundation Trust (mental health provider). Additionally the independent chair sought the expertise of the Chief Executive of Croydon MIND, who contributed to the Review and read the Overview Report.

1.6. Methodology

1.6.1. Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader, to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

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

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

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." [1]

1.6.2. This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

[1] See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf [accessed 15 April 2018]

1.6.3. This Review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the *Domestic Violence Crime and Victims Act 2004*. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Jasmine and/or Eric. Thirteen agencies submitted IMRs and chronologies, and one agency provided information only due to the brevity of their involvement. The chronologies were combined and a narrative chronology written by the Overview Report Writer.

1.6.4. *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Jasmine and/or Eric, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Seven IMRs made recommendations for their own organisation, and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this Review.

1.6.5. *Other Information:* Information was provided by London Borough of Croydon Youth Offending Service and the MARAC of the neighbouring borough.

1.7. Contributors to the Review

1.7.1. The following agencies and their contributions to this Review are:

Agency	**Contribution**
AIR Network	IMR and chronology
Croydon Health Services NHS Trust	Chronology
Croydon Clinical Commissioning Group (for the General Practices)	IMR and chronology
Multi-Agency Risk Assessment Conference (MARAC, coordinated by Croydon Family Justice Centre)	Information
London Ambulance Service	Chronology
London Borough of Croydon Adult Social Care Services	IMR and chronology
London Borough of Croydon Children's Social Care Service (including Looked After Children and Leaving Care Services)	IMR and chronology
London Borough of Croydon Housing Services	IMR and chronology
London Borough of Lewisham Adult Safeguarding	Information
London Community Rehabilitation Company	IMR and chronology

Metropolitan Police Service	IMR and chronology
National Probation Service	IMR and chronology
South London and Maudsley NHS Foundation Trust	IMR and chronology
Turning Point	IMR and chronology
Victim Support	IMR and chronology

1.8. The Review Panel

1.8.1. The Review Panel Members were:

Panel Member	Job Title	Organisation
Althea Cribb	Independent Domestic Homicide Review Chair	Standing Together Against Domestic Violence
Alison Finlay	Team Leader & Deputy Safeguarding Lead	Turning Point
Andrew Nwosu	Regional Head of Allied Health Professionals (NHS England representative)	NHS England
Antony Rose	Head of Ealing, Harrow & Hillingdon Cluster	National Probation Service
Cheryll Wright	Partnership and Intelligence Manager, Community Safety	London Borough of Croydon
Chris McCree	PMH Lead Centre for Parent & Child Support	South London and Maudsley NHS Foundation Trust
Fiona Bauermeister	Deputy Chief Executive	Air Network
Fiona MacKirby	Service Leader, Leaving Care	London Borough of Croydon
Jennifer Hoyle	Senior Operations Manager	Victim Support
Lucien Spencer	Area Manager, London South-East	London Community Rehabilitation Company
Myrna Harding	Trust Facilitator	South London and Maudsley NHS Foundation Trust
Nicola Funnell	Psychiatrist	South London and Maudsley NHS Foundation Trust
Rachel Blaney	Designated Nurse Safeguarding Adults	Croydon Clinical Commissioning Group
Russell Pearson	Review Officer	Metropolitan Police Service

Shade Alu	Deputy Medical Director (Safeguarding)	Croydon Health Services NHS Trust
Steve Hall	Quality Assurance Manager, Children's Social Care	London Borough of Croydon
Tanya Johnson	Practice Manager	Croydon Family Justice Centre
Yvonne Murray	Head of Tenancy, Housing Services	London Borough of Croydon

1.8.2. *Independence and expertise*: Agency representatives were at the appropriate level for the Review Panel, and demonstrated expertise in their own areas of practice and strategy, and were independent of the case. Panel composition also adhered to statutory guidance.

1.8.3. The Review Panel met a total of three times, with the first meeting of the Review Panel in August 2017. There were subsequent meetings in December 2017 and May 2018.

1.8.4. The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.9. Involvement of Jasmine's Family

1.9.1. The Croydon Community Safety Partnership notified the family of Jasmine in writing of their decision to undertake a review. The Chair of the Review and the Review Panel acknowledged the important role Jasmine's family could play in the review. From the outset, the Review Panel decided that it was important to take steps to identify and then attempt to involve any family, friends, neighbours and wider community. No other friends or contacts of Jasmine could be identified.

1.9.2. It was agreed to approach Jasmine's mother, father and (adult) child, for whom contact details were held by police. The letters were given to each person by the police Family Liaison Officer, so that the contact details were not shared.

1.9.3. Letters invited participation at a time and in a way of the contacts' choosing (e.g. a face to face meeting, telephone conversation or a letter), and emphasised that their participation was voluntary. The Home Office leaflet about Domestic Homicide Reviews was included, along with information about the support offered by Advocacy After Fatal Domestic Abuse (AAFDA).

1.9.4. No response was received from Jasmine's father.

1.9.5. Jasmine's mother informed the independent Chair, through the Victim Support Homicide Service, that she did not wish to participate in the Review but wanted to receive updates on its progress. The independent chair emailed Jasmine's mother in February 2018 and June

2018 to provide updates and offer different ways to engage with the Review if she wished to, including reading and commenting on the Overview Report. No response was received.

1.9.6. Jasmine's (adult) child informed the independent Chair, through the Victim Support Homicide Service, that they did not wish to participate in the Review but wanted to receive updates on its progress. The independent chair emailed them in April 2018 and June 2018 to provide updates and offer different ways to engage with the Review if they wished to, including reading and commenting on the Overview Report. No response was received.

1.10. Parallel Reviews

1.10.1. *Criminal investigation*: This was completed while the DHR was in its early stages (see 2.1.1).

1.10.2. *Coroner*: No inquest was held.

1.10.3. *South London and Maudsley NHS Trust (SLaM) Serious Incident Review*: Jasmine was under the care of SLaM at the time she died, as a result of which the Trust completed a Serious Incident Review. The Terms of Reference for the DHR extended past the scope of the internal review, and as a result a separate IMR was completed for the DHR; the full Serious Incident investigation and records were reviewed, and staff were re-interviewed.

1.11. Chair of the Review and Author of Overview Report

1.11.1. The Chair and Author of the Review is Althea Cribb, an Associate DHR Chair with Standing Together Against Domestic Violence (STADV). Althea has received Domestic Homicide Review Chair's training from STADV and has chaired and authored twelve reviews. Althea has twelve years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

1.11.2. Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.11.3. STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews.

1.11.4. *Independence:* Althea Cribb has no connection with the Croydon Community Safety Partnership, nor any of the agencies involved in this case.

1.12. Dissemination

1.12.1. The following recipients have received/will receive copies of this report:

- Croydon Community Safety Partnership
  - Croydon Domestic Abuse and Sexual Violence Committee
- The Review Panel
- Family of Jasmine
- Croydon Safeguarding Adults Board
- Standing Together Against Domestic Violence DHR Team

2. Background Information

The principle people referred to in this report						
Referred to in report as	**Relationship**	**Age at time of Jasmine death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability**
Jasmine	Victim	38	Mixed Black Caribbean / White European	Recorded that she believed in God and the 10 commandments but was not religious and did not attend church	British Citizen	Mental ill-health
Eric	Perpetrator of homicide	23	Black / African British	Believed to have been Catholic on arrival in country; further to that unknown	British Citizen	None known

2.1. The Homicide

2.1.1. *Homicide:* On the morning of the homicide in 2017, London Ambulance Service (LAS) received a phone call to attend Jasmine's address. Upon attendance, LAS found Jasmine lying naked in her kitchen. She had suffered multiple stab wounds and she was pronounced deceased. Jasmine's adult child and partner had made the phone call to LAS and were present when they arrived, but Eric, the perpetrator, was not. Eric had suffered stab wounds himself and was later found in a public place semi-naked and bleeding. Eric was taken to hospital for treatment to his injuries and then released into police custody. Eric was charged with the murder of Jasmine. At trial Eric pleaded 'not guilty' and entered a defence based on diminished responsibility due to mental ill-health; this was not accepted and he was convicted of murder. He was sentenced to life imprisonment with a minimum term of 16 years.

2.1.2. *Post Mortem*: The post mortem of Jasmine concluded Jasmine had died of stab wounds to the abdomen and chest.

2.2. Background Information on Jasmine and Eric

2.2.1. *Background information relating to Jasmine*: Jasmine lived in a one-bedroom flat in a block, provided to her by London Borough of Croydon Housing Services. She had moved there in 2013. No other tenants were listed. At the time of the homicide her (adult) child and their partner had also been living there for some months; more recently Eric was also living there; none of this was known to agencies at the time. In 2010 Jasmine called police alleging she had been sexually abused when she was a child on one occasion by an older male child and had suffered mental ill health ever since. No further action was taken (following discussion with the Crown Prosecution Service). In 2011 Jasmine pleaded guilty to causing criminal damage to her flat and was given an adult caution. In addition to this, police had contact with Jasmine in relation to her mental health (see next paragraph), including eight contacts prior to the Terms of Reference timeframe in which they responded to calls from Jasmine or others due to Jasmine's mental health crisis episodes or deterioration. In response Jasmine was either detained under section 136 of the Mental Health Act 1983, or contact was made with other services who were working with her.

2.2.2. *Jasmine's mental health*: Jasmine's first contact with mental health services (SLaM) was in 2002. She was admitted as an inpatient under the Mental Health Act 1983 (MHA). She was diagnosed with Bipolar Affective Disorder and was prescribed medication. Her condition on this medication remained stable and she was discharged back to her General Practice (GP) in 2006. Jasmine's GP referred her back into mental health services in 2008. She was managed as an outpatient and prescribed medication following a diagnosis of Schizoaffective Disorder with recurrent depression; this was complicated by alcohol and cannabis use. In 2011 Jasmine was admitted to inpatient care or detained under the MHA four times. She was diagnosed with Borderline Personality Disorder, which is now known as Emotionally Unstable Personality Disorder, impacted by substance misuse. The view of the SLaM Serious Incident investigating panel was that it was likely that she had bipolar affective disorder complicated by both emotionally unstable personality disorder and poly-substance misuse. She was prescribed medication with which she did not consistently comply. Following discharge from hospital in September 2011, Jasmine was treated with depot medication and remained stable. In October 2012 this was changed to oral medication at her request as she was concerned about weight gain. A further period of relative stability followed up until her admission in February 2014 (see below).

2.2.3. *Background information relating to Eric*: Eric arrived from his East-African country of origin in 2002/2003 (age 9/10), with his mother. His first contact with services appeared to be with Children's Social Care in 2005 with regard to his emotional welfare. He was in contact with

police in 2006 (age 13) when he was reported missing; he attended a police station and stated he did not wish to return home and was accommodated by London Borough of Croydon Children's Social Care. He was reported missing again in 2007 twice, and once in 2008 following which he was again accommodated by Social Care. This was in a series of Children's Homes, at which there were often issues between Eric and other residents and/or staff. During this time Eric was also arrested by police for criminal offences: 14 allegations and five court appearances including: offences against the person, offence against property, theft/similar offences, offences relating to police courts and prison, drug offences and (unsubstantiated) allegations of sexual violence. This led to his being within the remit of the Youth Offending Service (YOS), due to one referral order (2007) and four subsequent supervision orders (2007-2009). During that time YOS noted Eric to be a young man with a troubled family situation and history. His offending was not extensive and he was not deemed to be at 'high risk'. In 2007 YOS referred Eric to the Child and Adolescent Mental Health Service (delivered by SLaM; they received the referral but he was recorded as declining the service). In 2011 Eric was transferred from the Looked After Children service to the Leaving Care Service. He was in that year allocated a London Borough of Croydon property, from which he was evicted in 2015 (see below). Following this agency records do not identify where Eric lived.

2.2.4. *Synopsis of relationship between Jasmine and Eric*: Jasmine and Eric met when he moved into the flat opposite hers around six months before the homicide. They became friends and subsequently started a relationship. He had apparently moved in with Jasmine two weeks prior to the homicide. Eric had proposed to Jasmine the night before the homicide and they had celebrated this at home with Jasmine's child and their partner.

3. Overview and Chronology

3.1. Information Known to Agencies Involved

3.1.1. The timeframe for the Review was 1 January 2013 to the date of Jasmine's death. The following agencies held information about Jasmine and/or Eric from that time.

Agency	Jasmine	Eric
AIR Network		Y
Croydon Clinical Commissioning Group (for the General Practices)	Y	
Croydon Health Services NHS Trust	Y	Y
Multi-Agency Risk Assessment Conference (MARAC, coordinated by Croydon Family Justice Centre)		Y
London Borough of Croydon Adult Social Care Services	Y	
London Borough of Croydon Children's Social Care Service		Y
London Borough of Croydon Housing Services	Y	Y
London Borough of Lewisham Adult Safeguarding	Y	
London Community Rehabilitation Company		Y
Metropolitan Police Service	Y	Y
National Probation Service		Y
South London and Maudsley NHS Foundation Trust (SLaM)	Y	Y
Turning Point	Y	
Victim Support	Y	Y
Total Agencies: 14	**9**	**10**

3.1.2. No agency knew of the relationship between Jasmine and Eric. Those agencies that had contact with them both: the contacts were separate and no information was held about their connection. As a result of this the chronologies for Jasmine and Eric are presented separately.

3.2. Chronology of Agency Contact with Jasmine

3.2.1. Jasmine's involvement with agencies was primarily with SLaM; this had started (see above) in 2002 (aged 23) and continued until she died. The most significant episodes are captured here.

3.2.2. In December 2013 (aged 35) Jasmine moved into a one-bed flat on an existing secure tenancy (through mutual exchange). This was followed in January 2014 with a New Tenancy Visit. Jasmine disclosed her mental health issues (including diagnoses of Bipolar and Emotional Instability Disorder). The Tenancy Officer offered Jasmine extra support

from the team, which Jasmine declined. There was no further contact with Jasmine from that team.

3.2.3. In February 2014 police were called to a London Borough of Croydon building as Jasmine was reported to be shouting and screaming outside. Jasmine told officers that she was Bipolar, had a Personality Disorder and hadn't taken any medication for over a year. She was detained under the Mental Health Act (Section 136) and taken to an inpatient facility. At that time Jasmine had two children with her, one of whom was her grandchild. Jasmine was recorded as being unable to remember their names or where they lived but said she was looking after them while her (adult) child was away. Police liaised with London Borough of Croydon Children's Social Care who looked after the children while locating Jasmine's (adult) child. The police generated alerts (Merlins) for the children and for Jasmine; the latter was recorded as received by London Borough of Croydon Adult Social Care.

3.2.4. Jasmine was assessed and prescribed medication at the inpatient unit, and then discharged to the Community Mental Health Team. She subsequently refused her medication and it was changed; she stopped complying with that shortly after. While in the inpatient unit SLaM staff called police to report that Jasmine had attacked a member of staff; they wished the incident to be recorded, which it was. Also during this time Jasmine called police a number of times with allegations against staff and stating she wanted a blood test to ascertain if she was of royal blood. Police spoke with Jasmine and staff about the allegations, which were being managed within Jasmine's care plan and police took no further action.

3.2.5. In summer 2014 Jasmine's (adult) child called police reporting that Jasmine had attended their address wanting a place to stay and had then "*flipped out*" and threatened to kill them. Jasmine was detained under the MHA (section 136) and taken to an inpatient unit. Police made a notification (Merlin) to Croydon Adult Social Care, which they recorded.

3.2.6. Jasmine was transferred to the Psychiatric Intensive Care Unit due to her presentation. She was treated and discharged to the Home Treatment Team a month later (August 2014). That team made home visits to monitor and assess Jasmine's mental health and ongoing care plan. In early September 2014 she was discharged to the Promoting Recovery Team to continue her medication and recovery. Jasmine attended the clinic for her medication and home visits were made to monitor her mental state; these ended when her mental state was considered to be stable, and she was attending her scheduled medication appointments (monthly). This continued until March 2016 (see below).

3.2.7. Jasmine had no contact with any agencies other than SLaM from June 2014 to January 2015.

3.2.8. In January 2015 the London Borough of Croydon Housing Service Income Team contacted Jasmine with regard to rent arrears. A payment agreement was made and the service had no further contact with Jasmine.

3.2.9. In the summer of 2015 Jasmine registered with a new GP and had two appointments with regard to her physical health. She had no contact with the GP until March 2016 when the GP received notification that Jasmine had presented to the mental health team seeking support for low mood. Jasmine had attended asking for support in response to personal events that had upset her; she was seen urgently by the team and assessed. A plan was made for her care and medication.

3.2.10. In early May 2016 Jasmine began to state that she would not continue with her medication and she wanted to use 'natural remedies' such as St John's Wort. Later in May 2016 Jasmine was admitted to the inpatient unit following a MHA assessment at home, prompted by her non-compliance with medication and signs of relapse. She presented with "*grandiose beliefs … stating that God spoke to her on a daily basis*". She agreed to take a new medication and her mental state was seen to improve. The Home Treatment Team notified the GP.

3.2.11. In June 2016 Jasmine called police twice due to altercations or arguments with a neighbour. Police attended: in the first instance neither person was willing to pursue an allegation; on the second occasion assistance was provided. A notification (Merlin) was sent to Croydon Adult Social Care, which was recorded by that service.

3.2.12. Also in June 2016 Croydon Health Services NHS Trust received a referral from SLaM for Jasmine to attend regarding a health matter; she did not attend and was discharged, both Jasmine's GP and SLaM were notified.

3.2.13. The following month (July 2016) LAS were called to Jasmine's address; the caller stated Jasmine had taken an overdose and cut her wrists; that there was some bleeding but not serious, and that Jasmine had a knife. LAS called for assistance from police. The ambulance was then cancelled as Jasmine left the scene and was being treated as a missing person. Police recorded being called by LAS due to Jasmine's boyfriend (not Eric) calling them. Jasmine later returned to the property and was detained under the Mental Health Act (Section 136). A notification (Merlin) was sent to Croydon Adult Social Care, which was recorded by that service.

3.2.14. Once she was in the inpatient facility, Jasmine called police twice in July to allege another patient had assaulted her. The second allegation was of sexual assault; SLaM staff informed police that the incident had involved another patient stroking Jasmine's arm. Both incidents were dealt with within Jasmine's care plan and no further action was taken by police.

3.2.15. Following the allegation of sexual assault, Jasmine was referred by police to Victim Support. The service did not contact Jasmine to offer support.

3.2.16. At the end of July 2016 Jasmine was sent on leave from the inpatient unit to the care of the Home Treatment Team; her GP was notified. Five days later SLaM staff called police because Jasmine was missing: she had been granted unconditional leave for two hours and she had failed to return. The next day Jasmine called police and asked to be collected and returned to the unit. A notification (Merlin) was sent to Croydon Adult Social Care, which was recorded by that service. The notification also informed Adult Social Care of the alleged sexual assault (see above). The service then established that the alleged incident had taken place in Lewisham (in the inpatient unit) and therefore passed the notification on to London Borough of Lewisham Adult Social Care. The team in the local authority do not deal with mental health referrals, because they are dealt with by staff based in SLaM. The notification was forwarded by email to the SLaM team; it was sent directly to a named member of staff, not to the generic email inbox. That member of staff was on leave, and as a result the notification was never picked up. The out of office message from that member of staff stated clearly that referrals and notifications should be sent to the generic inbox but this was not done. While this situation should not have arisen, Jasmine had also reported to alleged assault to SLaM staff and therefore the situation was being addressed.

3.2.17. Towards the end of August 2016 Jasmine was granted leave from the inpatient ward but she did not return. SLaM staff attempted to locate her, including contact with police for help. While she was absent from the ward she was discharged to the Psychosis Community Mental Health Team. Following this police updated the ward that they had visited Jasmine's home and found her there; Jasmine then contacted the ward and attended to review her medication and care. Two notifications were made to Adult Social Care, which were recorded by the service.

3.2.18. At the end of August 2016 Jasmine alleged to police that she had been assaulted by her boyfriend (not Eric); he was arrested and taken to court. There was no further contact with Jasmine and this individual as a couple. No notification was sent to Adult Social Care.

3.2.19. In September 2016 Jasmine called police for help, claiming that another mental health patient wouldn't return her property; police spoke with the other person who provided evidence that they had offered to return the property already, and no further action was taken.

3.2.20. In December 2016 Jasmine's GP attempted to call her twice, the records did not state why. At the third attempt to call Jasmine, in January 2017, a male answered the number and told the GP they had the wrong number.

3.2.21. There was no further contact for any agency with Jasmine except for SLaM. Following discharge to the Psychosis Community Mental Health Team in August 2016, Jasmine

continued to have contact with that team, including attending for her medication, until she died. Jasmine was on 'depot' medication (medication administered through intra muscular injection) rather than oral medication (taken at home) so that the team could be satisfied that she was receiving it.

3.2.22. In November 2016 she informed the team that her (adult) child was living with her and providing her with support. In January 2017 Jasmine stated that her (adult) child, their partner and Jasmine's "*friend*" were living with her in her flat. She reported that they were looking for places to live but she was enjoying the company. She reported feeling well with no concerns. She was often 2-3 weeks late in receiving this medication, but her mental state appeared to remain stable.

3.2.23. This was followed in February 2017 with a phone call from Jasmine that her (adult) child was now her full time carer; they asked the team to update their system to reflect this. Contact from then on was mainly with Jasmine's (adult) child, including contact about appointments and Jasmine requesting a home visit as she did not have money to travel to the team. As a result she attended for her medication three weeks late but felt that she was "*doing fine*".

3.2.24. On that day Jasmine had called and was initially angry with staff because they would not attend her home for the medication to be administered; she called back to apologise and stated she was "*very anxious because my friend is threatening to harm me because I asked her to leave my flat*". Staff advised her to call police.

3.2.25. That day Jasmine then walked to the team's office for her medication; she stated she had no money because she was paying off debts incurred by a "*friend*" who was living with her (it was not clear if this was the same or a different friend to the female friend referred to above). She was recorded as appearing calm and stable in her mental state. She did not want the matter (with regard to the friend/friends) taken further and no action was taken. This was the last contact the team had with Jasmine.

3.3. Chronology of Agency Contact with Eric

3.3.1. From 2013 to 2015, Eric had contact or was known to police (Metropolitan Police Service), London Borough of Croydon Children's Social Care and the Multi-Agency Risk Assessment Conference (MARAC, coordinated by the Croydon Family Justice Centre) in relation to domestic abuse against his then partner; this included allegations and convictions related to verbal abuse, threats, physical violence and sexual violence. Eric's then partner is not the subject of this Review and therefore no information is presented here relating to them. Any learning identified by agencies in relation to this involvement is captured in section 4 below.

3.3.2. At the end of 2013 Eric (aged 20) was arrested for assault and no further action was taken. Shortly after he was arrested for a separate incident of assault, for which he was charged and appeared at the Magistrate's Court in May 2014. He was found guilty (see below). Neither of these were domestic related.

3.3.3. In 2014 (January to May) Eric had contact with London Borough of Croydon Housing Services and with his London Borough of Croydon Children's Social Care (Looked After Children) keyworker due to his continued rent arrears.

3.3.4. In January 2014 Eric was found guilty of possession of cannabis and was given a conditional discharge for 12 months. Police recorded that he could be violent and volatile.

3.3.5. Also in January Eric disclosed to his keyworker that he was a father of a child, and would be again, and that he wanted to be a "*good father*" to both children. In April 2016 he requested access to his Children's Social Care records; there is no evidence that he viewed them.

3.3.6. In May 2014 Eric was found guilty of the assault in December 2013 (see above). A pre sentence report was completed by National Probation Service and submitted to court; it recommended a Community Order with supervision requirements and a requirement to attend the Integrated Domestic Abuse Programme (IDAP). This was an offending behaviour programme aimed at men who had been abusive in their relationships aiming to change those behaviours. It has been replaced by Building Better Relationships. Probation recorded that this sentence had been imposed. In June 2014, due to Transforming Rehabilitation[2], Eric's case was transferred from probation to the Community Rehabilitation Company (CRC). From May to September 2014 probation and then the CRC attempted to engage with Eric in supervision and in attendance at IDAP. Due to his non-attendance at supervision and other appointments, in September CRC moved to take enforcement action against Eric and return him to court. During this process the court notified CRC that the sentence given to Eric was a fine, not a Community Order; as a result CRC's contact with Eric ended.

3.3.7. In May 2014 Eric and his then partner made cross-allegations of domestic assault to police. As a result, Eric was referred to Victim Support. Contact was not achieved in the first instance. A second referral was received by Victim Support at the end of May 2014 (criminal damage to a dwelling). On the second occasion the worker spoke with Eric. Eric declined support and stated his ex-partner was harassing him and that the only way to deal with this was through getting a restraining order. He stated he would continue to call the police if the harassment persisted. The case was closed.

[2] https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf [accessed 15 April 2018]

3.3.8. In June 2014 Eric's case was closed to the Leaving Care service; the record stated that this was because he had reached 21 years of age.

3.3.9. In July 2014 Eric was charged with assault against his then partner; he appeared in court in August 2014 when he pleaded not guilty and was bailed. The case was heard in the magistrate's court in December 2014; no evidence was offered and the case was dismissed.

3.3.10. Housing Services initiated court proceedings with Eric in relation to his rent arrears and contacted the Leaving Care service who stated they would contact Eric about it although his case was closed. In October Eric contacted leaving Care for support with the rent arrears and also because he had lost his job.

3.3.11. Following this process, in May 2015 Eric was evicted from the London Borough of Croydon property.

3.3.12. In 2015 (July to October) Eric attended outreach sessions with AIR Network, including sport and wellbeing sessions. In September AIR Network referred Eric to Turning Point, and he attended for an assessment with them. Turning Point offered Eric a treatment care plan to address his cannabis and housing issues, and he was referred onto a training pathway to work in the rail industry (he was subsequently removed from this due to non-attendance). He did not attend any appointments with Turning Point and his case was closed in December 2016.

3.3.13. In September 2015 Eric contacted Housing Services for help because he was homeless. He stated he had lost his job, had no support from the Leaving Care Team, and had lost his job because he had needed time off work to attend court with regard to access to his child (there are no agency records to confirm that a family court case was proceeding). He spoke with an income officer (as this was the service he had been in contact with in relation to rent arrears) who explained that they could support him with the debt issues but that he would need to contact the Housing Needs Team for information on his housing options.

3.3.14. Also in September 2015 Eric was charged with assault and two rape offences against his ex-partner (the same person he had been convicted of domestic abuse related offences against) following which he was put on bail with a condition not to attend his ex-partner's address. Eric was arrested in October for breaching bail, and at the same time interviewed regarding (and then charged with) more offences against the same victim, including threats to kill (this included a threat to kill if she did not withdraw the allegations of rape). Eric remained on remand until April 2016. When the trial came (May 2016) Eric pleaded not guilty; no evidence was offered and all charges were dismissed.

3.3.15. In October 2015 Eric attended the Leaving Care Service for help with housing and stated he felt depressed; advice and support were recorded as being given. In November the service was contacted by a prison nurse who had treated Eric while he was serving a

seven-day sentence, reporting that Eric was reporting panic attacks. The service confirmed that this was not something they had been aware of before with Eric.

3.3.16. Eric had no contact with services from then until August 2016 (see above: he was on remand until April 2016), when he again contacted the Leaving Care service for advice in relation to his homelessness. Advice was again given.

3.3.17. In October 2016 Eric re-referred himself to Turning Point; he did not attend the assessment appointments and his case was closed.

3.3.18. Eric contacted the Leaving Care service in November 2016 for advice in relation to contact with his child; advice was given.

3.3.19. At the start of 2017 Eric started to attend AIR Network sport and wellbeing sessions: six in January and February. A week after his attendance at a session, AIR Network referred Eric into Turning Point but that service was unable to make contact with Eric and his case was closed. Eric did not attend AIR Network again.

3.4. Any other Relevant Information

3.4.1. The Review received information from London Borough of Croydon Youth Offending Services, which has been incorporated into the information above (2.2.3).

4. Analysis

4.1. Domestic Abuse/Violence and Jasmine and Eric

4.1.1. The only evidence of domestic abuse from Eric to Jasmine was the homicide itself; there was no information presented to this Review, or gathered within the police investigation, to suggest that there had been abuse in the relationship prior to this.

4.1.2. Eric was known to a number of agencies as a perpetrator of domestic abuse against a former partner including physical assaults, verbal abuse, two alleged rapes and an allegation of threats to kill his partner.

4.2. Analysis of Agency Involvement

4.2.1. The IMRs and the Review Panel considered the following key lines of enquiry:

- Analyse the communication, procedures and discussions, and co-operation and joint working, which took place within and between agencies in relation to Jasmine and/or Eric.
- Analyse the opportunities to identify, assess and respond to individuals with the following issues:
  - Domestic abuse perpetration (Eric)
  - Mental health (Jasmine)
  - Substance misuse (Jasmine & Eric)
  - Rent / housing issues or homelessness (Jasmine & Eric)
  - Looked after child / leaving care (Eric)
- Analyse agency responses in relation to the characteristics of Jasmine and Eric, including how they intersected:
  - Race (Jasmine & Eric)
  - Religion / faith (Jasmine & Eric)
  - Mental health (Jasmine)
  - Substance misuse (Jasmine & Eric)
  - Looked after children / leaving care (Eric)
- Analyse what policies, procedures and training are in place for the agency to address the issues identified in the above two points.
- Analyse organisations' access to: specialist domestic abuse agencies for victims or perpetrators; mental health services; substance misuse services.

4.2.2. These were covered by the agency IMRs and the learning is outlined below. Where themes or wider issues emerge these are addressed in section five.

4.2.3. Where learning has been identified by agencies, their recommendations are summarised in this section and listed in section six.

AIR Network

4.2.4. The Croydon AIR Network programme is for 'treatment naïve' clients (i.e. those who have not accessed substance misuse treatment before) aged 18-30, and for the hardest to reach individuals effected by substance and alcohol misuse and or involved with criminal justice services. The programme is a sports and fitness activity-based programme incorporating personal development. Clients also have access to education, training and employment-related support and courses from AIR Sports Network staff. Clients are primarily engaged through community networking and intensive ongoing street work. AIR Network are commissioned by Turning Point to deliver this service in Croydon. Treatment naïve clients engaged with via community outreach are referred to Turning Point in order to be assessed into treatment by that organisation.

4.2.5. The service only had contact with Eric, who attended a number of sessions in 2015 and 2017. On both occasions multiple attempts were made to reengage him with the service before his case was closed.

4.2.6. Eric was offered support in line with AIR Network's programme, and referred to Turning Point for assessment. Eric did not display any behaviours that caused concern amongst staff. The service was unaware of his historic or current offending, and of any risks he may have posed; they were also unaware that he was a former Looked After Child. His known substance misuse was managed through referral to Turning Point and the ongoing work of the programme.

4.2.7. The IMR author for AIR Network outlines that whilst staff are required to attend safeguarding training there is no current requirement to attend other forms of health and wellbeing / social care training such as on mental health issues. This will be reviewed to ensure that staff are able to identify indicators of possible issues for their clients.

4.2.8. There was also learning in relation to the referral process to Turning Point: on the second occasion when Eric attended (2017) the referral was not made promptly: it was made once Eric had disengaged from the service. A recommendation has been made.

4.2.9. AIR Network highlighted that, due to the nature of their service (self-referral), the issues they are aware of among their clients are largely due to self-report. As a result they knew little of Eric's current situation or background. This will be reviewed, in particular to aim to ensure that the service receives and shares key risk information about clients. A review is also taking place of what staff record about clients' attendance: at the time Eric attended, only the fact of his attendance was recorded.

Croydon Clinical Commissioning Group (General Practices)

4.2.10. The Clinical Commissioning Group (CCG) completed an IMR on behalf of two General Practices (GPs) where Jasmine was registered: one from 2002 and another from June 2015 onwards. Eric was not registered with a GP. The IMR states that at each practice, there was one GP who had consistent contact with Jasmine during the period under review.

4.2.11. As part of the IMR process, the CCG requested domestic abuse policies from both practices: it was established that the practices had safeguarding policies but that these did not reference domestic abuse; an IMR recommendation is made. Since 2014 the CCG GP Safeguarding Lead Workshops have received presentations from the Croydon Family Justice Centre; and 35 practices so far have identified a named Domestic Abuse and Sexual Violence Lead. This includes one of the surgeries in this case, but not the other; an IMR recommendation has been made. The CCG is currently looking at the role of these leads, to ensure that the roles continue to develop and receive the support and information they need.

4.2.12. The IMR shows that the GP was receiving regular updates from SLaM about Jasmine's mental health. When Jasmine changed GP in mid-2015 this communication became less regular; and a request from SLaM for the GP to undertake a physical health check with Jasmine was not completed.

4.2.13. This contact increased again in 2016; but again a physical health check was requested that was not completed. There was regular contact in the middle of the year between the GP and SLaM over a physical health concern of Jasmine's, in which the GP tried to offer appropriate support and referrals.

4.2.14. When the GP could not reach Jasmine in early 2017, it was noted that a male voice had answered her phone and stated it was a wrong number; Jasmine was then seen in the surgery some weeks later, which the IMR identified as an opportunity to discuss with Jasmine her mental wellbeing, partner and family situation and potentially identify any current issues for her.

4.2.15. The CCG outlined that it is developing guidance with regards to safeguarding adults and children policy, and this will be disseminated to all GP surgeries through the CCG Forums as a good practice example. The CCG informed the Review that they introduced a safeguarding self-assessment for GPs and that this will soon become a mandatory audit for all GPs.

4.2.16. The CCG is now leading on a domestic abuse and sexual violence committee. People have identified themselves as leads and continued support would be ongoing.

4.2.17. Recommendations are made in the IMR to address the learning.

London Borough of Croydon Adult Social Care Services

4.2.18. Adult Social Care held records in relation to Jasmine but did not have direct contact with her. The service held seven records of notifications (Merlins) that had been made by police when they had responded to Jasmine in relation to her mental health. As these involved Jasmine being under the care of the mental health trust (SLaM), no action was required.

London Borough of Croydon Children's Social Care Services

4.2.19. The majority of Eric's contact with this service was prior to the Terms of Reference timeframe, with the Looked After Children Service (approximately 2007 to 2011 when he turned 18) followed by the Leaving Care Service (2011 to 2014 when he turned 21). The information submitted by the service suggests that Eric was fairly "settled" during his time under the care of the Leaving Care Service. He had a good relationship with his keyworker, and attended meetings every four to six weeks.

4.2.20. One piece of learning was identified from that time, which was that it was potentially inappropriate for Eric to be allocated a Croydon property due to his vulnerability (he had just turned 18 and had been in the care of the local authority for some years) and the view now is that he may not have been in a position to maintain that level of responsibility. The Leaving Care Service continued to support him, in particular in relation to maintaining his benefits (and not being placed on sanction) and with his rent arrears, but this was not successful in the longer term. This type of allocation no longer takes place in the same way; alternative options are pursued for individuals.

4.2.21. The service were notified by Children's Social Care safeguarding that Eric was a perpetrator of domestic abuse against his then partner. Eric's keyworker discussed this situation with Eric a number of times; the Service informed the Review that staff are trained on working with domestic abuse, including responding to perpetrators.

4.2.22. In 2015 the Leaving Care service advised Eric to see his GP following his disclosure that he was struggling with depression. This Review has established that Eric at that time was not registered with a GP, which would have presented a barrier to him accessing mental health support. The Leaving Care service informed the Review that Eric's Personal Advisor had recorded a number of conversations with Eric encouraging him to register with a GP; information about local practices had been given and Eric stated he wished to follow this up himself.

4.2.23. When a young adult is within the Leaving Care service, their overall physical and mental health is monitored as part of their Pathway Plan: once in place this is reviewed every six months as well as being part of ongoing discussions between the young adult and their Personal Advisor and 'in-touch' visits they carry out.

London Borough of Croydon Housing Services

4.2.24. Housing services had separate contact with Jasmine and with Eric. Contact with Jasmine was limited as she did not require additional support from the service, although this was

offered. The IMR outlines the process that would have been followed by the service if Jasmine had at any time disclosed experiencing domestic abuse; and that staff have received domestic abuse training and adult safeguarding training. Since Jasmine moved into the property, the New Tenant Visit Forms have been amended to include specific questions regarding a tenant's support needs, and whether they are receiving support from other agencies; this information is then recorded on the system.

4.2.25. The service followed procedure in relation to Eric being a 'vulnerable tenant' (due to being a Leaving Care client) and maintained regular contact with his Leaving Care keyworker throughout Eric's tenancy and the rent arrears issues. This included contact when the service started court proceedings that ended with Eric being evicted.

4.2.26. The IMR author took the opportunity of this review to identify any best practice learning, which is good practice even if this learning would not have impacted on their contact in this case. Three recommendations are made to: complete an audit of local procedures and guidance; review the procedures for eviction of Leaving Care client; and ensure that staff have refresher training on domestic abuse.

National Probation Service London Region (NPS) and London Community Rehabilitation Company (CRC)

4.2.27. Probation initially received Eric's case in order to complete the pre sentence report. In June 2014 Transforming Rehabilitation took place and the activities of probation (London Probation Trust) were split between the National Probation Service (high risk/MAPPA offenders) and the London Community Rehabilitation Company (medium and low risk offenders). As a result of this, Eric's case was transferred to the CRC as he had been assessed as medium risk in the pre sentence report.

4.2.28. In completing the pre sentence report (offence of common assault and battery against his then partner in December 2013) the probation officer was informed by the policies and procedures in relation to domestic abuse related offences and in light of Eric's history. Appropriate checks were also carried out with Children's Social Care, in line with procedure. Eric's mental health was considered as part of the process. The IMR author outlines that there could have been consideration, given Eric's young age and previous history of offending, of categorising him as high risk (rather than medium risk) of harm. This would have resulted, if he had been sentenced to an Order, in him being allocated to NPS.

4.2.29. Both the NPS and CRC IMRs highlight the issues in relation to the error in recording Eric's sentence that led to his contact with CRC that had not in fact been required by the court. NPS make two IMR recommendations to ensure that this is not repeated. The CRC IMR author sets out that a clear allocation framework now exists to determine the allocation of cases from London NPS to the London CRC at sentencing, that work alongside the professional judgement of probation officers.

4.2.30. The CRC also identified the issue in relation to the sentence. The IMR outlines that a clear process is now in place for cases to be processed from court to the CRC: an Allocations Hub reviews and accepts transfers and allocates them appropriately, including checking the sentence and ensuring that court papers are uploaded to the case management system. Additional learning points were outlined in the IMR as follows, with recommendations made to address these.

4.2.31. A notification of safeguarding concerns was received from the MARAC lead in relation to Eric's violence and abuse towards his then partner. There was a lack of evidence to identify whether there was any follow up in response to this information. The notification regarding safeguarding also indicated that Eric was on police bail for a further offence against his then partner. There was no evidence to suggest that this was followed up.

4.2.32. In a one to one meeting Eric stated that his partner was pregnant and his appearance was recorded as that of someone who seemed pre-occupied and disengaged. There was a lack of evidence within the recording of any exploration with regard to his partner or the pregnancy. Eric's prior convictions and the offence for which he was under the CRC indicated a pattern of violence: in the view of the IMR author this should have informed further exploration on the concerns highlighted above. An IMR recommendation has been made.

Metropolitan Police Service

4.2.33. Police involvement with Jasmine was dominated by her mental health needs. Officers responded to calls from Jasmine or her family/others and took appropriate action in either detaining her under the Mental Health Act or liaising with other agencies. In all but one case, alerts (Merlins) were raised to Adult Social Care. (The IMR points to recent Serious Case Review investigations which have demonstrated that there are no systemic issues in relation to completion of Merlin reports.)

4.2.34. The IMR outlines that the police response to mental health has been a focus for some years, including the commissioning of and response to an independent report (Lord Adebowale, 2013). The progress made in response to this includes:

- Introduction of the Vulnerability Assessment Framework (VAF), a simple checklist that helps officers recognise vulnerability and mental health.
- Established a Mental Health Consultative Group to advise the MPS on training, policy and procedures.
- In January 2017 the National Police Chief's Council (NPCC), launched national guidance around the roles and responsibilities of health care professionals and police.
- Reduced the number of occasions someone detained under s.136 of the Mental Health Act has been taken to a police cell as a place of safety by 92 per cent.

- Set up NHS Liaison and Diversion teams in every MPS detention centre across London.
- Community Multi-Agency Risk Assessment Conference's (CMARAC) continue to be introduced and are now in over 60 per cent of boroughs across London.
- Every borough now has a mental health liaison officer in post.
- A new MPS tool kit is in preparation to provide clear operational and tactical guidance when dealing with someone who has mental ill health, which will include recent changes to the law and national procedures.
- The introduction of Adult Come to Notice MERLIN (ACN) records.
- The integration of vulnerable adults into the MASH environment through the new (v.11) MASH Toolkit published on 26 October 2017.

4.2.35. Police were involved with Eric as a domestic abuse perpetrator from 2013 to 2015; this involved ten incidents and offences involving his then partner (not Jasmine). The partner was offered appropriate support by police, and when necessary referrals were made to the Multi-Agency Risk Assessment Conference (MARAC) and specialist support services. In addition appropriate safeguarding notifications were made, and police engaged with London Borough of Croydon Children's Social Care Services' processes. Where possible Eric was held accountable for his behaviour including charges being made in relation to allegations.

Multi-Agency Risk Assessment Conference (MARAC), coordinated by Croydon Family Justice Centre

4.2.36. The Review sought information from the Family Justice Centre in order to understand what actions may have been taken in relation to Eric when his then partner was referred into the MARAC. In 2014 there were three MARAC discussions in relation to Eric and his then partner. The minutes of all three meetings were requested but only the last set were available, in which it was established that the victim had moved far away (and Eric was at that time on remand) and therefore there were no actions.

4.2.37. In addition the case was heard in 2014 at a neighbouring borough's MARAC; it had been transferred (a 'MARAC to MARAC Transfer'), due to the location of the victim in that borough at that time. The location of Eric was discussed and an action made to establish his bail conditions, which were completed with information shared. The case was then transferred to another borough.

4.2.38. The information available to this Review suggests that the risk posed by Eric to his then partner was appropriately discussed and addressed within the MARAC process, including actions for agencies in contact with Eric to establish his whereabouts, bail conditions and his awareness of the location of the victim.

South London and Maudsley NHS Foundation Trust (SLaM)

4.2.39. This service had the most extensive contact with Jasmine, starting from 2002 and continuing up to her death. The IMR from SLaM provided a detailed analysis of the key lines of enquiry for this Review. The service had no contact with Eric; he was on their system as they had received a referral for him when he was a child.

4.2.40. The IMR concludes that staff managed Jasmine's care as effectively and sympathetically as possible, making appropriate judgements as to the correct course of treatment and care and working to engage her in that. The following areas of effective practice were identified:

- The Community Mental Health Team (CMHT) managed to engage Jasmine by keeping her on medication and keeping regular contact with her through persistence.
- When Jasmine's care co-ordinator was on leave her depot medication was followed up by the CMHT duty system.
- At interviews CMHT staff demonstrated empathy and sensitivity to Jasmine as the victim of homicide.

4.2.41. Additionally staff recognised Jasmine's substance misuse as a factor in her mental health and worked to address this with her. Jasmine's care coordinator in CMHT was the substance misuse lead for the team and therefore had the appropriate experience and knowledge to address these matters with Jasmine. Staff were proactive in contacting Jasmine's GP, and at times police, to ensure relevant information about Jasmine was shared.

4.2.42. The IMR analysis showed that there were two instances when staff should have been more proactive in identifying and acting on potential safeguarding issues. In July 2016 Jasmine was reported to have been pushing a neighbour's child around the local area in a pushchair: there should have been consideration of a notification being raised and contact made with Children's Social Care in light of the previous safeguarding concerns in 2014 (when Jasmine had two children in her care at a time when her mental health was relapsing).

4.2.43. When Jasmine saw the CMHT two weeks before she died she reported that someone had been taking her money and threatening her. She also had to walk to the team's office because she had no money due to paying off the debts of a "*friend*". A safeguarding alert should have been considered even though Jasmine did not want to matter taken further. Further enquiries could have explored this in the context of coercive control or possible economic abuse. Interviews as part of the IMR process suggested "*the team demonstrated a reasonable knowledge of the procedures involved in raising a safeguarding alert, but not necessarily what circumstances should trigger one*".

4.2.44. In relation to Eric, SLaM had recorded that he was heard at the MARAC, although he was not under the care of SLaM at the time; this is good practice.

4.2.45. In summary the following lessons were learnt, in response to which two recommendations have been made:

- Some staff interviewed in the CMHT did not have a thorough knowledge and awareness of domestic violence and its relationship to raising adult safeguarding alerts.
- Trust guidance was not followed to place an alert on ePJS regarding service users who are perpetrators of domestic violence.

4.2.46. Jasmine did not disclose domestic abuse to SLaM staff; if she had, the IMR outlines the procedure that would have been followed by staff, who have a domestic abuse policy and domestic abuse is covered within safeguarding adults training.

Turning Point

4.2.47. Eric's first contact with this service, when he was referred by AIR Network, led to an assessment which the IMR author is satisfied was completed in a timely manner. The Care Plan set out clear goals for Eric in relation to his cannabis use, housing, education / employment and health and wellbeing. Eric did not attend again until he re-referred, but then was not seen again after that contact. Eric was contacted repeatedly to encourage his engagement.

4.2.48. The IMR sets out that there is learning for Turning Point in relation to safeguarding. In his contact with the service Eric reported that he had a child: there should have been consideration of follow up with regard to the welfare of this child. Additionally the service did not request/record details of Eric's offending history: it was recorded that he was not on a formal treatment order from court, but the rest of that part of the assessment had been left blank.

4.2.49. Eric was discussed at MARAC subsequent to his involvement with Turning Point; had he reengaged it is possible that this information would not have been flagged. This process has now been changed to ensure that staff can flag MARAC discussions in relation to both past and current clients. The information (beyond the flag) is kept confidential and can only be accessed by senior management.

4.2.50. Recommendations have been made to address these and the service has subsequently taken a number of actions, listed in section six.

Victim Support

4.2.51. Victim Support were involved with both Eric and Jasmine, but separately and at different times.

4.2.52. The IMR sets out that contact was not attempted with Jasmine. It was transferred from police to the Victim Support VARS (Victim Assessment and Referral Service). It was placed on a Victim Contact Officer's (VCO) case management system 'pipeline', which is how the individuals and teams manage referrals, contact attempts and cases. Standard practice

would be for a case to 'clear' back to a team pipeline if the Officer had not attempted contact. Instead the audit history shows that the case remained open on that Officer's pipeline from the date of transfer to the date the IMR chronology was completed.

4.2.53. An internal investigation was completed for the IMR to understand why this had happened. At the time that Jasmine was referred, Victim Contact Officers were consistently allocated more cases than they were expected to get through (i.e. attempt contact) in one day. The expectation was that any left uncontacted at the end of the day would be returned to the allocation list to be reallocated the next day. The responsibility of doing this was with the Team Leader, not the Officers themselves. Due to the nature of the system in use then, it was possible that, if an element in the case entry were changed or entered incorrectly, that it would in effect be 'invisible' to the Officer and to the Team Leader. It is also possible that the Officer did not, in the long list of cases to be contacted each day, see that Jasmine's was consistently there.

4.2.54. The IMR outlines that there were challenges to the service at the time that Jasmine was referred, including a significant backlog of cases, a number of vacancies in the team, and change management in relation to IT systems and case management. The IMR author concludes that the missed opportunity to contact Jasmine was due to human error. The IMR outlines that procedures have been reinforced/newly implemented since that time which have been assessed as leading to effectiveness within the system. Nevertheless the IMR author identifies action to further reduce the possibility of this happening again: "*VS will be introducing a new call and IT integrated programme within the London VARS Team; this will ensure cases are never missed in VCO or team pipelines as all cases will be tracked through the [case management] system from referral to each allocation and contact attempts.*"

4.2.55. The IMR author concludes that appropriate process was followed in response to the first referral for Eric, which ended with his case being closed as he had not been able to be reached (despite a number of contact attempts). The Victim Contact Officer demonstrated professional curiosity in contacting police to understand the nature of the incident further; including recognition that in domestic abuse cases, the male is more likely to be the perpetrator and therefore they requested more information to identify the 'primary' victim/perpetrator.

4.2.56. Following the second referral, Eric was contacted and offered support, which he declined. The case notes suggested that the Victim Contact Officer may not have researched other cases under Eric's name, or picked up from the previous referral that Eric and his then partner had both been arrested for assault against each other. This is recommended in domestic abuse cases to ensure that a "*more attentive and enhanced approach*" is taken to supporting victims. The Victim Support Domestic Abuse Operating Procedures and

Independent Domestic Violence Advocacy (IDVA) Procedures include a tool to be used with male service users who present as victims of domestic abuse (or where cross allegations are made, as in the first referral); this was not used when Eric was contacted following the second referral. It would have supported the Officer to identify the appropriate service to signpost Eric to.

4.2.57. The IMR makes a number of recommendations to ensure that the above missed opportunities and learning are acted upon.

4.3. Equality and Diversity

4.3.1. The Review Panel identified the following protected characteristics of Jasmine and Eric as requiring specific consideration for this case, including how they may have intersected: race (Jasmine & Eric); religion / faith (Jasmine & Eric); mental health (Jasmine); substance misuse (Jasmine & Eric); Looked after children / leaving care (Eric).

4.3.2. The Review Panel agreed that the protected characteristics of age, gender reassignment, marriage and civil partnership and sexual orientation had no impact on the response Jasmine or Eric received.

4.3.3. The above, having been highlighted as specific characteristics, were addressed within the agency IMRs, and this is summarised below.

4.3.4. *Sex*: This factor is relevant due to the nature of homicide. Women are more at risk of domestic homicide than men; and men are more likely than women to be the perpetrators when domestic homicide occurs. In this case also, Eric was known to agencies as a domestic abuse perpetrator against a previous partner; serial perpetration by male abusers is well established in cases where they do not engage with support to change their behaviours. Eric was recognised as a perpetrator of domestic abuse, and where possible he was held accountable for his abuse through the criminal justice process. When convicted of assault, probation recognised the need for a specific domestic abuse programme, although this recommendation was not taken up by the court. Had he come to the attention of police for alleged abuse against Jasmine or another partner, this history would have been taken into account by agencies in understanding the risk he may have posed, while recognising that he had not been proven guilty of some of the allegations. If Jasmine or someone supporting her had had concerns over his behaviour (NB there was nothing to suggest she or anyone else had concerns), she or they could have made a ‘right to ask’ request to police under the Domestic Violence Disclosure Scheme, which, if granted would have provided information about Eric’s history.

4.3.5. *Mental Health*: Agencies were aware of Jasmine's mental health needs, and Jasmine would at times volunteer the information. As well as her ongoing engagement with SLaM, support was offered to Jasmine by police, Housing and her GP.

4.3.6. *Substance misuse*: SLaM were aware of Jasmine's substance misuse and this was managed within her care plan (see above). When Eric attended AIR Network and was identified as needing support in relation to substance misuse, he was referred on to Turning Point who attempted to engage him in treatment and support.

4.3.7. *Looked after Children / Leaving Care*: Agencies were aware that Eric had been a Looked After Child and that he had been within the remit of the Leaving Care service. In particular, Housing Services were proactive in trying to work with Eric's keyworker in relation to his rent arrears. The further issues relating to Housing and Eric's situation are addressed above.

4.3.8. *Adult at Risk / Safeguarding Adults*: Jasmine was not referred to Adult Social Care for her care and support needs. This could have been done due to her mental health needs but the Review heard that in Croydon 'integrated care' is provided and therefore Jasmine's additional care and support needs, including any potential safeguarding issues that may have arisen (but did not) would be assessed and provided by SLaM within her ongoing care plan. If her needs had extended beyond the scope of what staff could provide, then they would have sought advice from and/or referred to Adult Social Care.

4.3.9. *Race*: This factor was included due to Jasmine being of mixed ethnicity, and Eric having immigrated from an African country. Race/ethnicity have been shown to potentially impact on an individual's ability, willingness and confidence to engage with services, and to impact on how someone is treated by professionals. There was nothing in any of the agency records to suggest that this had impacted on Jasmine's or Eric's experiences of services. As it has not been possible to speak with family members as part of the Review, we cannot check this against their lived experiences.

4.3.10. *Religion / Faith*: This characteristic was included by the Review Panel due to the ways in which Jasmine's mental health need often presented: she would refer to her religious beliefs repeatedly and this formed part of her Care Programme Approach summary of need with SLaM. Agencies interrogated their records in relation to this and nothing of significance was found.

4.3.11. *Race and religion/faith*: The Review Panel discussed the fact that, for these protected characteristics, there were no agency records indicating that they had impacted in any way on their interactions with services or the care/support they had received. Given the information the Review Panel had about Jasmine and Eric, it seemed surprising that there was no discussion from the support agencies (e.g. Croydon Leaving Care Service, SLaM, AIR Network, Turning Point) about how their racial, ethnic or religious identities and beliefs

may have intersected with their other characteristics and impacted on their lived experience. It may be that they did not have any additional or different needs in relation to this, and it is important in the absence of any other information not to make assumptions about their lives; but discussions could have been appropriate. At the request of the Review the Looked After Children service re-reviewed their records to look specifically at this issue (as their contact had been outside of the Terms of Reference) to identify if there were potentially any issues for Eric that agencies could or should have picked up on. The Review Panel member found that there were a number of incidents or issues in Eric's past that could have impacted on his life course, and interaction with services. For example: Eric came to the UK aged 10, having moved from one family setting to another as well as moving countries; and from then on had experienced multiple and unstable accommodation and care environments. They highlight that "*despite actively saying he wanted to engage with education, sports and make a new start away from criminal activity, [Eric] was being defined by professionals mostly in terms of his presenting behaviour as difficult, rude, demanding and uncooperative*". This contact was some years ago; the service outlines that since then: "*there is an improved focus in the local authority on the quality and frequency of case supervision; a more robust case audit process and external moderation by the Council's improvement partners; a clear escalation process for Independent Reviewing Officers; the implementation of the Strengthening Families approach; the Multi-Agency Safeguarding Hub (MASH) provides a clear process for young people in need linking to Child and Family Assessments of need; there is more robust analysis of the circumstances of young people becoming looked after and planning for their permanence.*"

4.3.12. As a result of the Review Panel's discussion, a recommendation (1) is made for the agencies that had ongoing, sustained contact with Jasmine and Eric to reflect on their agency approaches and responses to the protected characteristics of their clients/patients to ensure that they are not just recording data but are having meaningful discussions to ensure they understand the experiences and needs of individuals. It is important that staff are supported in these discussions with adequate training.

4.3.13. The Review Panel heard that the Croydon BME (Black and Minority Ethnic) Forum (http://www.cbmeforum.org) is an umbrella organisation for Croydon's Black and Minority Ethnic voluntary and community sector, and could be a source of support and information in this area.

5. Conclusions and Lessons to be Learnt

5.1. Conclusion

5.1.1. No agency knew of the relationship between Jasmine and Eric, and there was no evidence of abuse in their relationship prior to the homicide itself.

5.1.2. Jasmine's mental health led to regular contact with SLaM who monitored her and responded to fluctuations in her presentation. Just before she died, Jasmine could have been identified as a vulnerable person at risk of being abused or exploited, through her disclosure that a female "*friend*" had allegedly been taking her money and threatening her; and her statement that she had no money due to paying off the debts of a "*friend*" who was living with her (who might or might not have been the same person as in the first disclosure).

5.1.3. Eric was known by some agencies to be a perpetrator of serious domestic abuse related offences against a previous partner; and by other agencies as someone who misused drugs and alcohol. His contact with these agencies was at different times which meant that some agencies were unaware of his history.

5.1.4. Agencies reviewed their contact with Jasmine and/or Eric carefully in response to the Terms of Reference and the key lines of enquiry, including identifying good practice as well as areas for improvement, in response to which recommendations have been made.

5.2. Lessons to be learnt

5.2.1. The independent chair and Review Panel were mindful of, and discussed at the Panel meeting, the fact that Croydon had already published two Domestic Homicide Reviews, and there were an additional four currently ongoing.

5.2.2. In addition to the themes and recommendations identified below, the Review Panel felt strongly that there is a need to bring all past and current DHRs together by the multi-agency partnership in Croydon, including the Community Safety Partnership, the Local Safeguarding Children's Board and the Adult Safeguarding Board. Themes should be identified across them all, with a resulting action plan to ensure that the learning is acted upon. The Croydon Community Safety Partnership informed the Review that this work was now underway: the Croydon Domestic Abuse and Sexual Violence Board has begun a monitoring process for all Reviews with a new tracker for recommendations and actions. This will be reported on to the Community Safety Partnership. This development is welcome.

5.2.3. The lessons identified by the chair and Review Panel are:

Identification of Adults at Risk and appropriate referral

a) SLaM identified in their IMR that a safeguarding adults alert should have been made for Jasmine when she attended the mental health team shortly before her death. While Jasmine stated she did not want the matter taken further, it would have shown good practice for this action to be taken in light of the potential vulnerability brought about by Jasmine's mental health. Whether this would have identified Eric as her partner at the time, and whether he was involved in either of the two disclosures Jasmine made that day, cannot be known. It may have been that, if Eric had been identified, and information sought from police about him, that staff could have worked to understand any risk he posed to Jasmine.

b) When Jasmine made an allegation of sexual assault, at a time when she was an inpatient with SLaM, the notification to adult social care never reached the appropriate team. Staff working with Jasmine were aware of the allegation and could therefore address it with her; but had this not been the case, then the notification would have been a missed opportunity to support her. It is essential that referrals are sent to 'generic' email inboxes and not to named people within a team. A recommendation (2) is made for this learning to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

Responses to perpetrators of domestic abuse

c) Police responded positively to allegations of domestic abuse related offences against Eric, made by his then partner. He was arrested and charged, and where possible prosecuted. Referrals were made to MARAC and specialist support services to ensure that the victim was safeguarded.

d) That Eric was given a fine for common assault and battery, rather than the probation-recommended IDAP programme and supervision, was a missed opportunity to hold Eric to account for his abuse and offer him a route to choose to behave differently. The Review heard that there is currently no Specialist Domestic Violence Court in Croydon (a pilot had previously been in place); a recommendation (3) is made for the Domestic Abuse and Sexual Violence Board to review this situation and take action if required.

e) The agencies that Eric was in contact with later (in the time that he is now understood to have been in a relationship with Jasmine) were unaware of his history.

Identification of children by services working with adults

f) Both Jasmine and Eric came into contact with agencies that should have considered taking action to ensure children associated with them were safeguarded (SLaM for Jasmine and the CRC and Turning Point for Eric). The emphasis in this learning is on the need for agencies, particularly those working primarily with adults, to 'think family' and consider the other people who may reside or be linked to a household in which there is a person who may pose a risk. A recommendation (4) is made for the learning

to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

6. Recommendations

6.1. Recommendations from Agency IMRs

6.1.1. This Review expects that all Review Panel member agencies will share the learning internally with all levels of staff once the DHR is published.

6.1.2. Following each recommendation, in italics, is an update on progress.

6.1.3. AIR Network:

a. AIR Network to ensure that referrals to Turning Point are made as soon as possible after engagement has started. Outcome: An individual's substance misuse and other complex needs are assessed and treatment and support delivered as soon as possible.

Update: The process has been improved so that AIR Network refers all new clients to Turning Point within two weeks of referral.

b. AIR Network to review their internal processes regarding the sourcing of external risk information. Outcome: To assess the need to have access to information that would make staff more alert to potential risks. Access to formally recorded known risk information would provide staff with a more holistic picture of an individual's risk. This would enable staff to be more vigilant about behaviours which could indicate an escalation in risk or deteriorating mental health.

Update: AIR Network have reviewed their internal processes concerning sourcing risk information about new clients. Staff are now required to ask the referrer for all information they have pertaining to the risk of harm the individual may pose to themselves or others and record this on a risk information form. This form becomes part of the clients file and will be reviewed as new information comes to light during our contact with the client.

c. AIR Network to set up processes to receive risk information from referring external organisations. Outcome: same as point above.

Update: Please see point b above. Staff are required to gain information about risk from the referring organisation.

d. Implement AIR Network's Risk recording process. Outcome: To capture risk information in a standardised process. Will make staff more aware of potential risk factors.

Update: AIR Network have produced a standardised form and process for recording risk information about a client which is now used across the organisation.

e. Complete internal review of level of contact detail recorded. Outcome: To ensure that AIR Network records sufficient level of information to more effectively support and

review an individual's progress and record any untoward or concerning behaviours that may indicate an increase or deterioration in mental health.

Update: AIR Network have reviewed their internal case recording processes and have developed a case recording form and process that is required to be followed after every contact with a client. This results in contacts being recorded in a systematic manner across the organisation.

f. AIR Network to assess the need for basic mental health training. Outcome: To have made a decision about the need for mental health training and sourced relevant training for staff.

Update: This is still in progress and is being looked at as part of a wider training evaluation in the organisation.

6.1.4. Croydon Clinical Commissioning Group (on behalf of the General Practices):

a. Curiosity regards impact of mental health on physical health and vice versa and to ensure follow up recommendations regards physical health check requests.
b. The practice must update their knowledge and understanding of adults at risk.
c. The practices should both review their safeguarding policies with the support from the CCG Safeguarding Team and incorporate Domestic Abuse including referral pathways.
d. Named General Practice should identify a Domestic Abuse and Sexual Violence Lead.
e. The practice must attend CCG Safeguarding Training, Updates and Workshops and other learning opportunities within the borough.

Update: All actions are being followed up with the individual practices and the wider general practice safeguarding leads via training, updates and forums from the CCG safeguarding team.

6.1.5. London Borough of Croydon Housing Services:

f. Complete audit of 'local' procedures and guidance. As part of best practice, Croydon Housing Needs will undertake an audit of local procedures and guidance documents with the express purpose of withdrawing those that do not comply with organisational procedure. I would recommend that this process is project managed to ensure completion of the audit and completion of follow up actions aimed at ensuring local compliance with organisational policy and procedure within an agreed timeframe.
g. Review Croydon Housing Needs procedures for eviction of leaving care clients. In this case, Croydon procedures were followed, however it is recommended that Croydon Housing Needs carries out a further review of procedures for eviction of vulnerable clients to ensure procedures are up to date and comply with current procedures.
h. Training: Tenancy staff have attended domestic abuse and adult safeguarding training. However it is important that refresher training is provided to all housing staff on a

regular basis. It is recommended that regular staff training should be provided to support staff members working with victims and perpetrators of domestic abuse to include: safe enquiry; responding, recording, reporting; safety planning; multi-agency working; working safely with perpetrators; legal remedies.

Update: The Housing Needs Department has recently undergone a restructure and as such we created a Development Officer role. This person will be the project lead for Tenancy and Caretaking ensuring all policies and procedures (including domestic abuse) are regularly monitored and reviewed to reflect any changes or gaps in the service.

6.1.6. London Community Rehabilitation Company:

i. We were emailed with concerns regarding domestic violence and a young child via a MARAC lead and there is no evidence of follow up action. Recommendation: MARAC process for the internal sharing information and follow up to be reviewed.

Update: The London CRC remain committed to local engagement in MARAC. Each borough has a designated operational and strategic lead for MARAC, who will attend monthly operational and quarterly strategic meetings as required and act as a single point of contact from partnerships. In addition, practitioners new to the organisation are required to engage in training around domestic abuse and safeguarding. This provides assurance of the importance placed on this area of work and that practitioners are aware of the need to focus on key areas of practice, including the prioritisation of information received.

j. As an organisation we now have a process for safeguarding checks to be completed and followed up, requiring management oversight. Safeguarding training was also rolled out to all staff. We are also in the process of updating our safeguarding training guidance and training as a result of REACTA, a new model. This is going to be rolled out across the organisation imminently. Recommendation: roll out and evaluate impact of REACTA.

Update: The new practice model for safeguarding was rolled out in the London CRC in March/April 2018. The majority of staff have now been trained in this approach and management information is being utilised to test compliance across London. The evaluation of REACTA is ongoing and is reviewed on a monthly basis by the London CRC safeguarding board, Chaired by the Director of Probation in London

k. Case records were not always updated on this case. Our organisational plan, meet and record directive ensures that all appointments have a clear outcome with regards to an appointment and staff have to report to their line manager if contacts are incomplete or not actioned. Recommendation: Fully embed Plan, Meet and Record.

Update: The plan meet record is essentially a recording convention for London, designed to ensure that the time between seeing a service user and recording information in Delius is minimised. The use of PMR also supports the professional judgement of Offender Managers in regards to setting the reporting frequency at which services users are seen. The use of Plan, Meet, Record remains an organisational instruction with the use of this approach being mandatory.

l. London CRC has clear Offender Management practice standards for case management that practitioners manage their cases in line with.
Update: The London CRC is fully compliant with this recommendation. Practice Standards are embedded across the organisation and are routinely updated to reflect changes to internal processes or external contract variations. The Practice Standards guide work across all areas of service delivery and contractual obligations.

m. All appointments and contacts with Offenders are now managed and evidenced under the following format. CRISSA – Checking, Review, Intervention/Implementation, Summarise/Set Tasks and Appointment. This format ensures clear and evidential recording of appointments and discussions. Recommendation: Clear quality assurance activity to assure use of Practice Standards, CRISSA etc.
Update: The response to this specific objective is captured in previous recommendations around CRISSA and practice standards. The use of CRISSA and PMR are part of the London CRC practice standards, and therefore part of the mandatory approaches to service delivery. The London CRC undertake a monthly quality assurance audit of cases in order to benchmark the quality of work being undertaken by practitioners. This audit reviews the quality of work around safeguarding and recording of information.

6.1.7. National Probation Service (London Region):

n. NPS London to ensure that Probation Sentence Notification results undertaken at court are verified against LIBRA (Magistrates Court) XHIBIT (Crown Court) recording systems.
Update: Ongoing.

o. NPS to ensure that in all Community/Suspended Sentence Orders imposed by the courts an order is held on NDelius our data recording system
Update: Ongoing.

6.1.8. South London and Maudsley NHS Foundation Trust (SLaM):

p. SLaM to review the domestic violence aspect of the adult and child safeguarding level 3 training in order to ensure it covers identification and how to respond to domestic abuse and violence concerns. There is an e-learning module on domestic violence and abuse for all Trust staff and this will be further advertised within teams to ensure

compliance. The Trust produced a short article in the SLaM News at the end of 2017 to re-advertise the website and training, and reinforce the need for clinical staff to be aware of their responsibilities in routine enquiry and safety planning. This will be revisited once this Review is finalised.
Update: Completed. The Trust provided an article in the SLaM News December 2017 re-advertising the DVA website, training and reinforcing the need for clinical staff to be aware of their responsibilities in routine enquiry and safety planning.

q. Named CMHT to incorporate the discussion of any adult or child safeguarding concerns and required actions into their monthly complex case formulation meeting.
Update: Completed. All safeguarding concerns are discussed by the multi-disciplinary team (MDT) and work in collaboration with the Croydon Adult Safeguarding Team based at the Jeanette Wallace House. This is logged on the tracker and reviewed accordingly. This is also discussed in the individual staff supervision for support and advice as needed by the Team Manager. The team psychologist leads the monthly complex case forum, the forum is tailored to individual needs including risk and management which includes safeguarding adults and children concerns.

6.1.9. Turning Point actions taken since identification of learning through the IMR:

r. We have regular monthly safeguarding meetings which are mandatory for all staff.

s. We now have a comprehensive safeguard register which is reviewed/audited and updated, the safeguarding lead reviews and chases up any outstanding actions and updates the register.

t. We discuss any safeguarding concerns in morning briefing, clinical team meeting and managers meeting.

u. We make sure all staff attend safeguarding training and refresh every 3 years – mandatory.

v. We have monthly surgeries where the safeguarding lead from the Croydon council attends to discuss any cases recovery workers have, this is also an opportunity to chase up outstanding actions.

w. Safeguarding issues are discussed in supervision and recorded.

6.1.10. Victim Support:

x. ACTION 1: Until the new call and IT programme is introduced Victim Support should consider Victim Support Officers (VCOs) self-emptying their pipelines at the end of their own shift to ensure the pipelines are fully emptied and prevent the loss of cases from view. To be discussed at the next Victim Assessment and Referral Service (VARS) management meeting in January 2018 and implemented if agreed.
Update: A new and improved call management system is being commissioned in the VARS service.

y. ACTION 2: Victim Support should ensure that services are resilient to pressures from restructure and resource limitations, and that business continuity plans are in place that account for IT failures, staff turnover and vacancy/absence cover, and that contact is prioritised in relation to risk as well as contact Service Level Agreement (SLA). This action is already under way. The learning from this DHR should be fed back to the VARS management team meeting in January 2018 and action points developed around improving triaging processes and built into the business continuity plan by January 2018.
Update: Business continuity plan is in place and feedback from DHR provided to VARS management team.

z. ACTION 3: Ensure present-day Victim Support practice is adhered to through continued use of dip-sampling and case review and feedback to VARS staff. This is already being actioned through the introduction of an improved case review and auditing process throughout the organisation on a national level. The VARS should be included in this explicitly. This should be taken forward by Heads of Service with discussion points issued to the VARS management meeting for January 2018, to be developed into the next stage of rollout with input from service teams.
Update: The VARS service has undergone a re-structure and new VARS managers are in post with responsibility for VCO case reviews and audit.

aa. ACTION 4: Ensure service explanation, confidentiality/information sharing, and subject access rights are clearly explained and explanations clearly recorded. This will be included in briefings to VCOs with immediate effect. A script will be developed to ensure the phrasing of this is consistent. The script will then be cascaded to all services and reinforced through case review and auditing. Briefings and script to be completed by end of February 2018; rollout through case management to be completed on an ongoing basis and reviewed in March 2018.
Update: GDPR compliant script now in place and used by VCO's. VARS Manager's quality assure through case management reviews and performance audits.

6.2. Overview Report Recommendations

6.3. The recommendations below should be acted on through the development of an action plan, with progress reported on to the Croydon Community Safety Partnership within six months of the review being approved by the partnership.

6.4. **Recommendation 1 (see 4.3.12)**: All agencies that had sustained contact with Jasmine and Eric to reflect on their agency approaches and responses to the protected characteristics of their clients/patients to ensure that they are not just recording data but

are having meaningful discussions to ensure they understand the experiences and needs of individuals; including ensuring staff are supported in these discussions with adequate training.

6.5. **Recommendation 2 (see 5.2.3.b)**: This learning from the Domestic Homicide Review to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

6.6. **Recommendation 3 (see 5.2.3.d)**: Croydon Domestic Abuse and Sexual Violence Board to review the previous pilot Specialist Domestic Violence Court and why it came to an end; and to take action where required including any training requirements for court staff and magistrates on domestic abuse.

6.7. **Recommendation 4 (see 5.2.3.f)**: This learning from the Domestic Homicide Review to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.

7. Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with Jasmine and Eric following the death of Jasmine in 2017. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1) To review the involvement of each individual agency, statutory and non-statutory, with Jasmine and Eric during the relevant period of time 1 January 2013 to the date of the homicide inclusive. To summarise agency involvement prior to 1 January 2013.
2) For agencies that had extensive involvement with Jasmine and/or Eric prior to 1 January 2013, to include in the IMR a narrative history of that contact.
3) To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
4) To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
5) To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
6) To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
7) To contribute to a better understanding of the nature of domestic violence and abuse.
8) To highlight good practice.

Role of the DHR Panel, Independent Chair and the CSP

9) The Independent Chair of the DHR will:

a) Chair the Domestic Homicide Review Panel.
b) Co-ordinate the review process.
c) Quality assure the approach and challenge agencies where necessary.
d) Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

10) The Review Panel:

a) Agree robust terms of reference.
b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently

senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
e) Agree and promptly act on recommendations in the IMR Action Plan.
f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
    - The purpose of the review has been met as set out in the ToR;
    - The report provides an accurate description of the circumstances surrounding the case; and
    - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Croydon Community Safety Partnership.
j) Implement your agency's actions from the Overview Report Action Plan.

11) Croydon Community Safety Partnership:

a) Translate recommendations from Overview Report into a SMART Action Plan.
b) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forward Home Office feedback to the family, Review Panel and STADV.
d) Agree publication date and method of the Executive Summary and Overview Report.
e) Notify the family, Review Panel and STADV of publication.

Definitions: Domestic Violence and Coercive Control

12) The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross government definition states that domestic violence and abuse is:

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

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

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

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

13) The Review Panel considered all protected characteristics (as defined by the Equality Act 2010) of both Jasmine and Eric and also identified additional vulnerabilities to consider.
14) The Review Panel identified the following protected characteristics of Jasmine and/or Eric as requiring specific consideration for this case:
    a) Sex / gender
    b) Race
    c) Religion and belief
15) The following issues have also been identified as particularly pertinent to this homicide:
    a) Mental health of Jasmine
    b) Substance use by Jasmine and Eric
    c) Eric as a former Looked After Child
    d) Issues relating to rent, housing and homelessness for Jasmine and Eric
    e) Serial perpetration of domestic abuse by Eric
    f) Possible issues of isolation for Jasmine and Eric
16) Consideration was given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk'. The Review Panel concluded that this would be a key line of enquiry for the Review.

    Expertise: The Review Panel agreed that the existing members of the Panel are sufficient to address the particular characteristics and issues in this Review.
17) The Review Panel agrees it is important to have an intersectional framework to review Jasmine's and Eric's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

18) The criminal investigation was ongoing when the DHR convened. The timescales of the Review mean that the trial will be concluded while chronologies and IMRs are completed, and before they are shared.
19) Jasmine was under the care of South London and Maudsley NHS Foundation Trust (SLaM) at the time of her death, and therefore a Serious Incident Review has started within the Trust. The Review Panel agrees:
    a. The DHR will be run in parallel to the SI Review as they are separate processes.
    b. The DHR Terms of Reference to be included in and addressed by the SI Review and for the SI Review report to be submitted in place of an IMR by SLaM.
    c. The timescales for both the DHR and the SI Review will not delay either process.

Membership

20) It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
21) The following agencies are to be on the Review Panel:
    a) AIR Sport Network
    b) Croydon Clinical Commissioning Group
    c) Croydon Health Services NHS Trust
    d) Family Justice Centre
    e) London Borough of Croydon Adult Social Care Services
    f) London Borough of Croydon Community Safety
    g) London Borough of Croydon Housing Services
    h) London Borough of Croydon Looked After Children / Leaving Care Services
    i) London Community Rehabilitation Company
    j) Metropolitan Police Service (Borough and Serious Crime Review Group)
    k) National Probation Service
    l) NHS England
    m) South London and Maudsley NHS Foundation Trust
    n) Turning Point
    o) Victim Support

Role of Standing Together Against Domestic Violence (STADV) and the Panel

22) STADV have been commissioned by the Croydon CSP to Independently chair this DHR. STADV have in turn appointed their DHR Associate Althea Cribb to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Administrator will provide

administrative support to the DHR and the DHR Team Manager Gillian Dennehy will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve their attendance at some panel meetings. The contact details for the STADV DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

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

24) Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Jasmine and/or Eric during the relevant time period:

   a. AIR Sport Network
   b. Croydon Clinical Commissioning Group (for the General Practices)
   c. Croydon Health Services NHS Trust (chronology only)
   d. Family Justice Centre
   e. London Borough of Croydon Adult Social Care Services
   f. London Borough of Croydon Housing services
   g. London Borough of Croydon Looked After Children / Leaving Care Services
   h. London Community Rehabilitation Company
   i. National Probation Service
   j. Metropolitan Police Service
   k. South London and Maudsley NHS Foundation Trust
   l. Turning Point
   m. Victim Support

25) Chronologies will be completed by the following organisations known to have had contact with Jasmine and/or Eric during the relevant time period:

   n. Family Justice Centre (in relation to the Multi-Agency Risk Assessment Conference meetings held in which Eric was discussed as a perpetrator of domestic abuse against another person)
   o. London Ambulance Service

26) Further agencies may be asked to completed chronologies and IMRs if their involvement with Jasmine and/or Eric becomes apparent through the information received as part of the review.

27) Each IMR will:

   - Set out the facts of their involvement with Jasmine and/or Eric.
   - Critically analyse the service they provided in line with the specific terms of reference: see paragraphs 1 and 2 and 27.

- Identify any recommendations for practice or policy in relation to their agency.
- Consider issues of agency activity in other areas and review the impact in this specific case.

Key Lines of Inquiry

28) In order to critically analyse the incident and the agencies' responses to Jasmine and Eric, each IMR should specifically consider the following points:

a) Analyse the communication, procedures and discussions, and co-operation and joint working, which took place within and between agencies in relation to Jasmine and/or Eric.

b) Analyse the opportunities to identify, assess and respond to individuals with the following issues:
   - Domestic abuse perpetration (Eric)
   - Mental health (Jasmine)
   - Substance misuse (Jasmine & Eric)
   - Rent / housing issues or homelessness (Jasmine & Eric)
   - Looked after child / leaving care (Eric)

c) Analyse agency responses in relation to the characteristics of Jasmine and Eric, including how they intersected:
   - Race (Jasmine & Eric)
   - Religion / faith (Jasmine & Eric)
   - Mental health (Jasmine)
   - Substance misuse (Jasmine & Eric)
   - Looked after child / leaving care (Eric)

d) Analyse what policies, procedures and training are in place for the agency to address the issues identified in (b) and (c)

e) Analyse organisations' access to: specialist domestic abuse agencies for victims or perpetrators; mental health services; substance misuse services.

As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

29) Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Croydon Community Safety Partnership on their action plans within six months of the Review being completed.

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

Liaison with the victim's family and [alleged] perpetrator and other informal networks

31) The review will sensitively attempt to involve the family of Jasmine in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Police Family Liaison Officer.
32) Eric will be invited to participate in the review, following the completion of the criminal trial.
33) Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information. This will include liaison between the independent chair and the lead for the SLaM Serious Incident Review to reduce duplication of contact and confusion for family members.
34) The Review Panel discussed involvement of other informal networks of Jasmine and Eric. The police Senior Investigating Officer will consider the information provided to police by Jasmine' neighbours in case they may be able to contribute. A contact of Eric's who gave a statement to police will be contacted by the independent chair (through police). Exploration will be made through information provided by agencies participating in the Review as to whether any further networks are known about and can be contacted.

Media handling

35) Any enquiries from the media and family should be forwarded to the Croydon Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Croydon Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.
36) The Croydon Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

37) All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
38) All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

39) It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

Disclosure

40) Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

41) The sharing of information by agencies in relation to their contact with Jasmine and/or Eric is guided by the following:

a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs (Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.

b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
   - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
   - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
   - partial redaction of record content.

c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).

d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
    i) It is needed to prevent serious crime
    ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

42) As there is a police criminal investigation, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.

43) The DHR Chair will discuss the issues of disclosure in this case with the police Disclosure Officer.

44) The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

8. Appendix 2: Descriptions of Agencies Involved

Service	Explanation
AIR Network	AIR Network is a sports and fitness based organisation which uses sport to engage individuals to make positive changes in their lives. The organisation provides individuals with support across a wide range of areas including health and wellbeing, mentoring, criminal justice, substance misuse and housing. AIR Network is commissioned in criminal justice and substance misuse.
Croydon Clinical Commissioning Group	Croydon Clinical Commissioning Group iIs a membership organisation made up of all GP practices in the borough of Croydon. They are responsible for commissioning (buying) healthcare services for the residents of Croydon. These will include healthcare services at hospitals, in the community and mental health services.
Croydon Health Services NHS Trust	Croydon Health Services provides integrated NHS services to care for people at home, in schools, and health clinics across the borough as well as at Croydon University Hospital and Purley War Memorial Hospital.
London Borough of Croydon Council Adult Social Care	London Borough of Croydon Adult Social Care is responsible for ensuring that adults who are in need of care and attention are assessed in a timely manner, needs identified and actions taken to meet those needs.
London Borough of Croydon Housing Services	Housing Services deliver services to residents of Croydon including: applying for a council house; finding rented accommodation; help for people who are homeless; and information and advice. They are the Social Landlord for council-owned properties including day to day management of tenancy issues; rent collection and support.
London Borough of Croydon Children Looked After / Leaving Care Services	Delivery of services for children and young people who need to live, either in the short term, or permanently, with substitute carers.
London Community Rehabilitation Company	London Community Rehabilitation Company (CRC) is responsible for the management of Low and Medium risk offenders who are subject to a Community Order, Suspended Sentence Order or released from custody on Licence.
Metropolitan Police Service	Police Service for London.

National Probation Service	National Probation Service (NPS) manages High Risk and MAPPA cases and private companies which manage Medium and Low risk offenders.
South London and Maudsley NHS Foundation Trust	SLaM provide inpatient and community mental health services in Croydon, Lambeth, Southwark and Lewisham.
Turning Point	Turning Point deliver the community substance misuse treatment for Croydon Borough. The perpetrator was known to Turning Point.
Victim Support	Victim Support is the independent charity for victims and witnesses of crime in England and Wales. In Croydon, Victim Support offers emotional & practical support and information to domestic abuse victims/survivors who are assessed as being of standard risk levels; domestic abuse clients assessed as being at high and very high risk are referred, with consent, for specialist IDVA support, whilst also being referred to MARAC. The services provided by Victim Support are free, confidential, non-judgemental and based on an empowerment model of support.

9. Appendix 3: Action Plan for Overview Report Recommendations

No	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
Air Network (6.1.3)							
A.	That an individual's substance misuse and other complex needs are assessed and treatment and support is delivered as soon as possible.	Communication to all staff to update them on new process		That an individual's substance misuse and other complex needs are assessed and treatment and support is delivered as soon as possible.	Fiona Bauemesiter		The process has been improved so that AIR Network refers all new clients to Turning Point within two weeks of referral. 28.10.2020 – email sent to Fiona for update for A-F
B.	To review their internal processes regarding the sourcing of external risk information.			Air Network now assess the need to have access to information that would make staff more alert to potential risks. Access to formally recorded known risk information now provides staff with a more holistic picture of an individual's risk. This enables staff to be more vigilant about behaviours which could indicate an escalation in risk or deteriorating mental health.	Fiona Bauemesiter		We have reviewed their internal processes concerning sourcing risk information about new clients. Staff are now required to ask the referrer for all information they have pertaining to the risk of harm the individual may pose to themselves or others and record this on a risk information form. This form becomes part of the clients file and will be reviewed as new information comes to light during our contact with the client.
C.	To set up processes to receive risk information from referring external organisations			See above.	Fiona Bauemesiter		Please see point b above. Staff are required to gain information about risk from the referring organisation
D.	Implement AIR Network's Risk recording process	Build awareness of new process with all AIR staff within 3 months of DHR.		To capture risk information in a standardised process. Will make staff more aware of potential risk factors.	Fiona Bauemesiter		AIR Network have produced a standardised form and process for recording risk information about a client which is now used across the organisation.
E.	Complete internal review of level of contact detail recorded			To ensure that AIR Network records sufficient level of information to more effectively support and review an individual's progress and record any untoward or concerning	Fiona Bauemesiter		AIR Network have reviewed their internal case recording processes and have developed a case recording form and process that is required to be followed after every contact with a client. This results in contacts being

				behaviours that may indicate an increase or deterioration in mental health.			recorded in a systematic manner across the organisation
F.	AIR Network to assess the need for basic mental health training.	To have made a decision about the need for mental health training and sourced relevant training for staff. To ensure all staff book onto Mental health training once sourced.			Fiona Bauemesiter		This is still in progress and is being looked at as part of a wider training evaluation in the organisation
Croydon CCG							
A.	Curiosity regarding impact of mental health on physical health and vice versa and to ensure follow up recommendations regards physical health check requests.					Estelene	All actions are being followed up with the individual practices and the wider general practice safeguarding leads via training, updates and forums from the CCG safeguarding team. 28.10.2020 – Email sent to Estelene for updates
B.	The practice must update their knowledge and understanding of adults at risk						
C.	The practices should both review their safeguarding policies with the support from the CCG Safeguarding Team and incorporate Domestic Abuse including referral pathways.						
D.	Named General Practice should identify a Domestic Abuse and Sexual Violence Lead.			Staff member volunteered for role of DASV leads.			Dr Debbie Berry is the named DASV lead within the practice. DASV leads are responsible for ensuring the practice is up to date with the local DA pathways and training opportunities. This information is shared with DASV leads by the DASV coordinator through a regular DA bulleting and email updates.

E.	The practice must attend CCG Safeguarding Training, Updates and Workshops and other learning opportunities within the borough	Become a IRIS informed practice	Email sent by Iris AE in in October 2020.	Training dates booked for IRISi training and identification.	Vanessa Richards – IRIS AE	October 2020.	
		Regularly attends the GP SG panel					
London Borough of Croydon Housing Services							
F.	Complete audit of 'local' procedures and guidance. As part of best practice, Croydon Housing Needs will undertake an audit of local procedures and guidance documents with the express purpose of withdrawing those that do not comply with organisational procedure. I would recommend that this process is project managed to ensure completion of the audit and completion of follow up actions aimed at ensuring local compliance with organisational policy and procedure within an agreed timeframe						The Housing Needs Department has recently undergone a restructure and as such we created a Development Officer role. This person will be the project lead for Tenancy and Caretaking ensuring all policies and procedures (including domestic abuse) are regularly monitored and reviewed to reflect any changes or gaps in the service. Email sent to Sharon Murphy, Head of Tenancy and Caretaking, 27/10/2020 for update.
G.	Review Croydon Housing Needs procedures for eviction of leaving care clients. In this case, Croydon procedures were followed, however it is recommended that Croydon Housing Needs carries out a further review of procedures for eviction of vulnerable clients to ensure procedures are up to date and comply with current procedures						

H.	Training: Tenancy staff have attended domestic abuse and adult safeguarding training. However it is important that refresher training is provided to all housing staff on a regular basis. It is recommended that regular staff training should be provided to support staff members working with victims and perpetrators of domestic abuse to include: safe enquiry; responding, recording, reporting; safety planning; multi-agency working; working safely with perpetrators; legal remedies.						
London Community Rehabilitation Company							
I.	MARAC process for the internal sharing information and follow up to be reviewed.	All new staff to attend training around domestic abuse and safeguarding. Each borough must continue to have a designated operational and strategic lead for MARAC.		This will provide assurance of the importance placed on this area of work and that practitioners are aware of the need to focus on key areas of practice, including the prioritisation of information received. The MARAC lead will attend monthly operational and quarterly strategic meetings as required and act as a single point of contact from partnehships.	Lucian Spencer	October 2020.	The completion of core safeguarding and domestic abuse training remains a key feature of new staff inductions. Practitioners are unable to hold operational responsibility for cases until such training has been completed. The gradual increase in caseload size over the first 6 months ensure that all new staff have effective oversight and are able to demonstrate their ability to apply theoretical knowledge and understanding into practice. The implementation of a new internal learning platform, Fuse, during 2019, provided an opportunity for all safeguarding level 1 and 2 training to be moved online. As such, despite challenges brought about by Covid, all staff have been able to access core training and renew safeguarding and domestic abuse understanding on a regular basis.

							Recently a focus on continuous professional development has resulted in the introduction of peer group learning and clinical supervision. This provides an opportunity for practitioners to reflect on their practice and to be challenged by operational colleagues and peers within a 'safe space'. The single point of contact for MARAC, and other single points of contact for areas such as safeguarding, are often involved and engaged within these learning groups. The London CRC continues to provide a single point of contact for MARAC. The challenge of MARAC resulted in the need for weekly attendance utilising Microsoft teams. Despite the restrictions put in place by the MoJ in relation to our access to external platforms, the London CRC has been able to purchase and acquire authorisation for the use of equipment to enable regular attendance at these meetings.
J.	Roll out and evaluate impact of REACTA	Management must have oversight of this new process. Safeguarding training must be rolled out to all staff. Update SG training guidance and roll out to all organisation.		The majority of staff have now been trained in the new practice model. Management information is being utilised to test compliance across London.	Lucian Spencer	October 2020.	The assessment approach of REACTA continues to be utilised by the London CRC. Enhanced management information enables each operational manager to track where assessments are or are not taking place, and take this forward within appropriate accountability structures. Although this approach has been maintained, the past 12 months

							have predominately focussed on the implementation of the new integrated assessment and management tool, Omnia. The 12 month roll out programme commenced in early 2019, with all practitioners now demonstrating competency within this tool. By aligning case recording and case assessment, risk assessments are updated more frequently across key criminogenic needs. Current management information tools enables risk review compliance to be tracked daily, with the expectation that risk assessments are updated after every contact with a service user. For the month of October 2020, the risk compliance rate in Croydon was 62%. This is an increase from 25% during August / September 2020 when this approach was adopted. In addition to the implementation of Omnia and continued use of REACTA, during 2019 the London CRC also placed greater emphasis on the quarterly and monthly audit process. Although suspended since March 2020 (due to Covid-19 and a shift in organisational resource and priorities) the QA approach has enabled a deeper dive into the quality of practice delivered across safeguarding and domestic abuse. The outcomes of each round of QA sit within an area accountability structure with areas of improvement / areas of development and good practice being identified. Where significant

							deficits are noted these are addressed within appropriate internal management processes.
K&L	Fully embed Plan, Meet and Record case records.	To ensure that the organisational plan, meet and record directive ensures that all appointments have a clear outcome with regards to an appoinments. That all staff report to their line manager if contacts are incomplete or not actioned.		The use of Plan, Meet, Record remains an organisational instruction with the use of this approach being mandatory. Practice Standards are embedded across the organisation and are routinely updated to reflect changes to internal processes or external contract variations.	Lucian Spencer	October 2020.	The London CRC continues to have clear operational practice standards relating to the need for practitioners to update engagement with service users on every contact. As noted within objective J, the implementation of a new integrated risk assessment and case recording system (Omnia) has provided an opportunity to track the completion of risk assessments on every contact with a service user. Alongside management information detailing 'incomplete outcomes' and cases with 'no next appointment', operational managers have assurance that information is being recorded at the correct frequency and in relation to those service users presenting the highest potential of serious harm. A renewed focus on PMR and cases with no next appointment has resulted in a significant upward trend in recording information in a timely manner. This can be evidence through quality audits undertaken in prior to Covid-19 restrictions. In the 3 audits undertaken, recording was noted as sufficient in 75% of cases reviewed. It is important to recognise that this value relates both to the timeliness of the recording and the quality of the information input into the assessment.

							Again, the commencement of risk review compliance information will compliment this approach and ensure all risk assessments are effective and defensible.
M.	Clear quality assurance activity to assure use of Practice Standards, CRISSA etc.			All appointments and contacts with Offenders are now managed and evidenced under the following format: CRISSA – Checking, Review, Intervention/Implementation , Summarise/Set Tasks and Appointment. This format ensures clear and evidential recording of appointments and discussions.	Lucian Spencer	October 2020.	The use of the format CRISSA remains a key part of operational good practice. Case management records should continue to follow the CRISSA format although should now more explicitly signpost the reader to updates within the risk/case assessment. The response to previous objectives, outline that the London CRC has continued to update operational practice to ensure practitioners are more frequently updating the risk assessment. Both external inspection (HMiP) and internal audits, noted that practitioners often utilised case management records as a way of assessing changing risk and to evidence a response. Although helpful, this information was difficult to extract overtime and could be lost when there was a change in practitioners brought about by factors such as attrition. Ensuring that any update in circumstances was recorded within a more dynamic assessment tool (omnia) was a key driver for this change in process. Consequently agencies who are reliant on information from the CRC, such as Courts, could current information in

							a timely manner. This adaptation remains more defensible as a practice tool and ensures aspects such as inclusion/disproportionality can be better taken into consideration when sharing information.
National Probation Service							
N.	NPS London to ensure that Probation Sentence Notification results undertaken at court are verified against LIBRA (Magistrates Court) XHIBIT (Crown Court) recording systems.						Email sent to Anthony O'Kane for further update. 27.10.20
O.	NPS to ensure that in all Community/Suspended Sentence Orders imposed by the courts an order is held on NDelius our data recording system						
South London and Maudsley NHS Foundation Trust (SLaM)							
P,S, T	SLaM to review the domestic violence aspect of the adult and child safeguarding level 3 training in order to ensure it covers identification and how to respond to domestic abuse and violence concerns	The E-Learning model will be advertised with all teams to ensure compliance.		The Trust produced a short article in the SLaM News at the end of 2017 to re-advertise the website and training, and reinforce the need for clinical staff to be aware of their responsibilities in routine enquiry and safety planning. This will be revisited once this Review is finalised.			Completed. The Trust provided an article in the SLaM News December 2017 re-advertising the DVA website, training and reinforcing the need for clinical staff to be aware of their responsibilities in routine enquiry and safety planning. 29/10/2020 – email sent to Chris McCree for updates.
Q.	Named CMHT to incorporate the discussion of any adult or child safeguarding concerns and required actions into their monthly complex case formulation meeting.		How often is this reviewed? Is there evidence of any disucssion s taking				Completed. All safeguarding concerns are discussed by the multi-disciplinary team (MDT) and work in collaboration with the Croydon Adult Safeguarding Team based at the Jeanette Wallace House. This is logged on the tracker and reviewed accordingly. This is also discussed in

			place in individual staff supervision> if so, how many?				the individual staff supervision for support and advice as needed by the Team Manager. The team psychologist leads the monthly complex case forum, the forum is tailored to individual needs including risk and management which includes safeguarding adults and children concerns.
Turning Point 6.1.9							
R,S, T, U,V, W.	Safeguarding and MASH consultation to be routinely addressed.			We have regular monthly safeguarding meetings which are mandatory for all staff. We now have a comprehensive safeguard register which is reviewed/audited and updated, the safeguarding lead reviews and chases up any outstanding actions and updates the register. We discuss any safeguarding concerns in morning briefing, clinical team meeting and managers meeting. We make sure all staff attend safeguarding training and refresh every 3 years – mandatory. We have monthly surgeries where the safeguarding lead			Email sent to Eoin Bolger 29.10.20 for update

	Ensure all elements of assessments are completed			from the Croydon council attends to discuss any cases recovery workers have, this is also an opportunity to chase up outstanding actions. Safeguarding issues are discussed in supervision and recorded.			
Overview Report Recommendations							
6.4	All agencies that had sustained contact with Jasmine and Eric to reflect on their agency approaches and responses to the protected characteristics of their clients/patients to ensure that they are not just recording data but are having meaningful discussions to ensure they understand the experiences and needs of individuals; including ensuring staff are supported in these discussions with adequate training.	Ensure adequate training is offered to all staff in the services involved, SLaM, AIR Network, Turning Point, Croydon Leaving care Service around E&D		All agencies involved have clear guidance for staff around equality and diversity policies as well as training opportunities to keep staff informed.			
6.5	This learning from the Domestic Homicide Review to be shared across the member agencies of the Community Safety Partnership, Local						

	Safeguarding Children's Board and Adult Safeguarding Board.						
6.6	Croydon Domestic Abuse and Sexual Violence Board to review the previous pilot Specialist Domestic Violence Court and why it came to an end; and to take action where required including any training requirements for court staff and magistrates on domestic abuse	Email to be sent to the DV court to make enquiries. Stronger relationship built with local court.		Court staff and magistrates will have a more in-depth understanding of domestic abuse and sexual violence and the impact on the survivor and their children/family.	Ciara Goodwin, DASV Coordinator	October 2020	Training offer completed by local IDVA service and specialist DA social worker in 2019 to court staff and Judges. Email sent to admin staff at Croydon court to enquire about changes – no response to date. Local IDVA service attended the court open day to promote the service and build partnerships with court staff – 2019.
6.7	This learning from the Domestic Homicide Review to be shared across the member agencies of the Community Safety Partnership, Local Safeguarding Children's Board and Adult Safeguarding Board.	To share learning from this DHR to agencies involved (SLaM, CRC, Turning Point) to ensure these services have a SG Policy in place when working with individuals which reflects the required SG procedures for the whole family.					

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Ciara Goodwin
Domestic Abuse & Sexual Violence Coordinator
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30 April 2020

Dear Ciara

Thank you for submitting the Domestic Homicide Review (DHR) report (Jasmine) for Croydon CSP to the Home Office. The report was assessed by the Quality Assurance Panel (QA) on 26 February 2020.

The QA Panel welcomed the way in which the report is clear and easy to follow. The analysis is robust and the tone respectful, utilising information taken from a broad range of sources. In particular, it was noted that a number of historical reviews were referenced in the report. The Panel particularly commended the equality and diversity analysis for discussing intersectionality and recommending that agencies don't just record protected characteristics but have *"meaningful discussions to ensure they understand the experiences and needs of individuals*".

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that, on completion of these changes, the DHR may be published.

Areas of final development include:

- At present only a partial explanation relating to delays of the DHR exists in Home Office correspondence. It would benefit the review to include in the Overview Report a full explanation of the reasons for the timescales.
- To aid clarity it would be helpful for the report to state if the panel composition adhered to the statutory guidance.
- The QA Panel felt that paragraph 3.2.18 would benefit from further exploration to explain some of the following questions:
    - Details of the police activities relating to this incident, in particular if a risk assessment was completed
    - Context of why this incident was not present in the police IMR.
    - Explanation of whether a MERLIN referral was sent to adult social care

    - Details of any referral to victim support
    - Was the victim signposted to any other support services?
    - What was the outcome of the court proceedings?
    - Did this case have any bearings on the victim's future?
    - Did it impact on how the victim engaged with future support services?
- Paragraph 3.3.6 states the date as May 2016, however it was queried by the QA Panel whether this should be May 2014.
- Paragraph 4.243 highlights that the victim was being threatened to hand over her money. In light of this you may wish to probe further coercive control in relation to the threats and possible context for paying her 'friend's' debt.
- It would be beneficial for the recommendations of each agency to be added to the Action Plan
- To strengthen the Action Plan further it would be helpful to detail the steps implemented to achieve outputs and outcomes of the recommendations. In particular recommendation one and three.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The Home Office believe it is helpful to routinely sight Police and Crime Commissioners (PCCs) on DHRs in their local area. I am therefore copying this letter to your local PCC for information.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel