

DOMESTIC HOMICIDE REVIEW

**London Borough of Brent
Case of Alexia**

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DHR OVERVIEW REPORT INTO THE MURDER OF ALEXIA, SEPTEMBER 2011

Preface

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

with a view to identifying the lessons to be learnt from the death.

1.2 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013.

1.3 The purpose of a DHR is to:

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

1.4 This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Alexia (pseudonym) in London in September 2011 and was initiated by the Chair of Brent Community Safety Partnership. No further details regarding the decision have been able to be located.

2 Introduction

Background

The original DHR began in October 2011 and a report was submitted to the Home Office on or about November 2012 for quality assurance. It was accompanied by a lengthy report detailing areas of dispute between the Chairs and the Metropolitan Police.

The report was assessed as inadequate for the following reasons:

- The Panel was very concerned that the disputes in these cases, between the Chairs, and the Metropolitan Police representative at the DHR Panels had not been resolved at a local level. They were also very concerned with the standard of both reports, and the lack of the victims' perspectives in what the QA Panel felt were both fractured narratives.
- It is essential that the issues between the Chairs and the Police in this case are resolved at a local level, before re-submission of the review.
- The reports need to have a clear narrative, that follows the Guidance and that are well structured, to enable the QA Panel to properly assess the reports and to decide whether appropriate lessons have been considered and learned from these tragic deaths.
- On reading both of the reports, many questions remained. The Panel considered that there were many gaps in the information, and sequence of events set out in the reports. They also felt that the Terms of Reference were not appropriate, and basic information to describe the circumstances leading up to the death of both victims need to be set out far more clearly. This must follow the format set out in the Statutory Guidance. These reports should be re-drafted to reflect these requirements.

Accordingly, Brent CSP engaged the services of a new report writer. All paperwork that could be located was provided to assist in the rewriting of the Overview Report to an acceptable standard.

Key barriers:

- No minutes of any DHR Panel meetings could be located. As such, all IMRs had to be accepted at face value. This is of concern given the unacceptable standard of the original terms of reference. It is also of concern that the original report states that the review was intended as a paper based review. Further examination of the IMRs, however, have shown that this appears to be incorrect and that relevant staff were, at least in some cases, interviewed.
- Names of and contact details for Panel members were not located and of those who were able to be identified, a significant proportion had retired or changed jobs. The previous Chair did not respond to requests for contact and shortly afterwards also left her job.
- There were no records located relating to confidentiality so it is unclear whether consent was granted or even sought regarding some of the people in this narrative.
- In the original report, the second Chair¹ stated that several contacts had been made with the family who declined to participate. Amongst the provided paperwork was a single letter to the victim's mother which addressed her incorrectly. There was no evidence of attempts to contact any friends or the perpetrator.
- There are contradictory narratives in the IMRs and it has not been possible to clarify these.
- In the original report, the second Chair claimed previous experience of DHRs. Enquiries have revealed only a tangential relationship to a single DHR conducted several years before DHRs were put on a statutory footing.
- The original report was submitted with a summary of key areas of dispute between the Metropolitan Police and the second Chair. These areas only listed the perspective of the Metropolitan Police and not the response of the second Chair / original report author. It was unclear from the paperwork provided who compiled

¹ Reference is made in the original report to a former Chair but no further details have been located.

this summary or who the person(s) were who had attempted to mediate the disputes.

As a consequence of all the above, an approach was made by the new report author to the Home Office requesting guidance on how to produce a publishable report with such limited and unverifiable information. The response was to review what was possible and to resubmit with the above information in the report.

Accordingly, **it is recommended that this report is not published.** In the event that this recommendation is not accepted by the Home Office, **a disclaimer should accompany the report stating that the contents have not been able to be verified and may contain glaring inaccuracies. Moreover, significant redactions will need to be completed so as to avoid potential breaches of the Data Protection Act (see section 9)**

3. Overview

Persons involved in this DHR²

Name	Gender	Age at the time of death	Address	Relationship with victim	Ethnicity
Alexia	F	23	Address 1	VICTIM	Black Caribbean
Child 1	F	5	Address 1	Daughter	Black British
Child 2	M	3	Address 1	Son	Black British
Child 3	F	11 months	Address 1	Daughter	Black British
Daniel	M	43	No fixed abode	Perpetrator and father to Child 2 & 3	Black Caribbean
Honour	F	50	Address 1	Mother (although some IMRs refer to her as Alexia's grandmother)	Black Caribbean
Lily	F	17	Address 2	Daughter of perpetrator	Black British

3.1. Summary of the case:

In September 2011, Lily was at home when she was visited by her father, Daniel just before 3.30pm. Lily states that Daniel told her that he had killed Alexia and left her in the bathroom. Lily asked Daniel how the victim had died. He replied, "I killed her". Lily then said "Are you sure you didn't just beat her up and leave her unconscious?" Daniel replied "No, I killed her". He left the address shortly afterwards. Lily then travelled from her home address in a cab with her friend Charlene to address 1. Once there she received no response at the door. It became apparent to Lily that two of Alexia's children (a son aged 3 and a daughter aged 11 months) were alone inside the property so Lily broke into the address. She found the two children inside. Lily walked to the bathroom and looked inside where she saw the bloodied body of Alexia lying on her back in the bath. Lily thought that

² All names in the above table are pseudonyms

the victim was dead so she immediately left the address with the two children and her friend. They went to the nearby address of a friend Tom, and told him what had happened. Lily returned with Tom and Charlene to address 1 where they eventually used Tom's phone to call the police. Police arrived at the scene at 1720 hrs, shortly followed by the London Ambulance Service who pronounced life extinct at the scene. Forensics suggest that the attack on Alexia had started in the bedroom but at some point moved to the kitchen where a large amount of blood was found. There had been attempts to clean up in the kitchen. Alexia was then placed in the bathroom where she bled out. A bloodied finger mark on the bath was matched to Daniel.

A bloodied kitchen knife was recovered during a search of the scene. The length and design of the knife were consistent with Alexia's injuries. The tip of the knife, estimated to be about three inches, was snapped off. Some of Alexia's injuries indicate that the tip of the knife was present when the attack commenced. The snapping of the tip is indicative of the ferocity of the attack.

Daniel was arrested three days after the murder at an address in Catford, London SE12. When officers entered his place of arrest, he told the arresting officers *'It's me, it's me you are looking for'*. The following day, he was charged with Alexia's murder. Daniel is a Jamaican national whose immigration status is that of an illegal over-stayer.

Alexia had three children aged 5, 3 and 11 months. Daniel was the father of the younger two.

3.2 Other witness accounts

Honour is the mother of Alexia with whom she lived at address 1. She describes Alexia as having a violent relationship with Daniel. They had split up and got back together on many occasions. Honour described Daniel as a possessive and controlling individual.

Honour states that on the day of the murder, Daniel arrived at address 1 just after 8am. He went straight to Alexia's room. Honour states that Alexia was lying on her bed asleep. Daniel was lying next to the victim either asleep or pretending to be asleep. When Honour left to go to church at 1215pm, Daniel was still in bed with Alexia.

Kalinda was a close friend of Alexia having known her for seven years. They spoke on the phone or saw each other on a daily basis. On the day of the murder, Kalinda received a call from Alexia just before 2pm. Alexia sounded very distressed. She said that she wanted Kalinda to come around and pick her up. Kalinda heard shouting and recognise Daniel's voice in the background. Kalinda began to prepare to go and collect the victim.

Kalinda described the relationship between Alexia and Daniel as a violent one. She described Alexia as an attractive young woman who was significantly younger than Daniel. He was jealous of the attention Alexia attracted from other men. Kalinda stated that Daniel had been regularly beating Alexia for most of their relationship. Alexia had apparently tried to leave Daniel on a number of occasions but he bullied her into staying with him.

4. Parallel reviews

The Post Mortem examination took place two days after the murder. The examination was carried out by Dr Fegan-Earl. The cause of death was given as shock and haemorrhage caused by multiple stab wounds. Dr Fegan Earl said that Alexia was subjected to a dynamic knife attack during which she would have fought for her life. She sustained numerous defensive wounds as she fought for her life including cuts to her palms

consistent with her trying to grab the knife. Alexia sustained multiple injuries any one of which would have been fatal on their own. These included a punctured aorta, spleen, lungs and liver. The level of force used by the suspect would have been severe. Dr Fegan-Earl believes that Alexia would have survived for one to two minutes.

A week after the murder Coroner Peter Straker opened and adjourned the inquest pending police investigations. In view of there being a criminal trial for Alexia's murder, it was not continued.

There were criminal proceedings which have been completed. Daniel pleaded guilty at the Central Criminal Court, and was sentenced to life imprisonment in May 2012. He will serve at least nineteen years.

Alexia's two youngest children witnessed the murder. No information was provided regarding the decision by the LSCB to not undertake a Serious Case Review.

5. Domestic Homicide Review Panel

No minutes of the DHR Panel have been located so the following information is lifted from the original Overview Report where the Panel members are listed as:

Independent Chair

Metropolitan Police Service

- Brent Borough Commander
- Brent Superintendent
- Brent Detective Chief Inspector of Public Protection
- ACPO DV Lead
- Critical Incident Advisory Team

London Borough of Brent

- Chief Executive
- Director of Strategy, Partnerships and Improvement Unit
- Director of Children Schools and Families
- Director of Housing and Community Care
- Head of Brent Community Safety Partnership
- Head of Safeguarding Children
- Head of Housing Solutions
- Assistant Domestic Violence Co-ordinator

Primary Care Trust

- NHS Brent
- NHS Brent - General Practitioners
- Imperial Hospitals Trust
- North West London Hospitals NHS Trust
- Primary Care Trust Chief Executive
- Designated Professional for NHS Brent

Local Probation Board

- Senior Probation Officer

UK Border Agency (UKBA)

- Senior Case Worker

- Professional Standards Unit

Voluntary Sector Organisations

- ADVANCE - Chief Executive Officer
- ADVANCE- Project Manager Brent
- ADVANCE- Project Manager Westminster and Kensington and Chelsea
- Victim Support Brent - Senior Service Delivery Manager

The original report also lists Home Office staff as Panel members but this was not, in fact, the case so their names have been omitted here. Moreover, it is likely that several of the above named roles were not actually Panel members but were included as people to whom the original report was circulated before submission to the Home Office. It has not proven possible to definitively discern which is which.

5.1 This Overview Report of the Domestic Homicide Review examines IMRs submitted to the original DHR Panel. Whilst this covers most of the agency responses given to Alexia, her children and Daniel, some missing agencies have been identified (see section 11).

5.2 All agencies listed as Panel members above also submitted an IMR. It is not possible to discern whether Panel members and IMR authors were the same people.

6. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved and has had no contact with any family members. Davina James-Hanman is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence.

Most of the IMRs contain statements of independence regarding their authorship. There is no information available about the independence of Panel Members.

7. Terms of Reference and Scope

The terms of reference do not contain the scope of the DHR. However, the original report states that the majority of accounts from agencies covered contact during the period 2005 until Alexia's death with additional information from UKBA dating back to 1998. It must be assumed therefore that this represents the scope.

The terms of reference for this DHR were as follows:

We aim to:

- *Establish whether there are lessons to be learned about the way in which local professionals and agencies worked together to safeguard domestic violence victims and their children*
- *Clarify what any lessons are, how they will be acted upon and what is expected to change as a result, and*
- *Improve inter-agency working and improve protection for domestic violence victims and their children.*

Purpose:

The review will seek to safeguard potential victims by:-

1. *Reviewing policies and processes to improve inter-agency partnership working*
2. *Analysing gaps in information and practice*
3. *Identify and sharing lessons on behalf of Brent Crime Prevention Strategy Group (CPSG.)*
4. *Recommending areas for improvement.*

8. Timescales

Scant information is available regarding timescales. According to the original report, the DHR began in October 2011 and was concluded in November 2012. No information has been located regarding the decision to hold a DHR or Panel meetings. However the original report also states that *'Given the importance of the subject area and the collective desire to improve, the partner agencies began making improvements immediately and are already acting on the recommendations and areas identified for further improvement, rather than waiting for the full report to be published.'*

This report has taken longer than is desirable to conclude. This is almost entirely the responsibility of the report author due to circumstances beyond her control but for which she expresses unreserved apologies.

9. Confidentiality and dissemination

9.1 The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved, for publication, by the Home Office Quality Assurance Panel. However, it remains unclear as to whom the original report was circulated.

9.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

9.3 The Executive Summary of this report has also been anonymised.

9.4 No information has been located regarding consent to share personal data. Whilst this is not legally of concern with regard to the victim, and it can be reasonably argued that information about the perpetrator has been shared in the public interest, it remains unknown as to whether the victim's children, the children of the perpetrator and other family members consented to having their information shared. As such, information regarding these people has only been included where not to do so would impair the understanding of the reader. Should this report be published, it is recommended that information pertaining to these individuals be redacted to avoid breaches of the Data Protection Act.

9.5 There is also the question of whether it is *ethically* justified to publish personal health data relating to the victim which may cause distress to family members (not least because of their religion) and the victim's children later in life. This relates specifically to Alexia's two terminations and her contemplation of a third.

10. Methodology

This report is an anthology of information and facts gathered from:

- The located Individual Management Reviews (IMRs) of participating agencies
- The Police Senior Investigating Officer
- The Criminal trial and associated press articles (including a tribute facebook page)

Due to the circumstances of this report, it has not proven possible to include information from:

- Members of the victim's family, friends or neighbours
- The perpetrator
- Discussions during Review Panel meetings.

11. Contribution of relevant agencies

11.1 It is not recorded how many agencies were contacted about this review although the original report does state that there was no agencies who reported that there was no contact with Alexia . It is thus assumed that Panel members represent the totality of agencies invited to participate.

11.2 An IMR was provided by NHS Brent which makes reference to a GP IMR. However, this IMR has not been located.

11.3 In addition, there was a period when Alexia was in temporary accommodation in Haringey and in receipt of health visiting services there. Neither Haringey Housing nor Haringey Health Visiting Service appear to have been contacted for information although some limited information regarding the latter is contained within the Brent Community Health Services IMR³. Mention is also made of Westminster Social Services being briefly involved at one point subsequent to a disclosure of domestic violence, of Alexia engaging with St Mungo's floating support service at the time of her death and Child 1 was at school. There are no records of these agencies being contacted for information.

11.3 Ten agencies provided an IMR as follows:

- Advance (IDVA service)
- Brent Children's Social Care
- Brent Community Health Services
- Brent Housing
- London Probation
- Metropolitan Police
- NHS Brent
- St Mary's and Imperial College Healthcare NHS Trust

³ Brent Community Health Services IMR notes that whilst she has included Haringey Health Visiting Services (HHS) in her IMR, she was not in a position to review or assess Haringey's Policies and Procedures.

- UK Border Agency⁴
- Victim Support

12. Chronology

Key background facts

12.1 Alexia had been in a relationship with Daniel for approximately five years although she was thought to have been separated from him for around 18 months when she was pregnant with child 3. It is unclear from the information provided whether this means five years in total or six and half years.

12.2 Both Alexia and Daniel were known to the UK Border Agency. Alexia had indefinite leave to remain but Daniel was an over stayer since 1999.

12.3 Daniel had been imprisoned previously, on two occasions, once for a driving offence and once for battery. The UK Border Agency whilst aware of the convictions was not in full receipt of the facts.

12.4 Daniel had been married and had two children by this marriage. It would appear that his relationship with Alexia started whilst he was still married. His conviction for battery was against his wife (now deceased).

12.5 Summary of Key events

Please note that in the narrative below, routine appointments have not been noted.

June 2005: Alexia visits her GP and is confirmed as being 20 weeks pregnant. In November she gives birth to a baby girl.

December 2005: Daniel is alleged to have assaulted his wife with an ironing board. His wife declined to support a prosecution so no further action was taken.

January 2006: Alexia is arrested for shoplifting. She receives a caution.

July 2006: Following an arrest for driving without insurance, Daniel is required to report to UKBA on a regular basis until November 2011.

August 2006: Daniel is accused of hitting his new partner (not Alexia) in the face with an iron. He is later convicted for occasioning Actual Bodily Harm.

October 2006: Police are called to address 1 following an argument between Alexia and her mother where Alexia said that she feared her mother was going to fetch a knife. Alexia took child 1 and left saying she was going to arrange alternative housing. A referral was made to Children's Social Care (CSC). Alexia makes an application to Brent Housing the same day. Her case is referred to mediation but as Alexia does not attend, the housing application is rejected.

November 2006: Alexia requests a termination and is referred for the procedure.

June 2007: An argument breaks out at address1 between Honour and Alexia's brother and police are called. Alexia leaves with child 1 to stay with a friend until her brother has calmed down. CSC are notified.

⁴ Now Home Office Immigration

August 2007: Alexia requests a termination and is referred for the procedure.

September 2007: Daniel is accused of assaulting his wife by grabbing her around the throat

November 2007: Alexia makes a housing application

December 2007: Police attend a domestic violence incident where Alexia is alleged to have assaulted Daniel with her mobile phone after she caught him checking her messages.

January 2008: Daniel is convicted of the assault on his wife and sentenced to attend a perpetrator programme. Two days later he is also convicted for the assault on his subsequent partner and given a 12 month suspended sentence.

January 2008: Alexia is cautioned for an assault on an unidentified female.

February 2008: Warrant issued for Daniel's arrest after he fails to appear at court on a theft charge.

February 2008: Alexia makes a request for a third termination. She is counselled about the health impacts of repeat terminations. Alexia later changes her mind and in August gives birth to a baby boy (child 2).

February 2008: Daniel is convicted of the second assault on his wife. He is sentenced to 150 hours unpaid work. He tells his Probation Officer that he no longer lives with his wife and is in a relationship, and living with, Alexia who he claims has no children.

April 2008: Alexia's housing application is progressed. She states she can be rehoused anywhere in Brent as she is not in fear of violence from anyone. She is accepted in June and placed into temporary housing in Haringey in the meantime.

May 2008: Daniel attends the first session of the perpetrator programme

July 2008: Alexia is arrested for shoplifting. Child 1 is with her so a referral is made to CSC. Daniel is also arrested for shoplifting (separate incident) the same day.

July 2008: Haringey CSC undertake an initial assessment. No child protection concerns are highlighted so no further action is taken.

August 2008: Alexia's mother calls HRC to report that Alexia is living with her boyfriend who is abusing her. A home visit is made but no evidence is found. Child 2 is also born this month.

December 2008: Alexia calls the police alleging Daniel had punched her in the face and stolen her phone. She withdraws the allegation two days later. Six days later the police are called after Alexia is seen running down the street with her new born baby, being assaulted by Daniel who is threatening her about making a withdrawal statement for the assault six days earlier. Alexia does not substantiate the allegation. Daniel is suspended from the perpetrator programme. Alexia makes a homelessness application on the grounds of domestic violence. On the same day, Alexia pleads guilty to shoplifting. A referral is made to Haringey CSC.

January 2009: CSC receive an anonymous letter stating that Child 2 is in danger, has marks on his body and is dressed inappropriately. The letter also alleges that Alexia is chased

around the street by her boyfriend. Investigations commence. Alexia experiences short term difficulties with her accommodation due to rent arrears but these are swiftly resolved. Alexia begins her probation sessions.

February 2009: Brent CSC meet with Alexia. She states she has no intention of allowing Daniel to have contact with child 2.

March 2009: Child 1 dials 999 and tells the police they are alone. A referral is made to CSC. Alexia insisted that the children had been left in the care of their Uncle. There was insufficient evidence to establish the facts so an agreement is drawn up with Honour in which she promises not to leave the children in the sole care of their Uncle or their mother until investigations are complete. It should be noted that other IMRs state that the children were left in the care of Daniel rather than the Uncle but this appears to be a confusion with a further incident in May 2009.

April 2009: Alexia reports an assault on her by Daniel to the police. He arrived at her address at the same time as she arrived home. Daniel allegedly held a knife to Alexia and threatened to kill her if he was arrested. The allegation was originally listed as Threats to Kill but later changed to Common Assault. A risk assessment was completed and graded as high. Alexia was referred to MARAC. Daniel was circulated as wanted, and charged on 1st September 2009 with Assault. A referral is made to Advance but attempts at contact are unsuccessful.

May 2009: Alexia's case is heard at MARAC. Records are unclear as to what the outcome of this was beyond sharing information. A CSC strategy meeting is held where another incident (date unknown) is shared that Alexia told the social worker: Alexia said that Daniel had come to her mother's home and asked to see the children. Alexia had stated that she needed to collect some clothes from her home so she, her mother, Daniel and the children went to her place. Alexia stated that she and her mother left the children with Daniel to collect some lunch. They had been gone for around 40 minutes when Daniel called and complained about the way the children were behaving. Alexia said that they started arguing and Daniel had said 'I'm going to fuck you up; the police are on their way'. Alexia returned home to find the police trying to get in, the door to her apartment wide-open and the children alone. At the end of May 2009, a further domestic violence incident was reported by Alexia. She was moving her car when Daniel appeared and began to argue with her. Whilst they were fighting, he produced a knife. He made off in her vehicle. A risk assessment was completed and graded as medium. Daniel was arrested and interviewed at the end of August. No further action was taken as Alexia declined to provide a statement but she is once again referred to MARAC but by Probation, not the Police.

June 2009: CSC conclude their section 47 investigation and proceeds to an initial child protection conference. This decision is later overturned by the manager who recommends a child in need plan.

June 2009: Daniel's wife dies.

July 2009: Alexia is again discussed at MARAC. There are no records of the outcome of this discussion.

August 2009: A third party told Alexia that Daniel had threatened to kill her which she reported to the police. Daniel threw a brick at Alexia's car, damaging her windscreen. She told police she was scared of Daniel. She was taken home by police to collect property so she could stay at her mother's address. On arrival, a burglary at her home was discovered,

believed committed by Daniel. The matter was risk assessed and graded as low/ standard with the rationale that she was no longer at the home address. A MARAC referral is made for this incident. Following his arrest and interview later that month, the matter was marked no further action. Alexia made another homelessness application saying she could no longer stay with her friend and could not return to her previous accommodation as Daniel was still 'at large'. In the meantime, Alexia moved back to address 1. Alexia is breached by Probation for failure to attend several appointments or for attending with her children.

Alexia is again discussed at MARAC although there are no records of what actions were taken as a consequence.

September 2009: Daniel is charged at court with common assault. He pleads not guilty and is remanded in custody. Alexia is present and this affords Advance an opportunity to speak briefly with her where the focus is mainly on housing. Alexia later reports to Probation that she is being pressured by Daniel's daughters to 'drop the charges' as they 'need their father now that their Mum has just died'. Alexia is offered a private sector tenancy and as such, her homelessness application is closed.

October 2009: Daniel is sentenced to eight months in prison. Daniel applies to stay in the UK on the grounds that his two daughters need him although arrangements have been made for them to live with another relative and he does not have regular contact with them. He tells the UKBA officer that his wife died 'a couple of weeks ago'.

December 2009: Brent CSC Manager decides to close the case because of a lack of engagement. Daniel is released from prison but held at an immigration centre. He is released the following month but still has reporting restrictions imposed.

February 2010: Daniel is interviewed for the first time by CSC but in respect of his role as father to his daughters. He explains the issues on which he is challenged as follows: Daniel said he came to the UK 6 months after his wife to study computing. His wife then became ill a year and a half later. Daniel said that they were together for 16 years and that he was a deacon in the church for over 10 years.

He said that for the last five years of her life, her situation got worse and it was in the last two years that they were not really together. Daniel said that it felt that his wife was his patient as he had to do everything for her and the intimate side of their relationship was no longer there. She was upset by this. Daniel said that although he left the house, he was involved, taking his daughters shopping and to the movies. Daniel admitted that he started to have girlfriends but he would always go back to the family house. He said that he had an argument with his girlfriend (not Alexia) when she pulled a knife on him so he punched her twice. When the case went to court he was found guilty. When he got back out, he went to the family home to get the car which he had bought for his wife in order to take his girlfriend (Alexia) out.

His wife got angry about this and she called the police to report that the car was stolen. The charges were eventually dropped as the car was in Daniel's name. He went on to say he had been out shopping with Alexia when they were stopped as she had been shop lifting. When he went to court he absconded and was on the run for a year.

Also in February 2010, Probation make a new CSC referral because of concern that Daniel has been released from prison and is calling Alexia requesting contact. Daniel obtained the telephone number from Alexia's mother. The Probation Officer was informed that Alexia should advise Daniel to seek advice from his solicitor regarding contact and she

should also consider changing her mobile number. Although Daniel does not have the new family address, extended family members should be discouraged from providing him with this. Alexia should also seek an injunction order and link in with ADVANCE for the purpose of making her house safe if she is still frightened. The Probation Officer confirmed that she had already provided this advice.

March 2010: Alexia is arrested for assaulting and injuring a shop assistant who was challenging her about shop-lifting. Brent CSC undertake a home visit and record that the place is untidy. Alexia arrived at the home address with a man whom she stated was a cab driver. However his vehicle did not have a taxi licence on the rear window that would indicate this. It is suspected that this is her ex-partner whom she advised she is no longer in a relationship with.⁵ Alexia's mother was also at the property and appeared dishevelled and asleep when CSC arrived. Concerns were raised that Honour was asleep and in the care of small children. Nevertheless, CSC close the case concluding: '[Alexia] is able to put forth good care, guidance and stability for both children. Alexia gave assurance that she has no intention of child 2 having contact at this time with his father and has maintained this stance when he has called her on her mobile phone. However Alexia has stated that possibly in the future she may allow contact in public in the community. This contact would be supervised by Alexia and Daniel would not be allowed to know where the children and their mother live.'

Alexia is also confirmed as being nine weeks pregnant this month.

September 2010: Brent CSC receive a referral from Westminster Social Care at the hospital. Alexia reported she had been assaulted by Daniel and was bleeding. She is heavily pregnant. Alexia claimed not to have seen Daniel since July. She was on a monitor and seen to be constantly monitoring her phone. Daniel turned up at the ward. Alexia reported she was living with her mother with whom she felt safe.

October 2010: Brent CSC undertake a core assessment. Alexia confirms that Daniel is the father of her unborn child and stated her relationship with him ended in July. The Social worker stated that child protection procedures would be initiated should she resume her relationship with him. Child 3 is born this month.

January 2011: Brent CSC receive an anonymous phone call. The caller alleged that Alexia went clubbing on New Year's Eve and had three children outside the club in a van, at the Old Kent Road. Alexia kept going out to check on the children. The anonymous caller stated that she would report her information to Police and local MP. The CSC manager decided that because the case had just been closed and welfare checks revealed no concerns, then no further action was warranted.

March 2011: Daniel is arrested for shoplifting. He had left his children in the care of their grandmother who in turn left them with a friend. The friend contacted police because she had no food for the children and planned to take them to the police station. Daniel was released and collected his children. A referral is made to CSC and a decision made to progress this to a core assessment as there is now evidence that Daniel is back in the children's lives (albeit that this has never been denied by Alexia this is widely interpreted as 'proof' that Alexia has been lying).

⁵ At a later meeting, this is refuted by Alexia and her mother who state that the man was a neighbour who often gives them lifts and to whom they make payments to cover his petrol although he isn't an 'official' taxi driver.

The core assessment begins with a visit to Alexia at home. The house was observed mostly clean and tidy, although the bottom bunk bed mattress smelt strongly of urine. Alexia stated she was no longer in a relationship with Daniel and that the relationship ended last year with the last domestic abuse incident which occurred when she was pregnant. Alexia said she did not report the incident to the police at the time but confided in a midwife. She stated that Daniel punched her on her back and arms. Alexia mentioned that Daniel still sees his children and they arrange through telephone contact to meet in public places such as the park. Alexia reports that these visits are supervised by her mother. She said that Daniel often attempts to restart a relationship with her which she has refused. A further home visit was undertaken in April when Alexia stated that Daniel had contacted her the previous Saturday to arrange a visit later on that day to see his children; Alexia said that he did not turn up. Alexia reported that the relationship has not changed between her and Daniel and she has no intention of continuing the relationship although is happy for him to continue contact with the children. Alexia identified no substance misuse in her history or any issues with mental ill health. During the visit, Alexia fell asleep.

Two days later, Daniel visits the CSC office at the invitation of the Social Worker. Daniel said he was unsure of the reason for social work involvement as his incident with the police is related to shop lifting and not the care of his children. It was explained to him that his children have come to CSC attention on a number of occasions.

Daniel said that he has unsupervised contact with all three children at the park and at his residence; he has no child protection concerns about his children. His last visit with child 2 and 3 was the previous day in the park. He said he saw the children approximately three times a week. Daniel stated that he had no intention of continuing a relationship with Alexia due to the age gap between them.

Daniel confirmed that the relationship with Alexia had ended last year whilst she was pregnant with child 3. He claimed that there had been no instances of domestic violence with Alexia and previous allegations against him that were made to the police were made with malicious intent. He did acknowledge that he had reported instances of domestic violence against him with his ex-wife although he claimed that those allegations were false.

May 2011: CSC conclude their core assessment and the case is closed. The closing summary states that four home visits were carried out and the father was seen. Welfare checks yielded no concerns about the children. School said that child 1 sometimes seemed sad. Alexia was advised that if she resumed her relationship with Daniel then child protection procedures would be started as she is unable to safeguard her children

June 2011: Alexia is charged and convicted of a new shop-lifting offence for which she receives a six month community order.

The police are called to another domestic violence incident when Daniel goes to Alexia's home and finds her in front of the house with her children. He snatched her mobile phone and broke it, apparently angry that she was not answering his calls. He was arrested later that month but denied the offence, stating phone was dropped. Alexia withdrew the allegation. Brent CSC are informed but decide no further action is required beyond advising Alexia to get an injunction.

July 2011: Brent CSC receive a referral from child 1's school. Child 1 was not collected on time and the school took her home. Alexia smelled of alcohol. Alexia said she went to the school but the gates were shut and she thought child 1 was on a school outing. School reported she did not seem bothered by the confusion and that child 2 came out onto the street naked whilst they were talking. A subsequent visit from Brent CSC results only in

denials from Alexia and a warning from CSC that if she resumes her relationship with Daniel, her children will be at risk.

September 2011: Police are called to Alexia's home as Daniel was kicking the door. He had left by the time that the police arrived. One week later, Alexia is murdered in front of child 2 & 3.

13. Agency contacts

Ten agencies had contacts with Alexia or Daniel who submitted an IMR. As noted above, there were additional agencies who had contact from whom no IMR was requested. IMR agencies are listed below with a summary of their involvement.

13.1 Advance (IDVA service)⁶

Advance received two referrals for Alexia but were unable to make contact. Upon receipt of the third referral, the IDVA met with Alexia and discussed housing and a small amount of safety planning. Subsequent entries in the IMR are unclear regarding further contact although on balance it would seem that whilst information was received from other agencies, no direct contact was had.

13.2 Brent Children's Social Care

As detailed in the combined chronology above, there were numerous contacts by Brent CSC and the two families to which Daniel was connected. Due to privacy concerns, only minimal details have been provided with regard to CSC's involvement with Daniel in respect of his daughters by his first wife. However, it is noted that similar errors made with this family, that is, a failure to fully engage with Daniel, a failure to appreciate the risk he posed and a willingness to accept what he said at face value, were repeated by CSC when they were once again engaged with his second family.

There is little value in repeating the extensive CSC involvement with the second family already provided in the combined chronology save to make the point that there were in total eleven assessment opportunities, none of which seemed to make any difference. See next section for more detailed analysis.

13.3 Brent Community Health Services

Alexia first came to the attention of NHS Brent Health Visiting Team (Hereafter referred to a CSB) following a 'Birth Notification' from Northwick Park Hospital in November 2005. No complications were highlighted on the midwifery records, neither were social issues identified. Alexia and child 1 were discharged to home to address 1. The new birth visit occurred within 14 days and Alexia engaged well with health agencies. No issues were identified and the family were assessed by HV1 as requiring core Health Visiting Services.

Child 1 was seen at the GP surgery for routine immunisations between December 2005 and April 2006. The next time CSB had any health involvement with the family was March 2008. This is normal contact for a family assessed as needing universal/core requirements.

In March 2008 Alexia failed to attend two appointments for child 1 to have her 2 year developmental check. The NHS Brent 'Did Not Attend (DNA) Policy' stipulates where there

⁶ Advance was the provider of the IDVA service at the time of the homicide. A different agency has subsequently been commissioned to provide this service in the Borough.

are two or more episodes of non-attendance an action plan should be agreed and recorded by the practitioner. The DNA policy was not followed.

Failure to attend health visitor appointments is an important sign that Health Visitors should recognise as a risk in vulnerable families. In this case an appropriate care plan should have been put in place to follow up this family. At the time however, Alexia was not assessed as 'at risk'.

In June 2008, a Pre-Assessment Checklist (PAC) was received into the CSB Safeguarding Team. PAC is issued by the Police in circumstances where there are issues of concern including domestic violence occurring in a family where there are children. Processes were followed regarding allocation.

HV3 tried to make contact. Alexia's mobile phone was switched off so a letter was sent but no response was received. There is no evidence in the Health Visiting Records to indicate any other follow up took place. However it was at this time that the family were relocating to Haringey.

In June 2008, Alexia and child 1 relocated to Haringey in temporary accommodation. Alexia was pregnant with her second child.

Haringey Health Visiting Services (HHS) records indicate that information sharing took place between Health and Social Care. The Social worker from Haringey Social Care contacted the Health Visiting Team in Haringey to communicate a plan of care for the family. NHS Brent was not informed that the family had moved out of the Brent area.

In July 2008, a home visit was undertaken by HV3 following the Social Care Referral. This incident highlighted a number of triggers around vulnerability. No concerns were raised by HV3 at the visit; the family would continue to receive a Core Health Visiting Service in Haringey.

Research indicates women are most vulnerable to domestic violence in pregnancy. Evidence suggests domestic violence often starts and intensifies in pregnancy. It is good practice for vulnerable women to be seen by a Health Visitor in the antenatal period. The Confidential Enquires into Maternal Death recommended all pregnant women should be routinely screened about DV in pregnancy and they should be seen at least once alone. It is unclear from the records if Alexia was alone with the children at the time of this visit. No evidence of routine screening for domestic violence in pregnancy was recorded in the Health Visiting Records.

In September 2008, Health Visiting records show that a New Birth Notification from St Mary's Hospital was received. The notification did not identify any risk factors by midwifery services. Records relating to birth details were transferred in a timely manner to Haringey Health Visiting Services.

The subsequent New Birth Visit by HV4 was conducted in a timely manner. Alexia reported that the family had not been seen by a midwife since discharge from St Mary's Hospital. New mothers should be routinely seen by a midwife at day 5 and 10 following the birth. There is no evidence in the Health Records to indicate child 2 was up to date with his immunisations. Alexia was not seen again by Haringey Health Visiting Services.

In June 2009, Haringey Health Services inform CSB that the family had now moved back to Brent. The records do not show further contact with Health Visiting Services until the Birth Notification of child 3.

In October 2010, the Birth Notification for child 3 was received and allocated accordingly. The address was noted to be Alexia's mothers.

A New Birth Visit by HV6 was completed within an acceptable timeframe at Alexia's mother's address. Details relating to Daniel were recorded in the records as the father to child 3. An opportunistic follow up visit was made a couple of weeks later by HV6. There is no communication in the records to explain why Alexia had moved back in with her mother.

The IMR author notes that it is unclear from the records if Daniel lived with Alexia at any time at any of the 4 addresses. To gain a good insight into family dynamics, HV6 could have asked questions about Daniel's involvement with the children.

13.4 Brent Housing

Housing were made aware of domestic violence on three occasions during Alexia's housing applications:

- 6 August 2008 - Alexia's mother phones to report possible abuse from partner.
- 16 December 2008 - Alexia presented herself at housing stating 'fear of violence' from her boyfriend
- 6 August 2009 - Alexia returns to Housing to state that she is again in fear of violence at her new address.

Action was taken on all three occasions with regards to accommodation and sharing information with other agencies.

13.5 London Probation

London Probation were involved with both Daniel and Alexia.

Daniel was subject to a Suspended Sentence Order with requirements of Supervision and a requirement to attend the Integrated Domestic Abuse Programme (IDAP) on 07/01/2008 for an offence of Assault Occasioning Actual Bodily Harm (ABH) against a previous partner. The Probation IMR states that Daniel punched the victim several times to the face although the Metropolitan Police IMR states that the victim was hit in the face with an iron. Daniel explained that the victim was someone he was having an extra-marital affair with over the previous two years.

Daniel was sentenced to a concurrent Suspended Sentence Order with Supervision and Unpaid Work requirement on 18/03/2008 for an offence of Common Assault. The pre-sentence report indicates the victim was his wife. This offence took place on 27/09/2007, prior to the start of the initial Suspended Sentence Order.

Daniel initially engaged well with Probation supervision, and despite a number of missed appointments with the Unpaid Work Unit (some of which were due to work commitments) he started attending the IDAP group promptly and positive feedback was received from course tutors albeit concerns were expressed about his hostility towards women. However, Daniel was then breached after several missed appointments. Daniel disengaged from Probation supervision at this time, and had come to Police attention including for incidents where he assaulted Alexia and one incident where he committed theft while he was with her. Daniel was eventually picked up by the Police and the breach warrant was actioned in October 2008. As a result of the breach of the Suspended Sentence Order, Daniel was sentenced to an eight month custodial sentence. As this was less than 12 months custody, he was no longer managed by the Probation Service after this

Alexia was sentenced to a Community Order with requirements to attend Supervision and the Women's Acquisitive Crime Programme in January 2009 following a conviction for an offence of theft in July 2008. She was later deemed unsuitable for the acquisitive crime programme and the Order was amended to a Community Order with one requirement of supervision in August 2009. She successfully completed this Order.

Alexia was later sentenced to a Suspended Sentence Order with one requirement to complete the Structured Supervision Programme for Women in June 2011 following an offence of theft on the previous December. Alexia was engaging well, and was referred for additional support from the St Mungo's Floating Support Service. She was murdered before completing the programme.

13.6 Metropolitan Police

The Metropolitan Police chronology runs to some sixty pages and it is not intended to reproduce it here given that key events have been included in the combined chronology above. What is clear is that the Metropolitan Police had extensive involvement with both Daniel and Alexia as both victims and perpetrators from 2005. It should also be noted that the operating procedures and risk assessments in use have changed considerably over this period. As such, this report has chosen to focus on the last two incidents reported to the police as this is where lessons that are still to be learned will be found. Prior to these two incidents, the police had not been involved for almost two years.

The two most recent incidents involving Daniel and Alexia were initiated by requests for police assistance from Alexia. Both were in response to aggressive behaviour towards her by Daniel. The first was in June 2011 when Alexia made an emergency call to police at 7.40pm. She reported that Daniel was kicking at the door to her home and demanding to be let in. The call was graded as an 'S' Significant response (which requires police arrival within an hour.) The address is a ground floor flat in a converted house, with a communal door leading to the street. When the police arrived they found that Daniel had already left in his car. Alexia told the officers that Daniel and herself had become partners five years ago, but had been separated for over a year. They also learnt that the couple had three children together, and that they all lived with Alexia. [Author's note: this is the first time that it has been suggested that Daniel may be the father of child 1] There had been no child access or contact issues. However, there had been no arrangements made for Daniel to visit that day, and she had not expected to see him. She stated that they had separated due to his physically and verbally violent behaviour.

Alexia explained that all that day Daniel had been calling her mobile phone. She had ignored his calls, as she did not want to speak with him. However, he had arrived at her home whilst she had been standing at the front talking on her mobile phone. He had grabbed the phone from her hand, and snapped it in half. She became scared and ran inside the house. Daniel began to kick at her door, but left when he learnt that the police had been called.

Officers found the damaged mobile phone outside Alexia's door. They called Daniel on his mobile phone and asked him to return so that he could be spoken to. The CRIS report records that a Form 124D was completed, and was later delivered to the station office at Wembley police station. The same officer also completed the CRIS record including the 'DV/Hate Crime Tab,' which is on the general page of the CRIS. On this it is stated that the risk had been assessed as 'Standard,' at the time. It is recorded that Alexia had told the officers that she was scared of Daniel, and that their relationship had been violent. She also told officers that he had attempted to strangle her, and that this incident had been reported to the police.

There is no record that research was carried out on history of the relationship. It is not known whether intelligence research was carried out, but not recorded, and whether officers were aware of the assaults that had caused referrals to MARAC in 2009. A referral was made to CSC.

Daniel went to Kilburn police station during the early hours of the following day. He was arrested on suspicion of causing damage to Alexia's mobile phone. He was interviewed and denied damaging the phone stating that the phone was damaged by Alexia herself, who had dropped it. At this point Alexia decided to withdraw her allegation, and a decision was made by an Inspector to discontinue the investigation. The Form 124D for this incident was not supervised, and the CRIS report was not supervised until after the matter was complete. The Domestic Violence and Hate Crime Tab on the general page of the CRIS was initiated by a reporting officer, but was not completed by a supervisor. The first supervisory input was the decision to discontinue it.

The second incident occurred a week before the murder. Alexia called the police to report an incident at her home involving Daniel. The report was subsequently classified as a 'Non crime book specified investigation,' with both persons recorded as being witnesses. At 1.32pm Alexia used her mobile phone to call for police assistance via the '999' system. The CAD record shows that the call was graded as being an 'S' significant response. The call was responded to by different officers from the above incident, they arrived at 2.13pm.

Alexia was at the address with her two younger children, when the police arrived. She told officers she had called them because Daniel had arrived without warning and had been demanding to be let in, but had left before the police arrived. Alexia explained that Daniel was the father of her children, but that they were currently not living together, because their relationship was over. She told the officers that although their relationship was volatile, he often saw his children and that there were no issues regarding contact. However, he had again arrived unplanned, and she had chosen not to speak to him.

Alexia reported that she had not seen Daniel for about a month prior to this event. The communal door from the street had been open, so he had come to the internal flat door. She had refused to let him in, as she was scared of him due to the previous incidents that had occurred in June. Alexia told the officers that Daniel left when the police had been called.

After a brief description of the incident it was recorded on the CRIS that no allegations had been made, and that there was no damage to the door. Only section six of the primary investigation was considered as this was treated as a non-crime investigation, and there were therefore no offences or suspects. It was then recorded that a Form 124D had been completed, but that an MG11 witness statement and record of injuries was not applicable. Intelligence research for the previous year which identified the incident in June, and risk assessment was carried out. The officer that completed the CRIS record also completed the 'DV/Hate Crime Tab' on the General Page of the CRIS. On this it is stated that the risk has been assessed as 'Standard.' This is despite the fact that only questions one to six only have answers. The Form 124D was examined and it shows that on this record all the questions were answered either as 'no' or 'not applicable,' apart from the first question where it was recorded 'He scares me.' A risk level of 'Standard' was selected. There is no record of risk management during the primary investigation.

The CRIS record states that Alexia and Daniel have children, and that two were present at the time of the incident, but it does not state which of the two they were. The Primary Investigation 'Immediate actions' records that a Merlin Pre-assessment report would be completed. However, it could not be found during this review.

The investigation was screened in and was subsequently allocated for investigation. Three days later the CRIS was reviewed by a supervisor and an instruction was placed upon the CRIS to contact the victim and conduct research. No further entries were made until it was recorded that Alexia had been found dead.

13.7 NHS Brent

This IMR appears to be a summary of all health IMRs with additional information from the GPs of both Alexia and Daniel. There is no rationale provided for this. As the other health IMRs have already been reviewed, the original intention was to solely assess this IMR with respect to the GP information. Reference is made in this IMR to a separate GP IMR but this has not been located. However, the summary nature of this IMR did not always make it possible to extract GP specific information. Where this has been possible, the information is included below and in section 14 but the author acknowledges that this may be incomplete.

Before moving to this, however, there are two issues of concern within this IMR. The author identifies the following risk factors 'in the victim':

- Teenage pregnancy
- Sexually active
- Previous domestic violence
- Black ethnic origin
- Large age difference - perpetrator was much older than
- Vibrant personality - dancer as reported in the press release 4th May 2012
- Involvement in petty crime as detailed in the IMR reports
- Numerous terminations of pregnancy as detailed in the IMR reports

It is possible that had the DHR Panel meeting minutes been located that greater clarity was sought over the inclusion of some of these points. It is, for example, possible that the author was identifying risk factors with respect to child protection rather than to Alexia. Even this explanation, however, does not make sense of some of the points.

In respect of risk factors for domestic violence, there is no evidence to show that any of the following are risk factors:

- Sexually active
- Black ethnic origin
- Vibrant personality - dancer as reported in the press release 4th May 2012
- Involvement in petty crime as detailed in the IMR reports

The second error is a reference to four terminations. There were two.

Most of the contacts that the GP had with Alexia and her children were routine medical matters. The GP also responded to requests for information and received information from others.

This IMR also states that Daniel's GP records were utilised for this IMR but the only information relation specifically to Daniel is as follows:

'Daniel accessed universal services with urinary symptoms and was referred to sexual health services. Daniel also accessed mental health services but was not taken on due to his reported fugitive status.'

13.8 St Mary's and Imperial College Healthcare NHS Trust

Alexia received maternity care at Imperial College Healthcare NHS Trust (St Marys Paddington site) for her second and third pregnancy. The second pregnancy proceeded as normal and no social conditions warranting concern were identified. The IMR's focus, therefore, is principally on the third pregnancy, in 2010, during which Alexia made a disclosure of domestic violence.

Alexia was referred by her GP in March 2010, for maternity care. The IMR reports that Alexia engaged well with maternity care with no missed scheduled appointments. Clinical risk assessment did not reveal any pre-existing medical or obstetric risk factors, it is clearly documented that there were no social risk factors. Her pregnancy appeared to be progressing normally.

On 13th September 2010, at thirty-four weeks gestation Alexia attended a scheduled antenatal appointment. At this consultation she disclosed that she had not felt her baby moving well, and that she had had some abdominal pain and some vaginal bleeding in the course of approximately the last six weeks. She had not sought any medical attention for this. Daniel was with her for part of this consultation but left during the latter part.

The midwife documented in the hand held maternity notes that the specialist nurse for safeguarding children & young people (SNS) was informed, together with "please see brown notes for further information on today's appointment." The midwife made a verbal referral to CSC, followed with a written referral on the agreed pro-forma, a copy of this referral was faxed to SNS.

SNS received a copy of the midwife's referral via fax at 1654 hrs that same day. Documented concerns are a history of domestic violence and that the alleged perpetrator is the father of the unborn and the previous child born in 2008 but not the father of the first child born in 2005. The written referral stated that violence was aimed at Alexia who had decreased foetal movements since the attack in July. Alexia reported not seeing him since but whilst being monitored on CTG she had received phone calls continuously [estimated to be more than twenty]. The referral stated that Alexia had said he would have found out from one of her girlfriends. She reported that she was living with her mother and felt safe and not being in fear of going home that day.

The following day, SNS visited the antenatal clinic to liaise with antenatal clinic sister and to see if any more information was available about the case and cause of concerns. SNS was given further documentation by the midwife. This documentation stated that when the midwife had further questioned Alexia about the domestic violence that she had disclosed, she said that there was a long history of domestic violence. Alexia said that Daniel had attacked her in July 2010, and following that episode she had bleeding per vaginum. Alexia said she had had no contact with Daniel since this episode. She went on to say however that after calling her twenty times on this day (13th September) he then turned up at the antenatal clinic. Documentation showed that he was not witnessed as being overtly aggressive at that time and that he went to put money in Alexia's car parking meter.

SNS made an entry on the electronic maternity record on 16th September to effect that a referral had been made to CSC, and the reasons for this referral. This entry stated that mother and baby should not be discharged without contacting CSC prior to discharge.

On 16th September the case was discussed at the Maternity Family Support Meeting. A Westminster City Council social worker present. The Westminster social worker shared information that the Brent Duty Social Worker had undertaken a home visit to Alexia on the previous day but it was unclear whether the visit had been at Alexia's mother's home

or Alexia's address. The outcome of the visit was unknown at this time. SNS filed a copy of the written notes from this meeting in the Child Protection File on Labour Ward and the Birth Centre so that the information would be available to clinicians should Alexia present again.

On 14th October the case was again discussed at the Maternity Interagency Meeting. The Westminster social worker shared information that the Brent social worker had carried out an unannounced home visit to Alexia the previous week and that she planned to see her on again to gather more information. SNS updated the child protection folders on the labour ward and the birth centre with the written notes from the meeting.

On 19th October Alexia presented herself to the Birth Centre in spontaneous term labour. She progressed to a normal birth 00:31hrs on 20th October, of a healthy female infant (Child 3). It is documented that 'Dad' was present, he clamped and cut the umbilical cord. Mother and baby were both well and were discharged home, to the care of Brent Community Midwives later that day, 20th October 2010. It is not recorded if CSC were informed of the birth and advised of the planned discharge to home.

When there are identified social risk factors, the usual practice is that the midwife who conducts the delivery telephones to inform SNS of the birth. If this is during the night a message is generally left on the voicemail to that effect and will be followed up by SNS in her capacity to co-ordinate safeguarding liaison and to provide supervision and support as required to front line staff. SNS has no recollection or record of receiving any notification from the birth centre staff that Alexia had delivered.

It is evident that SNS became aware of the delivery retrospectively as she documented directly in the maternity records at 0940hrs on the 25th October 2010. She does not recollect how she became aware, however it is her customary practice to regularly review the 'at risk' client list to ensure consistency. It is reasonable to presume that on this occasion she reviewed the client list of those due to deliver and identified that Alexia had given birth and therefore went to follow up and ensure relevant parties had been informed.

On 25th October 2010 SNS documented in the maternity notes that she had contacted Brent Social Care to inform them that Alexia had given birth and had been discharged to home on the 20th October. SNS was informed that the Social Worker had already undertaken unannounced visits to Alexia's home on the 6th and 19th October. She said that the information that she had regarding the domestic violence was from Alexia only and that she needed to verify information with the maternal grandmother and aunt. The social worker informed SNS that both of these relatives are able to provide support to Alexia. The social worker said that she was concerned about the mess and untidiness of the house but it was not unhygienic. She said that she would visit Alexia and her baby at home and would make contact with the health visitor and advise her of the domestic violence concerns within this family. SNS asked the social worker if she had provided Alexia with advocacy information to which the social worker said she had not discussed this with her but would do so.

13.9 UKBA

Alexia, along with her brother, applied for an Indefinite Leave to Remain (permanent residence) Visa at the British High Commission in Jamaica. After being refused by an Entry Clearance Officer they succeeded in their appeal and their visas were issued. They were then entitled to travel to the United Kingdom. Upon arrival Landing Cards should have been completed and an Immigration Officer should have checked their passports and visas. Unless the Immigration Officer had reason to believe that the passports or visas had been obtained fraudulently, or had been tampered with, they would have been allowed to pass through Immigration Control. The UK Border Agency does not have a record of when the

victim or her brother entered the United Kingdom, and such information is not captured on their paper files or the CID.

Once they had entered the United Kingdom they were entitled to rely on the facilities, services and benefits provided by both the national and local government, equivalent to British Nationals. Any matters involving domestic violence, housing, medical assistance, criminal activity etc., would be dealt with by the relevant United Kingdom authorities and services. Consequently the UK Border Agency's involvement with the victim had effectively ended, except to advise any agency or body of their Immigration Status in the United Kingdom.

No further action would normally be taken with a person who has been granted Indefinite Leave to Remain in the United Kingdom, unless any evidence came to light to suggest that this leave was obtained fraudulently. There has been no such evidence in this case.

Daniel arrived in the United Kingdom in March 1998 and was granted six months leave to enter in the United Kingdom by an Immigration Officer. At that time, no pre-entry interview or visa was required to enter the United Kingdom by Jamaican nationals. Upon arrival, if the Immigration officer was satisfied that he was a genuine visitor, and that there was no information to suggest that he would be a risk to any individual or the United Kingdom, he would be granted six months leave to enter in the United Kingdom by virtue of a stamp in their passport.

Consideration is given in the following section as to whether Daniel was correctly considered for deportation once he had obtained a criminal record, and whether sufficient efforts were made to obtain an Emergency Travel Document so that he may be returned to Jamaica.

13.10 Victim Support

In June 2011, Victim Support received a referral from the Metropolitan Police after Alexia had her mobile phone stolen. In line with their policy and procedures, three attempts were made to contact Alexia; all were unsuccessful and Brent Police were subsequently informed of this.

14 Analysis

14.1. The individual management reviews have been carefully considered through the view point of Alexia, to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines.

14.2. Unfortunately, the terms of reference agreed for this review were inadequate. As such, each IMR varies considerably in terms of its quality and thoroughness. Moreover, the terms of reference directed IMR authors to only consider their contact with the victim and her children albeit that some IMR authors were more thorough.

14.3 Advance

Although Advance had limited contact, there was one occasion where a face to face meeting was held and housing information provided. The IMR states that this meeting also included a 'small amount of safety planning' but provides no further details.

The IMR author concludes: *'We had two external audits in May 2012 with Community*

Legal Services Commissions and CAADA Leading Lights which we passed and so I feel the issues highlighted in this case were already addressed in a bid to improve practice.'

Overall, the IMR was substandard so it is not possible to determine whether additional lessons could have been learned. It should be noted that since the murder occurred, Advance has had three changes of CEO and is no longer the provider of IDVA services in Brent.

14.4 Brent Children's Social Care

This IMR is well written and thoroughly examines the many ways in which practice fell below expected standards.

Risk factors were not properly identified on a number of occasions. This included the risk that Daniel posed to his first family so that CSC supported his application to remain in the UK to maintain contact with his daughters even whilst he was in prison for domestic violence. It is highly likely that Daniel's desire to look after his children was fuelled by his fear of deportation. This does not appear to have featured in the assessment and should have been explored with him and have been flagged as a warning. Despite the number of concerns about Daniel, no record was opened on the ICS in respect of him, no intelligence was sought from the police to inform assessments and the connection between him and his children with Alexia was not made until after the murder. There is evidence that he gave Alexia's name to the social worker involved with his daughters and that he gave his daughters names to the last worker involved with Alexia and her children. Neither worker checked the Brent Social Care system to see if either family was known. Both workers knew that Daniel was understood to perpetrate violence against his partners.

Other examples of where risk failed to be identified include when Daniel perpetrated a serious assault on Alexia for which she needed 20 stitches. This assault took place while she was living in Haringey. There is no evidence that this was discussed with her when she came to attention in Brent Social Care despite concerns that Daniel was violent.

Although Alexia was no longer in a relationship with Daniel, there was evidence from both parties that he still was having contact with the children. The risks involved in this never seemed to be considered and the lack of a chronology on the records meant there was no real overview of the risks.

Daniel was seen twice by Social Care staff. In both interviews he referred to the domestic violence and in both he minimised or denied his culpability. Workers should have been alert to this behaviour and should have provided challenge. His behaviour ought to have increased their concern about his involvement with all five children.

There was no comprehensive police intelligence report in respect of Daniel. Had comprehensive information been amassed about Daniel then this could have and should have been used in interview with him and Alexia to ensure that all parties knew the risks and proper plans could be made to manage these.

Daniel allegedly assaulted Alexia when she was eight months pregnant with child 3 and there was another alleged incident two months earlier. The latter resulted in a hospital admission for bleeding. It is well known that the risks to women from violent partners increase during pregnancy but this information does not appear to have featured in the response to the referral.

It would appear that the understanding about domestic violence appears to have either been very limited or there was not proper supervision or reflection to help workers understand the dynamics at play. The understanding of relationship and what threats this

might hold in domestic violence appears to hold to notions of sexual relationship and/or cohabitation. It is well known that women are more vulnerable to serious assault when they end violent relationships and this does not appear to have been taken into account. The continued relationship that parents may have to have for their children was not explored and therefore no risks were ever managed for the children or for Alexia. The possibility that Alexia may have wanted or sought contact with Daniel for any reason appears not to have been considered.

Professional knowledge about the effect of domestic violence on children is not explicitly considered in any of the assessments and there is no evidence of this being explored with either Alexia or Daniel. There is very little description of the children and there is little attempt to engage with child 1: her view of her life is largely absent despite her being the focus of repeat Social Care assessments. The Munro review of child protection stresses the importance of engaging with an understanding the child's experience. To present a parent with their child's view of abusive relationships or neglectful homes is extremely powerful. The last set of referrals in respect of the children represented missed opportunities to engage with child 1.

There was a report that child 1 and 2 were left unattended, an anonymous report that Alexia all three children in a van while she partied, a report from school that Alexia did not collect child 1 from school and smelled of alcohol when staff called to the home, Honour was found to be sleeping whilst in sole care of the three children and Alexia was so tired she fell asleep during a social work visit. The role of the assessment is to gather all historical concerns and review each new incident in the light of what is already known. The cumulative evidence is that there were inconsistent routines and inconsistent care givers. The assessments should have explicitly assessed the potential for neglect.

There was a lack of curiosity on the part of workers regarding the criminality of both Daniel and Alexia. Findings from national SCRs indicate that persistent criminality is a feature in families where children are seriously harmed. This lack of curiosity may have been attached to either class or cultural notions in the workers but it is a significant gap in practice.

Daniel told both social workers in his two face to face interviews that he had been a deacon in a local church for 10 years. The records do not show whether they asked him what this entailed and how he achieved this status. It is an evident device on his part to shroud himself in respectability to minimise the criminal and violent aspects of his lifestyle. On both occasions he also minimised or denied his violence yet despite the existence of contradictory information, he was not challenged about this.

The decision to proceed to ICPC in 2009 in respect of Alexia's children was good and reflected the cumulative concern about the children. This decision was not implemented and indeed was reversed by the team manager. The manager decided to proceed within the children in need framework unless Alexia failed to cooperate. The case was closed at a later date because Alexia failed to engage which should have been a cause for increased concern, not less. The most significant plan that was repeated at the end of several interventions was to go to ICPC should there be further incidents with Daniel or the relationship resume. This was never implemented.

The best form of child protection is support and empowerment of the non-abusing parent. There is evidence that workers spoke to Alexia on a number of occasions to establish her views about her relationship with Daniel. Alexia was invited to comment on her commitment to the relationship but no work was done with her to unpick what her relationship was with Daniel and what strategies or legal framework she could employ to keep him away. There was no information on the ICS to attest that Brent Social Care knew

any other agency such as probation was doing this work with her. Alexia was signposted to solicitors on one occasion.

The IMR author states that *'because workers did not engage with Daniel he was not offered any services. It is not known whether he was referred to services by probation in response to his offending. It is unlikely that he would have engaged with any service to address his violence as it is clear from the two interviews with him that he either minimised or denied his action.'* As can be seen from the other information in this report, Daniel was in fact on a court ordered perpetrator programme where he is reported to have engaged well. The communication from Brent Social Care to other agencies appears to lack purpose other than a welfare check. There is no evidence of curiosity about the information from prisons or probation.

There was also an issue with regards to information sharing with/from the police which has subsequently been resolved by the creation of a MASH. However, it remains a matter of some concern that despite several MARAC meetings, Brent CSC seem to have remained unaware of the full extent of Daniel's criminal history.

There is evidence that workers did receive supervision about their work with this family. However the frequency is out of step with the Brent Policy. The quality of the supervision records indicate a task/issue focused approach rather than a reflective one. It is not always possible to capture the reflective quality of supervision in the records and the workers individual records were not sourced for this report. This case is characterised by social workers/managers not following through on actions. This indicates that workers were not robustly supervised and that managers were not suitably accountable for their decisions.

There is evidence that restructure and capacity issues within Brent CSC impacted on this case. These have subsequently been resolved.

14.5 Brent Community Health Services

This IMR is troubling as the author does not appear to be in possession of some basic facts concerning the murder (eg that two of Alexia's children were present when the murder occurred, that the body was found by Daniel's daughter and not an acquaintance, that the victim lived with her mother, not her grandmother, the address of the perpetrator is incorrect and that he was the father of two of Alexia's children, not one). Due to the lack of DHR Panel meeting minutes, it is not known if this was challenged. In the absence of adequate terms of reference, the IMR author used her initiative and followed the format set out in *Working Together to Safeguard Children*.

Most of the contact that Brent Community Health Services had with Alexia and her children were routine. Nevertheless, there are still some incidents of note that should have triggered concerns.

The IMR does identify a lack of curiosity on the part of the Health Visiting Service and a failure to follow procedures when Alexia did not engage with services.

Despite contact over the course of six years, no records could be found before 2010 of Alexia ever being screened for domestic violence. This is despite the known increased risk during pregnancy and in the post-partum months and the recommendation in 2003 (DH) and 2004 (Confidential Inquiry into Maternal Death) that all Health Visitors should routinely screen. At the new birth visit for child 3, Alexia was screened and disclosed a history of domestic violence (from two months previously) but answered no when asked

about current abuse. This was not followed up in any of the subsequent visits nor was any attempt made to fill in the gaps in Alexia's records such as who she lived with.

The two year check for child 1 was missed twice and no follow up appears to have been made. Health Visitors are expected to be proactive in ensuring attendance and through their role give anticipatory guidance to families. There is no evidence in the Health Visiting Records to suggest there was any further follow up or if the 2 year check was complete.

When the PAC was received, contact was attempted but was unsuccessful. There is no evidence in the Health Visiting Records to indicate any other follow up took place which does not comply with the DNA policy. The two missed appointments and no action plan to engage with the family are clear examples of below standard practice of health professionals. Health professionals did not adhere to correct procedures to follow up this family in a timely and effective way.

At the new birth visit for child 3, a history of domestic violence was identified and Alexia told HV6 "*I will call the police if necessary.*" Alexia was noted to be aware of the effects of domestic violence on her children. Alexia's mood was not assessed using any Mood Assessment Tool such as the Edinburgh Postnatal Depression Scale (EPDS) or the newly introduced Mood Assessment Tool. There is evidence in the Health Visiting Records that a discussion about depression had taken place.

The Family Health Assessment (FHA) questionnaire was completed by Alexia. Question 8 asked 'have you experienced any of the following events?' Alexia circled domestic violence and documented that there was a history of domestic violence, and that a social worker was previously involved. The last episode involved a verbal argument when Alexia was 38 weeks pregnant. There was no PAC in the records which may indicate this episode was not reported.

Question 9 asks 'are you currently experiencing domestic violence?' This question was answered 'no'. This point should have been further explored by HV6 through sensitive questioning because the last episode of DV was very recent. HV6 documented in the action plan - healthy child, core health visiting input unless further domestic violence. This visit by HV6 demonstrates some insight into the knowledge around domestic violence but this was a missed opportunity to enhance the case.

Good Health Visiting Practice includes completing the Family Health Assessment taking into account the risks and resilience factors and the potential impact on health and development of children. HV6 discussed the impact of domestic violence on the children with Alexia but did not take account of the risk factors. It would be difficult for HV6 to apply a holistic approach to the assessment with clear gaps in information. At that time the CHPP required Health Visitors to look beyond the child to their family context, reviewing family health as a whole, working in partnership with adult services and building family strengths and resources. (Social Exclusion Task Force 2007). There is no evidence in the records to suggest what measures HV6 undertook to ascertain this missing information.

In November 2010, a fax was received into the Brent HV department from Brent CSC informing the health visitors that social care was involved with the family. Information had been received regarding concerns for Alexia and the children due to domestic violence perpetrated by Daniel. The Social Worker informed CSB that a Pre-birth Assessment had been completed with no further concerns highlighted. Therefore Brent CSC closed the case, with a view that all professionals involved would re-refer if concerned.

The IMR author notes that following an interview with HV6, it was clearly evident there was an overall lack of appreciation of complexities of the situation.

There was a further missed opportunity in April 2011 when HV6 spoke to Alexia on the telephone following a request for follow up from Brent CSC. HV6 documented that Alexia had reported child 3 was up to date with immunisations. This was an ideal opportunity to question Alexia about how things were at home, including the fathers involvement with child 3, child contact arrangements and any further episodes of domestic violence.

A Message was left for Brent CSC to contact HV6. The records do not show that there was a response. The needs of Alexia were not met in respect of managing the incidences of domestic violence which should have been kept under review by HV6 in line with good practice. There is no evidence to suggest HV6 was sufficiently sensitive to any changes in need, despite the re-involvement of social care.

Also in April 2011, HV6 undertook an opportunistic visit at the home address by HV6. Honour, the children and an unidentified male were present. The house was noted to be cluttered with clothes and family belongings everywhere including black storage bags. It was difficult for HV6 to address any domestic violence issues due to the unknown male at the home. The gentleman was not identified in the records. Although separating from a violent partner should result in women and children being safe from harm, the danger does not automatically end.

Moreover, the point of leaving an abusive relationship is the time of highest risk for a victim. Contact arrangements can be used by violent men not only to continue their controlling, manipulative and violent behaviour but also as a way of establishing the whereabouts of the victim(s). This was a key opportunity for HV6 to offer Alexia an appointment to be seen alone to discuss any issues and to establish if Daniel was having child contact. No further communication or contact was made by HV6 to the family after this date.

The IMR author concludes that HV6 health visiting practice was sub optimal. A good practising HV would have assessed risk factors and looked at the impact of Alexia's parenting capacity, family health and environmental factors on children's health. Wellbeing is assessed to identify children and families who require additional support to achieve the 5 outcomes identified in the Every Child Matters (2008)

In June 2011, Child 1 was seen by School Health Advisor at school for routine health and weight check. No social issues were identified or recorded. Schools in Brent do not receive PAC information; therefore the school nurse would not be aware of the wider family issues in this case.

14.6 Brent Housing

This IMR contains no introduction and is mostly written in note form. As such, the assessment of this IMR is limited due to insufficient information.

On each of the three occasions that housing were made aware of domestic violence, action was taken with regards to accommodation and sharing information with other agencies. However, procedures were not followed with respect to signposting Alexia to support services.

Overall, the IMR was substandard so it is not possible to determine whether additional lessons could have been learned.

However, it should be noted that in 2012, the Housing Needs department underwent a major review and restructure. The new structure has brought together all the assessment elements of housing into one team. This new assessment team has lead officers who specialise in different aspects of housing, one of which is domestic violence. This officer is responsible for ensuring that all assessment staff are routinely trained in domestic violence awareness.

14.6 London Probation

Daniel was correctly assessed as suitable for the IDAP group work programme at the Pre-Sentence Report (PSR) stage. He was referred to the programme promptly and pre-group work was completed to a sufficient standard. However, it is of concern that a place did not become available for five months. Daniel lies and tells his Probation Officer that his current partner has no children so his attendance on the perpetrator programme is not communicated to Brent CSC.

Daniel completed several modules of IDAP with mostly positive feedback from programme tutors. It is also positive to note that when it became clear that Daniel had disengaged from the supervision process and IDAP that breach action was initiated. Also, the case was discussed at MARAC in May 2005, when it was confirmed that he was wanted on a breach warrant. In September 2009, Daniel was arrested and in October, he was sentenced at Harrow Crown Court. His original Suspended Sentence Order was activated due to the breach and ongoing risk issues

However, of concern are the two occasions when the Probation Officer for Daniel was sent concerning information from IDAP tutors regarding risk to the Alexia and this was not followed up with referral or checks to Brent Social Care and contact with the Community Safety Unit / Advance. Also, information should have been shared with CSC when Daniel reported he felt suicidal when he left Court in November 2008. Also, when Daniel was sentenced to eight months custody as a result of the breach, the Probation Officer should have informed MARAC and CSC that his case would now be terminated as Probation do not manage offenders sentenced to less than 12 months custody. This information sharing should have taken place as Daniel would continue to pose a risk to Alexia or indeed any other woman he formed a relationship post release, particularly as he would no longer be required to undertake any structured work to address his domestic abuse issues.

Alexia

When Alexia was subject to supervision there is evidence of regular contact between the Supervising Officer (SO) and Brent CSC in relation to the risk Daniel was presenting to Alexia's safety and her children. There is evidence that while Alexia's case was re-allocated to different Social Workers, the SO made sure each new worker was appraised of Probation's concerns and involvement with Alexia,. The Probation Officer for Alexia referred her to MARAC due to the ongoing concerns for her safety.

When Alexia was sentenced to a new Community Order for offences of Theft and Common Assault (against a store security guard) in June 2011, the new allocated officer made contact with CSC who informed her that a recent assessment had taken place and that the case was closed. There is no evidence however that the supervising officer made a new referral based on the new offences. However she did speak to CSCs who undertook a home visit to Alexia's home in July and informed them of her involvement in the case. The Supervising Officer was informed by Alexia throughout the period of supervision that she was no longer in a relationship with Daniel and throughout the period of supervision,

Alexia made no mention of any new incidents of abuse indicating a risk of harm and no Police information was received which would indicate an escalation of risk in terms of domestic abuse.

It was established early on that the programme requirement attached to Alexia's Order in 2008 was too onerous taking into account her status as a single mother and her childcare issues. The probation officer continued to engage Alexia and there is evidence of some effective one to one work carried out in supervision.

In 2011 Alexia was sentenced to a Community Order with a requirement to complete the one to one Structured Supervision Programme for women. This was delivered by a female officer and there is clear evidence that twelve sessions of the programme were completed. Alexia also received support from the St Mungo's floating support worker in relation to her housing needs.

The IMR does acknowledge that a home visit was never carried out and that this would have assisted in the risk assessment process and may have identified a need for more appropriate interventions.

Overall, in relation to Alexia there is clear evidence of regular review and information sharing with MARAC and CSC by the supervising officer in relation to the risk presented to her by Daniel. Despite this, the risk assessment identifies risk to Alexia's children due to her past inability to effectively protect herself from Daniel.

14.7 Metropolitan Police

In the first of the two incidents described above, had research of MPS databases for the previous five years been undertaken, this would have revealed the violent history of this relationship. MPS Domestic Violence Standard Operating Procedures state that research should include the previous five years. Had this been done, it would have identified a significant series of domestic violence and child care issues. It would also have revealed that Alexia had been the subject of referrals to the MARAC. Acquiring this information may have impacted on the subsequent risk assessment and management. There was no indication that background research did take place. Alexia told the officers that her relationship with Daniel had been violent and abusive. However, they did not know the details, and so would not have been competent to establish the level of risk or to begin managing it effectively.

The answers given by Alexia in response to the risk assessment should have caused further investigation to be completed. There is no indication that this information was explored or developed. Instead it appears that the investigation focussed on the damaged mobile phone. The information about threats and attempts to strangle her should not have been classed as a 'standard' risk.

In line with expected practice, a referral was made to CSC. However, the report stated that Daniel had previously committed a serious assault in which he struck Alexia with an iron. This is factually incorrect as he was actually convicted for this offence against his wife, not Alexia. In the second incident, the notification to CSC (Merlin) could not be traced. The child care issues in this incident were not addressed. It is likely that access to this couple's children was the catalyst for this incident. However, they were not named and no Merlin or Crimint reports were completed with regard to them. The purpose of this type of Merlin report would have been to alert all relevant agencies to any potentially escalating risk factors. Even though the risk level was assessed as 'Standard,' it would be expected that Alexia would have been offered advice about her own and her children's safety. If this did take place it was not recorded.

The investigation was recognised as a Domestic Violent incident, but was not treated as such. There does not appear to be any acknowledgement that Alexia's relationship had previously been assessed as high risk, and had been referred to the MARAC twice. Although the risk assessment did include the heightened risk factors this was not reflected in the risk level, and no risk management took place. Furthermore, this matter was not supervised as it should be according to MPS policy. It is not known why it was not supervised during the primary investigation stage, but highlights the need for a secondary risk assessment by CSU trained staff.

Alexia had told the officers that their relationship had been volatile, and that due to past incidents she was scared of Daniel. This indicated that risk factors were present. Analysis of these incidents has concluded that it may have been more appropriate to deal with the incidents as 'harassment.' This applies particularly to the second incident, as it was strikingly similar to the allegation in June, and indicated a continuing 'course of conduct.' This may have allowed attempts to control Daniel's behaviour with harassment warnings and perhaps additional civil remedies. The way the incidents were actually approached did not address Daniel's behaviour.

In the second incident, it is unclear whether the Form 124D was actually completed whilst the officers were speaking to Alexia, as information that appears on the text of the CRIS report did not appear in the answers to the 124D questions. All the questions have been answered 'no or 'n/a.' This is with the exception of the first question, which asks the subject about their perception of the risk. The answer is 'He scares me.' The fact that Alexia had told the officers she was scared of Daniel due to previous incidents was not explored. This should have been drawn out during the DASH risk assessment process. Questions such as 'have you separated?' and 'do they try to contact you etc?' or 'do they threaten you?' are marked as not applicable. This risk assessment must be flawed, as the answers to the questions do not reflect the information that was known to the officers that spoke to Alexia. The reason that the officers had been called was that Daniel was persisting with unwanted contact, and making threats. The Form 124D was signed by a supervisor. However, the supervision did not include ensuring the details corresponded with the associated CRIS report.

The Standard Operating Procedures for the investigation of Domestic Violence requires that all CRIS, 124D and Merlin reports are supervised as soon as possible. When the risk assessment is Medium or High, they must be allocated to a supervisor to complete the secondary part of the DASH risk assessment. It should be noted that it is possible that even non crime Domestic incidents may warrant a medium or high risk level. In this instance positive action was taken in that the CRIS report was screened in for further investigation. However, it was not reviewed by a supervisor until three days later. No further action was recorded on the CRIS until after Alexia's death. When the investigation was screened in the issues discussed above could have been identified by a trained Community Safety Unit officer. It is not possible to comment on these timescales for supervision and action, without knowledge of the officers' workloads and how they prioritised their investigations.

On both occasions, therefore, the risk assessment was flawed. However, it is a key issue that on the day of the murder, Daniel had apparently been allowed in to Alexia's home with her consent. They had been sharing her bed on the morning that she died. It is also known that Alexia was alive at least an hour after Alexia's mother had left to go to church, as there was definite contact with another witness several hours later.

Daniel appeared to be having contact with his children by arrangement, and would therefore have had contact with Alexia. Also, it would seem that Alexia's mother was unconcerned to see him there on this occasion. This may suggest that Alexia and Daniel

were having contact that was not attracting police attention. In both the incidents reviewed Alexia requested no police action after the initial complaints.

Therefore, although there are concerns that these incidents could have been dealt with more appropriately, it is possible that Alexia and Daniel were having regular contact, which resumed on each occasion after police involvement finished. Any control measure that could have been introduced, would have been ineffective if Alexia continued to allow Daniel into her home. These observations are made in order to illustrate the clear need to take firm ‘positive action’ when domestic violence incidents are reported, and the victim has previously withdrawn allegations. When allegations are withdrawn the case should always be reviewed by a CSU supervisor.

14.9 NHS Brent

As noted above, it was difficult to extract the GP specific information from the IMR. However, the author does note that: ‘The GP is expected to have the records of a patient from cradle to grave and also to be the gatekeeper of information. But this requires that all information is sent to the GP from various health providers for an individual. The GP records had gaps in information as illustrated in the table of information that make would have made up the jigsaw.

	Mother	Children
GP	Dec 2008- attack April 2011- SS closed the case	
Health visitor		Pre Assessment Checklist (PAC) 05/06/2008
Health visitor St Mary’s Hospital	Domestic violence disclosure Pre-birth assessment- closed the case	
NPH		08/2011- TAR admission

The GP did not have the information from the PAC, nor from the midwifery service

There was no documented involvement of MARAC nor a referral to an IDVA.

It is unclear if the IMR author is referring to the GP being informed of such a referral or means that the GP did not make such a referral.

14.10 St Mary’s and Imperial College Healthcare NHS Trust

The maternity booking appointment appropriately included a social risk assessment and the midwife clearly documented that there were no known social risk factors, albeit that it is not specifically written that domestic violence was explicitly explored. The maternity notes design in use at that time did not have a set of specific social risk indicators to guide discussion, but only have a box titled ‘social risk’. It is not recorded whether Alexia was accompanied at the booking consultation which could have precluded such a discussion taking place.

When Alexia disclosed domestic abuse in the course of a scheduled antenatal consultation at approximately 34 weeks pregnant, the midwife was sensitive to this risk indicator and responded appropriately. Whilst the documentation in the hand held maternity notes

would appear ambiguous to a lay reader, this is an informed deliberate strategy to protect women whose partner (or any other perpetrator of abuse) may have access and opportunity to see her hand held notes and any explicit reference to her disclosure would potentially increase her vulnerability to further attack. The hand held notes signposted staff to read further documentation in the hospital (brown) folder and mentioned the specialist nurse for safeguarding children & young people by name, not role, which is a commonly accepted signal amongst the team, to seek further information in relation to social risk.

The midwife acted appropriately and accountably in line with extant policies and guidelines, informing social care verbally and in writing, and copying the information, without delay to SNS. The midwife also ascertained that Alexia did not believe herself to be at immediate risk of further abuse and stated that she was not afraid to return home.

The SNS acted appropriately in following up the case with antenatal clinic staff the following day to ascertain further facts, liaising with social care. The SNS took appropriate steps to immediately place an alert on the maternity electronic register. The opening page of the electronic register states 'social worker requested' signalling social concerns and to refer to the full social care section. Here SNS had entered the reason for referral and the nature of concerns, together with advice 'do not discharge mother & baby without contacting Social care first'.

The case was discussed at two subsequent multi-disciplinary/inter-agency Maternity Family Support Meeting, and the SNS appropriately updated written alerts to maternity staff for when Alexia delivered her baby.

There is no documented evidence that the midwife who gave intra-partum and immediate postnatal care was aware of the social history, nor if the midwife who carried out the postnatal examination on the morning of 20th October and arranged the discharge to home, and care of Brent Community Midwives, was aware either. It is not documented that social care had been contacted to inform them of the birth, nor to discuss discharge plans. There is no documented evidence of any discussion with Alexia as to any social or relationship issues.

The midwife has no direct recollections of the case. However her customary practice is to request the hospital brown folder during working hours, or if delivery is at night to request it for the following morning. She does not recall seeing the alert on the maternity electronic register. The last entry prior to discharge from hospital was timed at 1000hrs and relates to a postnatal check, the signature is illegible, name not printed; the discharge summary is unsigned and the signature/print name identification section not completed.

It is of note that the birth centre was particularly busy over the twenty four period when Alexia was an in-patient. There were a number of births that same morning (20th October 2010) and it is feasible that the midwife conducting the postnatal examination and discharge process was called away to care for another labouring woman, before she an opportunity to call for the hospital brown folder. Whilst it is not common practice for midwives to routinely check the child protection folder, in this instance it was documented in the hand held notes that further sensitive information was in the brown folder. This should have prompted staff to access the brown folder as soon as possible.

This presents an opportunity for learning and a reminder that maternity clinical staff must routinely review the hospital brown folder, for all admissions, regardless of the place of birth, and in a timely manner. However in this instance, the SNS promptly took corrective

action, ensuring that social care were informed. There is documented evidence of the social worker visiting Alexia and her baby at home. Therefore it is unlikely therefore that the failure to follow the plan to discuss the postnatal discharge with social care had an impact on the outcome in this case because that failure was quickly rectified some 11 months prior to her death.

14.11 UKBA

At the time of his travel to the United Kingdom, there was no known information available to the UK Border Agency to suggest that Daniel may be of risk to any other individual. Given the non-visa requirement for Jamaican nationals in 1998, it is considered that the opportunity for identifying any risks at that time was very limited. Since 2003 Jamaican nationals have been required to apply for a visa before travelling to the United Kingdom.

On 11th November 2009 Daniel was considered under the UK Border Agency's Harm Matrix. This rates Immigration Offenders in to the following categories of A, B or C and allows the agency to analyse and prioritise cases. A is the highest score. Daniel was rated as 'Harm Assessment: A' following his detention in October 2009 at HMP Bullwood Hall. This was due to Daniel being a Foreign National Offender.

On 8th January 2010 is noted on Daniel's UK Border Agency's CID records (Special Conditions screen) that he was responsible for criminal activity and had been sentenced to 8 months for breach of a court order.

There is no information to suggest that any other agency or organisation enquired about any risk factors relevant to Daniel's immigration status.

It is not known whether the 'Harm Assessment : A' was specifically shared with the police or any other agency, however given that this was based on his custodial sentence, it is noted that Daniel's criminal record was available to other agencies. The 'Harm Assessment : A' rating in itself does not illustrate any specific risk factors or disclose any new information and therefore would have been of very limited use to any other agency.

In respect of Daniel, the only relevant plan or service to provide in this instance was to offer the Foreign National Prisoners Return Scheme. The scheme was established on 12th October 2006 to facilitate the early removal of a Foreign National Offender (FNO) to their home country. The primary aim of the scheme is to encourage FNOs to leave the UK at the earliest possible opportunity, so reducing the time and costs associated with time spent in prison and immigration detention. Whilst the scheme is voluntary, those who depart under it are subject to enforcement decisions. The applicant will receive a grant of up to £1,500 when the application is made whilst the FNO is serving their custodial sentence or up to £750 for those FNOs who apply after completing their custodial sentence.

On 7th October 2009 Daniel was seen by an Immigration Officer at Wormwood Scrubs HMP where he stated that he was not interested in the Foreign National Prisoners Return Scheme.

On 11th November 2009 the UK Border Agency considered Daniel against the criteria for deportation for non-European Economic Area nationals:

- A custodial sentence of 12 months or more either in one sentence or as an aggregate of two or three sentences over a period of five years, or a custodial sentence of any length for a drug offence (other than possession).
- A court recommendation (only for those over 17 years of age).

It was considered that Daniel did not meet the deportation criteria, as outlined above. He had served a 9 month custodial sentence for assault occasioning actual bodily harm (ABH) and there is no indication that he was recommended for deportation by the courts.

Daniel made the following wishes known to the UK Border Agency:

- On 7th October 2009 Daniel informs an Immigration Officer at HMP Bullwood Hall that he has no interest in Foreign National Prisoners Return Scheme and that he wants to remain in the UK to care for his three children.
- On 28th October 2009 Daniel states that his wife passed away recently, but that he also has a girlfriend and baby in the UK. This is the first instance that the UK Border Agency is aware of the relationship with Alexia, but no name or further details are taken regarding the matter.
- On 1st November 2009 Daniel advises that his solicitor will be submitting an application on Humanitarian Grounds to stay in UK as his wife died from a rare medical condition and has left behind two children.

With respect to the family of Daniel, on 8th August 2006 an application was made for his two daughters to obtain indefinite leave to remain in the United Kingdom on the basis of the seven year concession for children (in force at the time). On 9th March 2009 the UK Border Agency received a letter stating that his wife no longer wished Daniel to be included in the application. On 6th July 2009 the UK Border Agency received a fax stating that his wife had died. The application was finally granted on 5th November 2009.

UK Border Agency records do not contain any information regarding any domestic violence, medical issues, housing or other matters that Daniel either experienced or was engaged in.

It is possible that if the UK Border Agency were fully aware of matters involving Brent Probation and the Metropolitan Police Service, this may have impacted upon the prevention of the homicide.

After Daniel's arrest in July 2006, he was placed on weekly reporting and he reported on 125 occasions, on 23 occasions he did not report, one occasion was cancelled, and in two occasions it is unknown whether he reported or not. From January 2010 he was placed on a Restriction Order and he reported on 13 occasions, one occasion was suspended for unknown reasons, and on one occasion it is unknown whether he reported or not. From June 2010 he was placed on monthly reporting and he reported on 15 occasions until 13th September 2011 when he was placed in to custody by the police.

When the Metropolitan Police telephoned the UK Border Agency in September 2011 requesting a status check of Daniel, it is noted on CID:

'It is not clear why no action has been taken to obtain travel document and set RDs' (Notes 13th September 2009)

On 16th March 2012 the CCD Briefing & Correspondence Team, who dealt with the suspect's case, were asked if efforts to re-document Daniel were as robust as possible. In a reply dated 23rd March 2012, they stated:

'An ETD (emergency travel document) interview was attempted by CCD's Ops team on 12 Nov. 2009 but Daniel failed to co-operate with proceeding. There is no evidence on file that further attempts to re-document Daniel was made.'

The difficulty in re-documenting immigrants and removing them to their country of origin is widely acknowledged within the UK Border Agency and by the Home Affairs Committee. It is possible that if attempts had been made to re-document Daniel, particularly when he⁷ was first encountered as an over-stayer in July 2006 that he may have complied with the process. However, it is not possible to say with any degree of certainty how compliant Daniel would have been if the re-documentation process had been attempted earlier

It is noteworthy that although a re-documentation attempt was made in November 2009, that Stansted Enforcement Office requested the Criminal Casework Directorate to make another attempt in December 2009. This was considered by the Criminal Casework Directorate but it is recorded on CID that there were insufficient resources to attempt the process. It was noted later in December 2009 that a re-documentation attempt needed to be made, but there is no further evidence to suggest that was undertaken at any subsequent stage. A copy of his passport was available to use as supporting evidence when submitting the application to the Jamaican High Commission.

It is considered that it was a failure of the UK Border Agency not to attempt to re-document Daniel until over three years after his encounter as an over-stayer.

Daniel was detained from 30th October 2009 until 31st December 2009 in criminal custody in HMP Bullwood Hall, and from 31st December 2009 until 15th January 2010 in Immigration detention in HMP Bullwood Hall. On 4th January 2010 Daniel applied for bail which was granted by an Immigration Judge on 11th January 2010. The Bail Summary opposing the release of Daniel submitted by the UK Border Agency stated:

- He did not leave the United Kingdom when his 6 month visa expired.
- He was only detected in 2006 by police for driving without insurance, and believed that he would have remained at large if not for this chance encounter with the police.
- He has breached his reporting conditions in the past.
- He had been imprisoned due to battery and in breach of a court order.
- He had obstructed the removal process by failing to cooperate with the ETD process.
- It is the intention of the UK Border Agency to remove him once a travel document becomes available.

It is noted that the Bail Summary does not contain any information relating to the domestic violence, medical issues, housing or other matters that Daniel either experienced or was engaged in.

It is considered that if the UK Border Agency were fully aware of matters involving Brent Probation and the Metropolitan Police Service and were able to disclose this information to the Immigration Judge, this may have impacted upon the decision to release Daniel on bail. Therefore he would have remained detained and this may have prevented the homicide. It is not possible to say with any degree of certainty what decision an independent Immigration Judge would make if the aforementioned information had been disclosed, but it is considered that it would have been strongly in the UK Border Agency's favour in maintaining the continued detention of Daniel.

14.12 Victim Support

There is no analysis due to the brevity of contact.

⁷ Asylum seekers that are kept in the country during their immigration procedure. Identification with a view to (re-) documenting an irregular migrant is indispensable.

15. Equality and diversity

All nine protected characteristics in the 2010 Equality Act were considered by the report author although the same cannot be said for all the IMR authors who, overall, dealt with this aspect poorly..

Several protected characteristics were found to have relevance to this DHR. These were:

Age: Alexia was 23 and Daniel 43 at the time of the murder. Their relationship is believed to have begun at least five years earlier. Although both parties were adults, this is a significant age gap and a risk factor for abuse. This was only identified by one IMR author.

Marital status: Alexia was not married to Daniel. Evidence from the Crime Survey of England and Wales indicates that unmarried women are more at risk of domestic violence than married women although the highest risk group is separated women. Alexia was attempting to separate at the time of the murder.

Pregnancy: Alexia was not pregnant at the time of her murder although it should be noted that the elevated risk of domestic violence during pregnancy actually increases following birth. At the time of the murder, child 3 was eleven months old and Alexia originally began separating from Daniel whilst pregnant.

Religion and belief: Daniel's statement to Children's Social Care that he was a Deacon at his local church seemed to afford him a veneer of respectability and protected him from further scrutiny; an issue identified by the CSC IMR author. No IMR author, however, identified that Daniel was a Deacon at a Pentecostal church, a strand of Christianity that is vehemently opposed to abortion. As such, the impact that religion may have had on Daniel and his feelings towards Alexia, were not considered as it is highly probable that he was the father of at least one, if not both, of the three terminations Alexia underwent. Daniel also spoke at his Probation sessions about how his fixed religious ideas had contributed towards his use of violence towards his partners, feeling justified when they failed to meet his expectations.

Ethnicity: Both Alexia and Daniel were from Jamaica. Although several agencies had their ethnicity recorded as Black British, neither was in fact a UK citizen and Daniel was in the UK illegally. As such, his insecure immigration status was not considered by any IMR author bar UKBA.

Due to this misallocation of ethnicity, most IMR authors did not consider the impact that cultural expectations of both relationships and gender roles may have had on their relationship. The exception to this was London Probation who recorded in their files a statement from Alexia that in Jamaica, domestic violence was very common and something she almost expected. However, it was not recorded if or how this was challenged.

Sex: Alexia's sex is also relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed⁸. Latest published figures show that just over half of female victims of homicide aged 16 or over had been killed by their partner, ex-partner or lover (54%). In contrast,

⁸ Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover. This was another factor that every IMR author failed to identify.

16. Lessons learned

The lessons arising from this DHR are divided into two sections: process issues relating to the DHR itself and lessons arising from the homicide.

16.1 Process issues

It is something of an understatement to state that this DHR has not gone smoothly. To avoid issues arising in future DHRs, the following is recommended:

1. The CSP needs to take greater ownership of the process. This is in specific reference to their responsibilities in:
 - checking the credentials of any prospective Chair
 - recognising the (high) potential for disputes at the start of the process and agreeing a process for resolving these. Any protocol needs to consider disputes between the Chair and the CSP as well as disputes between the Chair and Panel members.
 - ensuring that the process begins on the right footing by maintaining oversight of the development of the terms of reference
 - prompting broader thinking about the involvement of family and friends. People who knew the victim or perpetrator are able to offer valuable insights into the circumstances and decisions and compromises made. In this particular DHR, the victim had a wide-ranging group of friends, none who appear to have been contacted. Efforts do not appear to have been made to interview the perpetrator nor any of his extensive social network.
2. If staff change during the course of a DHR, a replacement must be allocated and a detailed handover process completed.
3. IMR authors need to be reminded that equality and diversity issues must be addressed as an integral part of the process and not as a half-hearted afterthought.
4. IMR authors should also be reminded that the victim in a DHR is to be afforded respect and that this includes being given status as a person and not just referred to as 'Mum'. Failure to do this led to confusion in several IMRs with Honour being incorrectly referred to as Alexia's grandmother. However, the point still stands irrespective of these errors.
5. Critical lessons can be lost if all relevant agencies are not invited to contribute. If agencies are excluded for whatever reason, this must be recorded.

16.2 Lessons to be learned from the DHR

16.2.1 Information sharing is a process not an outcome

Whilst information sharing was not perfect, in general it was above average. However, there is no point whatsoever in sharing information if no changes are made as a consequence. Alexia was referred to MARAC three times but there appears to have been no action as a consequence. Good referrals were made to Children's Social Care but in most cases, this resulted in no further action. In part this seems to be because of a failure

to view the family holistically and to link incidents together rather than seeing them in isolation.

16.2.2 Impunity

It is now well established that impunity is a major contributory factor to violence against women. There is documented evidence of Daniel being violent and abusive to three separate women, even whilst terminally ill or pregnant or holding a baby. This is not to criticise the Police or Probation in this case but a comment on sentencing. The difficulties in prosecuting when the victim is unable or unwilling to support the process is appreciated, and prompt breach action was taken by Probation when Daniel committed further violence whilst on a perpetrator programme. Nevertheless, Daniel was able to commit violence against three separate women and for this not to result in a custodial sentence until 2009. At the same time, he was subject to immigration reporting requirements which he has not complied with on 12 occasions at the time of his incarceration. The message Daniel received over and over again was that he could continue to assault women and fail to comply with the authorities yet not risk his liberty.

16.2.3. Risk factors

Several risk factors were present which did not appear in records as risk factors. These include: repeat terminations (the likelihood of a woman seeking a second or more termination experiencing domestic violence is exceptionally high); assaults in public places which indicates confidence on the part of the abuser that he will not be held accountable, assaults committed whilst Alexia was holding a child (this did trigger concerns for the child but not apparently, Alexia) and Daniel's expressions and Alexia's reports of Daniel's sexual jealousy.

16.2.4. Flawed understanding of domestic violence

There remains a stubborn belief amongst professionals, clearly present in this DHR, that the one and only response to domestic violence is to encourage, and in the face of resistance, threaten and coerce, the victim to leave an abusive relationship. Not only does this fail to acknowledge that (a) effective separation is almost certainly not within the control of the victim but holds her accountable for not achieving it (b) misplaces the responsibility for ending the abuse on the victim when it is the behaviour of the perpetrator that is the issue (c) misguidedly assumes that the abuse and relationship are synonymous when they are wholly separate entities in that ending one does not necessarily have any impact whatsoever on the other except to increase rather than decrease the risk of homicide (d) incorrectly assumes that if Daniel was non-resident and an ex-partner that Alexia and the children were safe despite documented evidence of his continuing contact with the children and (e) fails to acknowledge that the professional is merely mimicking the abuser's behaviour when issuing threats. Perhaps most importantly within this context, separation is the single greatest voluntary act that a victim can undertake that will most radically increase her risk of being murdered. There is no evidence outside of Probation of Alexia being offered any support to affect and maintain separation from a violent and controlling man. There is, however, ample evidence of Alexia being threatened with the removal of her children if she failed. A running thread throughout all of the health and social care IMRs is a total absence of concern for Alexia and the near invisibility of Daniel.

16.2.5 . Poor decision making in Children's Social Care

The chronology indicates that adequate weight was not always afforded to the history with this family in that incidents were treated in isolation rather than linked together. Whilst Brent CSC spoke to other agencies there was no coming together to have proper discussions. There was no real plan ever with the work for these families and this inevitably contributed to a loss of focus. There is also some poor decision making by managers with regard to stepping down from child protection conferences and closing the case for non-engagement rather than stepping it up. Failure to review instructions on what to do if the relationship resumed again is evident with each new referral. There are also technical issues with the system not linking children automatically. There was also a complete failure to get to grips with Daniel or to link his two families together. The lack of engagement with fathers is a recurrent theme in serious case reviews.

The lack of chronologies was also evident in health services.

16.2.6 Absence of the voice of the child.

The Munro review of child protection in England clearly states that child protection should focus on the child's experience and this can only be truly gained by working directly with the child. There is very little evidence of direct work with the three younger children in particular, a matter of some irony given that almost all interventions from health and CSC were supposed to be on their behalf. The records do not provide vivid descriptions, any real observations or any conversations with them. There was much better engagement with the older girls but they are by virtue of age more likely to be able to communicate readily with social workers. The focus of the work with Alexia appears to have hinged on deciding whether she was in a relationship with Daniel rather than what life looked like for their children. Had this been the focus then it is more likely a picture of neglect and chaotic home life would have emerged.

16.2.7. The invisible perpetrator

The engagement of fathers within the whole process is pivotal to the success of interventions. There needs to be equality all agencies actions/requirements that are set for parents and their ability to manage/access their children. There were sanctions towards Alexia and none for Daniel leaving him wholly unaccountable for his behaviour. There needs to be a balance of sanctions and support. The often needed, intervention of the threat to remove a child or children can increase the reluctance of a victim to report or be honest with agencies. It is important to ensure that this sanction is balanced with opportunities to report further abuse. It is important to consider how interventions such as non-contact or unsupervised contact with one parent can be implemented and to offer alternatives if appropriate.

16.2.8. Cross authority working

There was evidence of partnership processes being in place across Brent. However this case highlighted the issues associated with residents that move in and out of the borough. There is little cross borough information sharing and limited knowledge as to where individuals go should they move. Tracking of high risk cases should be improved, as should information sharing from temporary home boroughs to the main home borough.

16.2.9. Lack of common risk assessment

Common assessment tools and processes are available across partner organisations but these were used sporadically in this case. However some agencies did not have such tools while other agencies had to use their own risk tools. In addition, these tools may assess risk differently. Partnership tools, such as DASH, CAF, CRAMM and Bernardo's risk assessment tool, were all used in this case at various stages. However these tools all assess risk in

different ways and do not always transfer across to each other. Whilst it is recognised that all agencies must use their own professional framework it is felt that there should be one tool that is agreed upon with regard to definitive partnership risk score. At the time of this case there was not one agreed risk identification tool.

16.2.10. Restructuring / handover processes

There is a need for appropriate hand over processes when internal staffing changes take place. The same applies when considering organisational restructuring. The impact that these changes have on current case work as well as interactions and interfaces with other departments must be considered when such changes take place. All agencies should ensure that there are full and comprehensive notes made in each case. This should include contact with other agencies and the outcome of any correspondence or conversations. Any agreed actions between agencies must be fully documented.

16.2.11. MARAC

The MARAC (domestic violence multi-agency risk assessment conference) was in place at the time of this case. However no notes of the MARAC meetings or actions could be located. It did not prove possible, even from the combined chronologies, to identify any actions that could be attributed to the MARAC meetings. The absence of any safety planning is of concern.

The MARAC process has since been reviewed and improved in order to better deal with cases.

16.2.11. Assumptions

Throughout the health and social care reports, suspicions are recorded about Alexia on exceptionally flimsy evidence. There are references to suspicions of drug taking because she sometimes appeared dishevelled and once fell asleep during a CSC visit. This was at a time in her life when she had a young baby and Alexia's own explanation was that the baby was keeping her up at night. In addition despite it being established that Alexia was involved in shop-lifting, her ownership of designer clothes was attributed to possible prostitution. It is clear that some professionals disapproved of this 23 year old going out clubbing and having more than one sexual partner. Alexia is widely assumed to be lying about her relationship with Daniel although her narrative is absolutely consistent⁹ throughout and was later confirmed by friends during the criminal investigation. It may be that there was additional evidence that was not provided to this report author and it is possible that the above is merely an example of good professional curiosity. However, as it stands currently, there is an underlying sense of stereotyping and judgements that have left the report author wondering to what extent this acts as an explanation for Alexia's sporadic non-engagement.

17. Conclusions

17.1 In reaching these conclusions the author has focused on the following questions:

⁹ The sole inconsistency is when Alexia states shortly after child 2's birth that she has no intention of allowing Daniel to have contact. It is clear that their relationship did resume after that point and is probable that when she made the initial statement that she was indeed telling the truth and that they later reconciled.

- Have the agencies involved in the DHR used the opportunity to review their contacts with Alexia, her children and Daniel and to openly identify and address lessons learnt?
- Will the actions they take improve the safety of domestic abuse victims in Brent in the future?
- Was Alexia's death predictable?
- Could Alexia's homicide have been prevented?

17.2 The IMRs have been variable in quality. Some have been excellent but as is noted elsewhere in this report, several left much to be desired and in one instance, appears to have been lost.

17.3 It is possible that had this process been effectively executed, that additional lessons may have come to light.

17.4 A range of lessons have however been drawn out in individual IMRs which are set out in the attached action plan. Several new lessons have also been identified through this process. Provided those recommendations are fully and promptly implemented, they will improve the safety of victims of domestic abuse.

17.5 The author does not believe, on the basis of evidence seen, that Alexia's death was predictable.

17.6 It is more complex to address the issue of prevention. Certainly it was possible to engage Alexia in services a shown towards the end of her engagement with Probation and St Mungo's floating support service. Agencies that failed to engage therefore, need to examine their processes to see what more can be done. Had Daniel been effectively removed from the UK, he would clearly not have had the opportunity to kill Alexia. As such the question of preventability remains an open question.

18. Recommendations

18.1. National Recommendations

18.1.1. That the Home Office commission a review of the statutory guidance to include more detail about roles and responsibilities in the event of disputes between any combination of Panel Members, Chairs, report authors and the CSP. It is not uncommon for these to occur and the current guidance is ambiguous.

18.2 Individual Agency Recommendations

Brent CSP

That this report be considered and work undertaken to ensure that:

- The recommendations below have been implemented
- That there are no outstanding lessons to be learned from this DHR that remain unaddressed (including paragraph 16.1)

The single agency recommendations below are taken from the IMRs. Given the length of time that has passed, it is recognised that any of these may well have been achieved or superseded by other events.

Brent Housing

Create a post within the Housing Options Team to be the lead officer for Domestic Violence

Develop and implement an interim (paper) structured social risk assessment tool for midwives to utilise at the maternity booking assessment until such time as the electronic maternity patient record is implemented. This will serve to act as aide memoir to discuss key issues such as domestic abuse, and provide a vehicle for explicit recording of domestic abuse as a routine enquiry. If routine enquiry is not feasible at the first appointment because the woman is accompanied this will be recorded and the routine enquiry made at a subsequent appointment.

UKBA

The UK Border Agency should make immediate efforts to re-document immigrants as soon as they are encountered and keep detailed records of the progress.

The UK Border Agency must improve the timeliness of the processing of immigration applications, especially where vulnerable adults or children are concerned.

Other statutory agencies, whether responsible for victims or suspects should routinely and immediately contact the UK Border Agency to share information and intelligence. (This is already contained within the “Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children”).

NHS Brent: General Practice

Within GP protected learning sessions GPs, practice nurses and other clinicians working within the GP services should receive dedicated training sessions on:

- Domestic violence to include a DV Risk Assessment Matrix
- Information sharing

Challenge and support with other practitioners outside the Health economy

All documents pertaining to patients are scanned in to their records as appropriate. To check with audit after 6 months.

Domestic violence and child abuse should be a differential diagnosis during consultations

Ealing ICO Hospital Trust- Community Service Brent

The FHA Performa should be reviewed and harmonised for all Health Visitors working in the ICO. The Performa should be much more transparent and comprehensive to include a separate social history section.

Health visiting teams should have an appropriate guideline protocol for handover of cases during periods of leave particularly long term leave. Information should be clearly evident in case records and to other professionals. The clinical leads should discuss all cases with the health professionals within the team and allocate accordingly. This should include documented evidence on the key events sheet of a signed handover and the name of allocated Health Visitor in their absence. These cases should be individually reviewed with case records available at the point of handover

All Health visiting staff working in CSB must attend single agency child protection training level 3. In accordance with the intercollegiate document 2010 assuming competence at level 1+2 first.

Implement a Guideline for management of faxes received into Willesden Health visiting team. This needs to include documentation and actions on the new RIO system introduced July 2011

To work in line Harrow community services CSB should consider a specialist Health Visitor to caseload victims of current or historical domestic violence

Imperial College Health Care NHS Trust

Develop and implement an interim (paper) structured social risk assessment tool for midwives to utilise at the maternity booking assessment until such time as the electronic maternity patient record is implemented. This will serve to act as aide memoir to discuss key issues such as domestic abuse, and provide a vehicle for explicit recording of domestic abuse as a routine enquiry. If routine enquiry is not feasible at the first appointment because the woman is accompanied this will be recorded and the routine enquiry made at a subsequent appointment. Nb this is already incorporated into the design of the incipient maternity electronic patient record due for implementation in 2013.

North West London Hospital Trust

All documentation has to be entered onto the IT systems held by the trust

Metropolitan Police

Brent BOCU must ensure that when a victim wishes to withdraw an allegation of domestic violence, the case is reviewed by a Community Safety Unit (CSU) supervisor.

Brent BOCU must ensure that when officers attend a Domestic Incident, intelligence research is undertaken to include at least the last five years using the Integrated Information Platform, as required by the MPS Operating Procedures. Where possible officers should be encouraged to search beyond five years.

Brent BOCU must ensure that supervision and risk assessment during the secondary investigation of domestic violence is conducted by trained CSU supervisors. This is required by both the MPS Standard Operating Procedures (SOP) and by CAADA guidelines.

Brent BOCU must comply with the Domestic Violence SOP regarding the completion of Book 124D. The information and risk assessment must be transferred to the CRIS report.

Brent BOCU must ensure that Book 124Ds are supervised when they are completed and also when received by the Community Safety Unit (CSU.).

Brent BOCU must ensure that the supervision of Domestic Violence investigation is intrusive and contain well detailed action plans, and reviews of the risk. Risk assessment must be dynamic.

Brent BOCU must ensure that all response team officers are aware of the DASH risk assessment model, and that the information is correctly recorded on the relevant CRIS report.

Brent BOCU CSU must ensure that when a Book 124D is submitted incomplete, missing or of a poor standard, it is immediately referred back to the original supervisor.

Brent BOCU must ensure that when children come to notice in the process of a domestic violence investigation, a Merlin entry is completed (*vide Every Child Matters (ECM)*).

The MPS must ensure that all relevant officers and staff are trained in the use of the book 124D, with the DASH risk assessment model. Also, that supervisors are trained and encouraged to intrusively supervise risk assessments.

That the MPS update the CRIS system to reflect the new DASH model rather than the older SPECCS+ system.

That the MPS may consider changes to the Standard Operating Procedures for the investigation of the Domestic Violence so that initial standard risk assessments are subjected to secondary supervision by the BOCU CSU, to ensure that the risk level is correct.

London Probation

Re-launch of the London Probation Trust Safeguarding Procedures locally in Brent.

Local drive to increase home visiting in the borough

The introduction of reflective supervision for Probation Staff in Brent.

Brent Social Care

Social workers will attempt to engage fathers and or father figures in assessments. Framework I records will be created for fathers/father figures children subject of social work assessment.

A system to 'show all related people' is investigated for the ICS in Brent

All open cases will have an up to date chronology

MASH systems are implemented in Brent

IDVAs are co-located in Brent Social Care to assist social workers in their day to day assessment of domestic abuse referrals

A Children's IDVA is co-located in Brent Social Care to assist workers to engage children in assessments.

Brent Social Care considers developing and implementing a system to introduce more scrutiny to the management of repeat referrals.

Brent Social Care considers implementing a handover meeting for open cases or recently closed cases that transfer across locality services.

Brent Social Care audits cases to ensure that partners are suitably engaged in CIN and child protection work.

Brent Social Care robustly implements CIN planning and review systems
All decisions to proceed to ICPC are discussed with SCD5.