HARINGEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the homicide of Louise

December 2013

Independent Chair and Author of Report: Laura Croom

Associate Standing Together Against Domestic Violence

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1. INTRODUCTION

1.1 Details of the incident

1.1.1 In December 2013, at 4:59 one morning, the body of Louise was discovered by a member of the public face down, in a pool of blood at the foot of a tall block of flats. The Metropolitan Police Service (MPS) and London Ambulance Service attended and at 5:11, her life was pronounced extinct.

1.1.2 Enquiries revealed a history of domestic abuse of Louise by Damien who lived on the fourteenth floor in the block of flats. CCTV captured him walking past Louise's body and several witnesses reported having heard a disturbance.

1.1.3 The MPS forced entry into Damien's flat. They did not find Damien there, but found hand marks that indicated that Louise had either fallen or been pushed from the living room window.

1.1.4 Damien was circulated as 'Wanted' by the police and surrendered at 20:30 hours to Tottenham police where he was arrested, interviewed and bailed pending an investigation. Because of the way, Louise died, the police investigation took some time to find the evidence necessary to meet the threshold for charging Damien.

1.1.5 **Criminal trial outcome**: On 17 February 2015, Damien was charged with murder and subsequently convicted on 6 August 2015.

1.1.6 The Review Panel expresses its sympathy to the family and friends of Louise for their loss.

1.1.7 **Post mortem.** Haringey Mortuary conducted a Special Post Mortem. The cause of death was found to be multiple injuries, consistent with a fall from a height of fourteen storeys. The pathologist was not able to exclude the possibility that some of the injuries were caused by other means.

1.1.8 The blood screening tests on Louise were positive for cocaine and cannabinoids and the pathologist concluded that she was likely to have been experiencing the effects of the cocaine when she died.

1.2 The review

1.2.1 This Domestic Homicide Review (DHR) was commissioned by Haringey Community Safety Partnership (CSP) in accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004 and in compliance with that section has regard to the Revised Statutory Guidance for the conduct of Domestic Homicide Reviews published by the Home Office (HO) in March 2013. The draft report of this review was completed by the time that the December 2016 Guidance was published. Some changes in response to that Guidance have been made: the removal of the Preventability section and a fuller Review Panel list.

1.2.2 The MPS notified Haringey CSP that the case should be considered for a DHR. Haringey CSP determined to conduct a DHR and notified the HO and commissioned Standing Together Against Domestic Violence (Standing Together) in June 2015 to provide a chair for this process. There have been several changes of Strategic Lead since these steps were taken and the dates on which these processes were started are not known to the current Lead.

1.2.3 The purpose of this review is to:

a) 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.

b) 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.

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

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

1.2.4 The review process does not take the place of the criminal or coroners' court nor does it take the place of any disciplinary process within any of the agencies involved.

1.2.5 The first panel meeting was held on 13 July 2015. Subsequent meetings were held on 20 October, 2 November, 14 January 2016, 27 April, 6 July, and 20 December. The draft report was reviewed at a meeting on 20 December 2016.

1.2.6 The Executive Summary and Overview Report were presented to the Haringey CSP on 22 September 2017. They were submitted to the Home Office (HO) on 2nd February 2018. The HO provided notification and approval for publication on the 26th July 2018.

1.2.7 The final report was distributed to the following before publication:

a) The Review Panel
b) Standing Together DHR Team
c) Haringey Safety Partnership

1.2.8 Once published, the final report will be shared with the governance boards and committees of participating statutory and voluntary agencies.

1.2.9 **Delays/Difficulties in obtaining information for this review.** HO guidance states that the review should be completed within six months of the initial decision to establish one. There were a number of delays to this review.

a) Because of the way Louise died, the police investigation took some time to find sufficient evidence to prove that Louise was murdered and therefore that the death should be the subject of a DHR.
b) The information from the MPS and the Hertfordshire Constabulary was extensive and therefore additional time was agreed for the police services to compile and analyse their information. Then there were several panel meetings in close succession to review all the information gathered.
c) There were a number of delays in gaining the GP report for Damien and the GP, a sole practitioner, retired in the course of this. The Review Panel was particularly interested in the GP report as Damien had used sickness notes to excuse himself from a number of interventions intended to help him address his offending and substance misuse. The Haringey CCG and National Health Service (NHS) England became involved to assist. At the time of writing, our understanding of the GP's involvement is limited to a chronology that he prepared before he retired.
d) There were also delays in gaining information from Louise's employers. Louise was employed by Haringey Council but worked at several sites occupied by the Haringey Pupil Referral Unit (PRU) and Louise was managed on site. Both Haringey Council's Human Resources department and the PRU (at the Octagon, one of the sites) felt that the other needed to provide more information. The management of the Octagon has changed several times since Louise's death and the Review Panel has resigned itself to working without more information from Louise's managers on

site. Our information from Haringey Council is limited to disciplinary actions undertaken against Louise.

e) To gather a better understanding of Louise's situation at work, the Haringey Strategic Lead for Violence against Women and Girls (VAWG) interviewed several staff members who had worked with Louise during her time as a cleaner at the different PRU sites. Information gathered during that interview is synopsised below.

f) As there were so many agencies involved, the writing of this report took more time than expected as the author sought to reconcile reports and to understand, as far as is possible, what Louise's view of her situation was.

g) Finally, there were delays associated with giving Louise's family time to read and respond to the report.

1.2.10 **Confidentiality.** The pseudonyms used in this report were agreed with Louise's daughter to protect the identity of the individuals involved.

1.3 Terms of Reference

1.3.1 The full terms of reference are included in **Appendix 1**. The draft of this report was written before the refreshed 2016 HO Guidance was implemented and therefore was written under the guidance published in 2013.

1.3.2 The review looked at the involvement of statutory and voluntary agencies with Louise, Damien and Jade during the period of 10 February 2005 to the date of her homicide. This time frame was agreed by the Review Panel to be appropriate as there was an incident on 10 February 2005 when the perpetrator abused a previous partner in such a way that it should have informed subsequent contacts and assessments of Damien.

1.3.3 The terms of reference included any engagement with Jade, Louise's daughter, as Jade was a young person when Damien came to her notice as a friend of her mother's. Also, Jade provided support to Louise, was a victim of Damien's abuse and was a witness to some of the incidents.

1.3.4 Agencies were asked to summarise their involvement before 10 February 2005, which they did and this information was compiled into a combined chronology.

1.3.5 The Review Panel was comprised mainly of agencies from or which operate in Haringey as Damien lived in that area at the time of the homicide and it was the location of the homicide. Louise also lived and stayed at various places in London. Louise had an address in Hertfordshire and Jade lived in Hertfordshire, so the CSP in Hertfordshire

was contacted and provided the Review Panel members and contact details for agencies in Hertfordshire that had had contact (see the list of Review Panel members and Individual Management Reviews (IMR) below).

1.3.6 During the CSP scoping exercise prior to the first panel meeting and in the course of this DHR, additional agencies were contacted and asked to search their records for contact with Louise, Jade and/or Damien. Louise stayed at the homes of friends and family, as well as having two addresses herself in the timeframe of this review, so there were a number of addresses to search for. The agencies that reported having no contact were:

1.3.7 London Borough of Haringey

a) Hearthstone – domestic abuse service in Haringey
b) Whittington Hospital
c) London Fire Brigade

1.3.8 Hertfordshire County Council

a) National Probation Service, Hertfordshire
b) BeNCH Community Rehabilitation Service
c) Hertfordshore Community NHS Trust (HV and school nurses)
d) Hertfordshire County Council
e) Hertfordshire Partnership University NHS Foundation Trust
f) Hertfordshire County Council's Children's Services
g) Safer Places -- Hertfordshire specialist Domestic Violence services
h) East of England Ambulance Service – some contact reviewed by chair but found to be not relevant to this enquiry
i) Hertfordshire Victim Support

1.3.9 At the first and at subsequent panel meetings, there were discussions of whether the new information provided suggested that we should involve additional agencies or processes. We invited Her Majesty's Prison Service (HMPS), the Crown Prosecution Services (CPS), Multi-Agency Public Protection Arrangements (MAPPA) and the Haringey Integrated Offender Management (IOM) processes to provide information in the course of the review. In light of information gained, the chair asked several services to re-check their files.

1.3.10 In the end, the Review Panel reviewed information from 24 sources: IMRs, interviews, meeting notes, and notes of the internal review.

1.4 Parallel and related processes

1.4.1 **Inquest.** An inquest into Louise's death was opened by the coroner in December 2013 at the North London Coroners Court and adjourned. The case was concluded upon Damien's conviction for murder.

1.4.2 **Criminal prosecution.** Damien pleaded not guilty to a charge of murder and was found guilty and sentenced to life imprisonment with a minimum tariff of 17 years on 6 August 2015. The MPS supplied Review Panel members with a list of proposed witnesses so that IMR writers would not contact anyone on the list until the trial had concluded.

1.4.3 **Internal review in Haringey**. Haringey Council swiftly undertook an internal review to consider the Council's involvement with Damien. This review concluded and reported in February 2014, several months after Louise's death. This is synopsised in the Analysis. The action plan was last compiled in July 2015 with some actions still outstanding. This appears in **Appendix 6**. The Chair of this Review and the Chair of the Internal Review had an email exchange to ensure that this review had all the information gained from the internal review.

1.4.4 The chair and Review Panel discussed the internal review at the first meeting and the VAWG Strategic Lead in Haringey circulated the resulting action plan to Review Panel members. The agencies that were involved in the internal review were also on the Review Panel:

(a) Haringey Anti-Social Behaviour Team (ASBAT);

(b) Homes for Haringey;

(c) Drug and Alcohol Action Team – including commissioned services: Haringey Advisory Group on Alcohol (HAGA), Drug Advisory Service Haringey (DASH) and Westminster Drugs Project (WDP);

(d) Offender Management Unit – London Probation Trust at the time, MPS, Community Safety Team, Drug and Alcohol Action Team (DAAT), Gang Exit Unit (not included here as not relevant in this case), and

(e) Haringey Human Resources as Louise was an employee of the Council when she died.

1.4.5 **National Offender Management Service.** The London Community Rehabilitation Company (LCRC) provided a serious further offence review for the National Offender Management Service after Louise's murder. This was requested for this review. The LCRC reported that this was not a publishable document and therefore could not be shared with this review. However, they also reported that the lessons from that review

focussed on individual practice and are redundant in light of the re-organisation of probation services that have since occurred.

1.5 Review Panel membership

1.5.1 The Review Panel included members from Haringey (as Damien lived there and Louise did from time to time), Hertfordshire (as Louise and Jade lived there), and Enfield (as Louise previously lived there), as well as from broader areas where an agency has a wider geographic base. The chair was grateful for their contributions and support. The panel members changed over the course of the review and the list of all those who served on the panel is in **Appendix 7**.

Name	Agency	Job Title
For Haringey		
Colin Chapman	Barnet, Enfield, and Haringey Mental Health Trust	Service Manager
Jon Abbey	Children and Young Person Services (CYPS)	Director of Children's Services
Elizabeth Balgobin	Haringey Advisory Group on Alcohol/RISE (HAGA)	Interim Chief Executive
Hazel Ashworth	Haringey Clinical Commissioning Group (CCG)	Safeguarding Adult Lead
Jeni Plumber	Haringey Council	Adult Services
Fiona Dwyer	Haringey Council	Violence Against Women and Girls (VAWG) Strategic Lead
Eubert Malcolm	Haringey Council	Head of Community Safety and Regulatory Affairs
Tricia Howarth	Haringey Council	Senior HR Business Partner
Stephen McDonnell	Haringey Council	Integrated Offender Management, Anti Social Behaviour Team
Nick Smith	Haringey Council	Housing Commissioning Lead
Claire Drummond	Haringey Council	Housing Related Support

Sarah Hart	Haringey Council	Public Health
Chinyere Ugwu	Homes for Haringey	Community and Customer Relations Director
Mary Mason	Solace Women's Aid	Chief Executive Officer
Karen Ingala Smith	Nia	Chief Executive Officer
Nicole Booty	North Middlesex University Hospital NHS Trust	Safeguarding Lead
For Hertfordshire		
Tracy Pemberton	Hertfordshire Constabulary	Detective Chief Inspector Safeguarding, Partnerships & Policy
Tracey Cooper	Hertfordshire Clinical Commissioning Group (CCG)	Safeguarding Adult Assistant Director
Annelise Hillyer-Thake	NHS England Central Midlands	Head of Safeguarding
Sharon Erdman	Refuge	Senior Operations Manager
For London-wide services		
Cassie Newman	London Community Rehabilitation Company (LCRC)	Head of Strategic Partnerships
Pam Chisholm	Metropolitan Police Service (MPS)	Review Officer, Critical Incident Advisory Team
Neil Dean	Metropolitan Police Service (MPS)	Case Officer, Murder Investigation Team
Ian Watson	Metropolitan Police Service (MPS)	DI
Angela Middleton	NHS England	DHR London Lead Patient Safety Lead, Mental Health
Caroline Birkett	Victim Support	Area Manager
For national services		
Andrew Blight	National Probation Service (NPS)	Assistant Chief Officer

Barbara White	HM Prison Service	Operations Manager – London & Thames Valley
Malcolm McHaffie	Crown Prosecution Service (CPS)	Deputy Chief Crown Prosecutor
For Enfield		
Shan Kilby	London Borough Enfield	DV Coordinator

1.5.2 The agency representatives were appropriate in their level and expertise. There were a number of staff changes in the course of the review, with managers keeping a watching brief to support new staff members on the panel. In the interests of confidentiality and with agreement, the chair and the VAWG Strategic Lead reduced the circulation list for this DHR several times.

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

1.6 Independent Chair of the Review

1.6.1 The Independent Chair of the Review is Laura Croom, an associate of Standing Together, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnership.

1.6.2 Laura Croom is an independent consultant in the field of violence against women and girls. She completed the HO accredited training for DHR chairs and has worked in domestic abuse for 12 years. She is an experienced DHR chair.

1.6.3 Laura Croom was commissioned to scope the domestic abuse provision in Haringey statutory services in early 2014, and she supported Solace Women's Aid's IDVA service through the early stages of Leading Lights accreditation in 2009 – 2010. She has no other connection with Haringey Council or any of the agencies involved in this case.

1.7 Methodology

1.7.1 The review sought information initially from the agencies represented on the Review Panel and from the GP practices attended by Louise, Damien and Jade. Damien had a great deal of contact with criminal justice agencies and he was discussed at a number of multi-agency meetings so the chair sought information about those meetings and the decisions taken there.

1.7.2 IMRs were provided by these services in Haringey:

a) Metropolitan Police Service (MPS)
b) Haringey Council – Human Relations department
c) Homes for Haringey
d) Haringey Advisory Group on Alcohol (HAGA)/RISE
e) Solace Women's Aid
f) Victim Support Service, London
g) Haringey Anti-Social Behaviour (ASB) Team
h) London Community Rehabilitation Company (LCRC)
i) London Ambulance Service (LAS)
j) North Middlesex University Hospital (NMUH) Trust
k) The Grove
l) Multi-Agency Public Protection Arrangements (MAPPA)
m) Haringey Integrated Offender Management (IOM)
n) GP for Damien

1.7.3 IMRs were provided by these services in Hertfordshire:

a) Hertfordshire GP for Louise
b) Hertfordshire Victim Support
c) Hertfordshire Constabulary

1.7.4 IMRs were provided by these national services:

a) Crown Prosecution Service (CPS)
b) Her Majesty's Prison Service (HMPS)

1.7.5 Information was also provided by:

a) Enfield Multi-Agency Risk Assessment Conference (MARAC)

1.7.6 The agencies contacted that had no relevant contact with Louise, Damien or Jade were:

a) Nia, a domestic abuse service
b) Whittington Hospital
c) East and North Hertfordshire NHS Trust
d) East of England Ambulance Service
e) Hertfordshire Probation Service
f) BeNCH Community Rehabilitation Company (CRC)
g) Hertfordshire Community NHS Trust
h) Hertfordshire County Council
i) Hertfordshire Partnership University

j) Hertfordshire County Council Children's Services
k) Hertfordshire Specialist Domestic Violence Service

1.7.7 The PRU, where Louise worked, is an academy and reported that they had provided the information they had to Haringey Council when Louise died.

1.7.8 The quality of most IMRs was high. The chair asked several services for more information. This was particularly the case with Hertfordshire Constabulary as the Review Panel member from that organisation changed 4 times in the course of this review.

1.7.9 The agencies made recommendations of their own. Many actions were completed in the course of this review.

1.7.10 Additional information:

a) The chair asked for a report on Hertfordshire's response to domestic abuse provided by SafeLives in June 2015, which was provided.
b) The chair asked for information about the change in drug and alcohol services in Haringey.

1.8 Approach to this review

1.8.1 The perpetrator in this case was well known to the criminal justice services. As a result, the IMRs and chronologies from agencies, the police in particular, were extensive. In order to keep this report to a readable length, some information has been summarised to ensure that areas identified for agency learning stand out. The chronology provides more detail.

1.8.2 The other difficulty that this amount of material presented was fitting it into the template provided by the HO that separates the facts from the analysis. With so much information, the separation of the facts and analysis led to repetition that created confusion in the initial draft of this.

1.8.3 Standing Together consulted the HO for advice and the HO recommended that clarity should take precedence over adherence to the template suggested in the Guidance.

1.8.4 Commentary and updates on agency responses are found in the Facts and Agency Commentary section for that agency and are clearly identified. The themes from the commentaries are then brought together in the Analysis and Lessons Learned section of the report.

1.8.5 We have also combined the information from MPS and Hertfordshire Constabulary in a chronological account of the events with police services. This helps the reader understand Louise's experience of the relentlessness of Damien's offending and abuse. It also provides a framework for understanding the engagement of other services and Damien's and Louise's responses. The police force involved is clearly identified in each incident.

1.8.6 Damien was a danger to women in general, but was particularly abusive towards current and previous partners. To demonstrate this, women with whom Damien had had a relationship are noted with a prefix of P (for partner) and then a number. Other women with whom he did not have a relationship but was abusive or threatening towards are noted with an F (for female) prefix.

1.8.7 The Review Panel considered a significant quantity of material relating to reports about and allegations made against Damien as well as claims made by him. The Review Panel noted that many of these matters have not been tested by the courts for reasons that are often not clear. However, the role of the Review Panel was to review the actions of agencies against what they knew at the time and make recommendations to improve responses where appropriate. The Review Panel was satisfied that the information it reviewed was provided in good faith and concluded that, taken together, the material presented an overwhelming picture of relentless abusive and controlling behaviour towards women by Damien.

1.9 Contact with family and friends

1.9.1 The MPS Family Liaison Officer provided information about the DHR process to Jade, the daughter and only child of Louise, and she agreed to speak to the chair. The chair and a Standing Together Administrator attended Jade's home and interviewed her on 14 March 2016.

1.9.2 Jade reported that the family has broken up as a result of Louise's death and that she no longer sees many of them. It was decided that interviewing other members of Louise's wider family might exacerbate the ill feeling. Such divisions often occur where families feel strongly yet differently about how best to engage when a family member is the victim of domestic abuse. Louise's father who was a great support to both Louise and Jade died a year and a half after Louise.

1.9.3 When the draft report was completed, a copy of the report was sent to Jade who shared it with her cousin, Nicky. The Chair and DHR manager of Standing Together attended to gather their feedback. Jade and Nicky had read about a quarter of the report.

Corrections were made where required. Where they questioned the information presented in the report, the information was double-checked with the relevant agencies. At this time, however, Jade and her cousin feel that this is all too late. They feel that everyone failed Louise and reading the account of this upsets and angers them.

1.9.4 Haringey's VAWG Strategic Lead met Louise's co-workers on 22 September 2016 and provided the chair with a transcript of that meeting. The information gained at that meeting is included below.

1.10 Contact with the perpetrator

1.10.1 The chair, in consultation with Haringey's Acting VAWG Strategic Lead, decided not to incur the cost and delay of trying to talk to Damien. This decision was based on the information provided by agencies that showed that Damien had shown no insight into his own behaviour and made no attempt to seek help or change. He had consistently confounded efforts to address his criminal behaviour and his substance misuse. As a result, it was felt that an interview with him would not advance Haringey's understanding. The Review Panel endorsed this view at the fifth panel meeting.

1.10.2 As the VAWG Strategic Lead in Haringey changed in the course of this DHR, the chair asked the new lead if she wanted the Review Panel to re-visit that decision. She agreed with the decision that had been taken previously and no contact was attempted with the perpetrator.

1.11 Equalities

1.11.1 Damien was a heterosexual black male who was 43 at the time of Louise's death. Louise was a 43-year-old heterosexual white woman. They were not married. The protected characteristics of disability, gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was disabled, nor was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs as far as we can tell from the records and Louise was not pregnant. The responses of agencies to them do not appear to be motivated or aggravated by their race, age, or marital or civil partnership status.

1.11.2 The protected characteristic that does appear to have influenced events was the gender of the victim in that domestic abuse is a gendered crime with the overwhelming majority

of victims being female and the perpetrators being overwhelmingly male.[1] The impact of Louise's gender on the response she received from agencies is explored in the Analysis.

[1] (1) '89% of those who had experienced 4 or more incidence of domestic abuse were women.' Walby, S and Allen, J, *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*, 2004.
(2) 'The intensity and severity of violence used by men is more extreme, men being more likely to use physical violence, threats, and harassment. From Hester, M *Who Does What to Whom: Gender and Domestic Violence Perpetrators*, 2009.
(3) Sharp-Jeffs, Nicola, and Kelly, Liz, 'Domestic Homicide Review (DHR) Case Analysis', (June 2016),p.11.The report can be found at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf. This shows a similar disproportionate experience of women (92% of victims in the DHRs it has chaired) as victims of domestic abuse.

2. FACTS AND AGENCY COMMENTARY

2.1 Louise's homicide

2.1.1 In December 2013, at 4:59 one morning, the body of Louise was discovered by a member of the public face down, in a pool of blood at the rear of a large block of flats. MPS and LAS attended and at 5:11, life was pronounced extinct.

2.1.2 Because enquiries revealed a history of domestic abuse of Louise by Damien who lived in the block of flats on the fourteenth floor, the MPS forced entry into Damien's flat. They did not find Damien there and found no evidence of a struggle, but found hand marks that indicated that Louise had either fallen or been pushed from the living room window.

2.1.3 CCTV captured Damien getting into a lift, clearly agitated, soon after the call from a member of the public. He looked towards Louise's body and then left the scene. Several witnesses reported having heard a disturbance. They heard a female voice shouting 'let me go', 'stop, and stop, stop!' and 'get off me, get off me'. They reported sounds that suggested that force was being used against Louise and the sound of 'dragging'.

2.1.4 Damien was circulated as 'Wanted' by the police and surrendered at 20:30 hours the same day as the murder to Tottenham Police where he was arrested, interviewed and bailed pending an investigation. On arrest, Damien provided a prepared statement denying pushing Louise out of a window or murdering her.

2.1.5 The post mortem found that the cause of death was multiple injuries, consistent with a fall from a height of fourteen storeys. The pathologist was not able to exclude the possibility that some of the injuries were caused by other means.

2.2 Damien's sentencing

2.2.1 Because of the way, Louise died, the police investigation took some time to find the evidence necessary to meet the threshold for charging Damien. On 17 February 2015, Damien was charged with murder and subsequently convicted and sentenced on 6 August 2015 to life imprisonment with a minimum of 17 years.

2.3 Information about Louise

2.3.1 Louise was a white British female who was 43 years old when she died. She appears to have stayed at different addresses. She had a flat in Enfield but sometimes stayed with her mother at another address in Haringey, London, sometimes in Hertfordshire at her sister's house, or her daughter's flat and, at other times, it appears, with Damien. Louise also visited her father who lived in Haringey.

2.3.2 Louise was employed by Haringey Council from 23 July 2001 until her death. She was a cleaner at several sites occupied by the Pupil Referral Unit (PRU) in Haringey and was suspended at the time of her death.

2.4 Information about Damien

2.4.1 Damien is a black British male who was 43 years old at the time of Louise's murder. Damien was unemployed and lived in Haringey. He was a tenant of Homes for Haringey.

2.4.2 Damien was well known to the criminal justice services. He was convicted on 32 occasions before Louise's death for 47 crimes.

2.4.3 During the time period under review, Damien was in prison on ten separate occasions, including times on remand, and served between one day and two years during these periods of incarceration. He was the subject of MAPPA. He was a habitual user of cocaine and cannabis. The evidence of Damien's bad character requested by the chair from the MPS for this review ran to four pages. His criminal activities ran across five London boroughs and Hertfordshire. The MPS and Hertfordshire Constabulary both contributed IMRs for this review.

2.4.4 The Review Panel discussed briefly whether Damien had mental health problems. None of the agencies or services involved in the review had information about a mental health assessment or diagnosis and such problems were not identified by his GP.

2.4.5 This report will focus on what was known about Damien's violent and controlling behaviour before and during his relationship with Louise.

2.5 Information about the relationship between Louise and Damien

2.5.1 There is little that is clear about the relationship between Louise and Damien. Her family and others report that the two had known each other since school. Louise referred to

their '27-year friendship' when talking to the police. Her colleagues understood that they had been in an intimate relationship on-and-off for some time.

2.5.2 In the reports of the police call-outs, even Damien and Louise differ in their characterisation of their relationship. Sometimes they refer to themselves as friends, sometimes as partners, sometimes as ex-partners. It is possible to conclude that they lived together off and on from the concierge reports of their relationship and of storing Louise's clothes on several occasions when Damien threw them out of his flat.

2.5.3 Damien suggested that he and Louise had some sort of business relationship as well, as he talked about money that Louise owed him for looking after his 'business' when he was in prison. The review revealed no form evidence of this however.

2.6 Information about Louise from her daughter

2.6.1 Louise had a daughter, Jade, who was 23 at the time Louise died. She agreed to meet the Chair of this Review and a member of Standing Together staff at her home.

2.6.2 Louise was one of 8 siblings, 7 of whom were living at the time of her death, as were both her parents.

2.6.3 Jade was living with both her parents in 2008, when she was 17. She later moved out and lived separately in Hertfordshire.

2.6.4 Jade described her mother as a lover of life and a free spirit. She said that Louise was a vibrant and happy woman. She described her mother as a forthright person who would 'name the elephant in the room'.

2.6.5 Jade said that Damien and Louise knew each other from their school days. Jade became aware that her mother was spending time with Damien in 2007.

2.6.6 Louise and Jade's father separated in 2006, but continued to share their house in Hertfordshire while Jade was living at home. Damien did not like this and in 2008 he came to the house a number of times (this is the occasion in February 2008, noted in the MPS facts section, par 2.8.70). Jade's father calmly explained the situation to him, but Damien eventually forced his way into the house. Jade awoke to find her father and Damien fighting. She was 17 at the time. Jade thought that Damien was trying to kill them. She locked her mother in a cupboard and tried to help her father until the police arrived. Jade reports that this is when the family realised that Damien was dangerous, violent, obsessed and unwell.

2.6.7 Jade says that the police arrived and took Damien away and that he went to court but was released. She and her family did not know what happened with that case and found

out from their neighbours in Haringey that Damien had been freed. Jade felt that the family lost faith in 'the system' after this.

2.6.8 Jade suffered a panic attack later that night. She said that there was no follow-up with her by any agencies after the event; there was no welfare check or safeguarding contact.

2.6.9 Changes in Louise's life as a result of Damien's presence. Jade described Louise's and Damien's association as more like ownership than a relationship. She said that Damien was obsessed with Louise, that he took her wages for drugs and used to march her to a cash machine when her wages were paid. He called her constantly. Jade did not know of any pleasurable times that her mother had with Damien.

2.6.10 Jade said that Damien followed Louise home from work and sometimes jumped out at her when she went to work early. The family often accompanied her to work because of this. Damien threatened to burn her building down.

2.6.11 Jade realised that her mother was being hurt physically by Damien but did not realise the extent of it until Louise lived with her for a period in 2009. Jade saw Louise's bruises then. Jade said that there were lots of injuries over time.

2.6.12 Jade said that her mother was terrified of Damien because he knew too much about her and her family, where they lived. Jade says that her mother felt trapped and that she could not get away.

2.6.13 Louise had a few close friends but Jade does not think that her mother talked to them because her mother felt ashamed.

2.6.14 Response of the services to Louise. Jade said that her mother received letters from Victim Support (VS) and others. (VS London notes that it is not standard practice for VS to send letters to victims of domestic abuse). She said her mother was told to ring the domestic violence helpline but that was no good as she needed pro-active help. The only time she could safely talk was when she was at work.

2.6.15 Jade reported that she accompanied her mother to the Emergency Department (ED) at North Middlesex University Hospital (NMUH) (this aligns with the entry for 20 April 2010 in the review from NMUH). Her mother was asked about her injuries, which included a dislocated shoulder, and Louise was truthful with the staff. She was given a leaflet on domestic abuse.

2.6.16 Jade said that staff at the school where Louise worked had encountered Damien and knew how dangerous he was. But Louise worked at night, so did not have much contact with people when at work. Louise's manager at the school understood what was

happening and was very helpful, suggesting that Louise could sleep at the school if she felt safer there. The manager understood why Louise's father came to school to meet her and walk her home. But she also noted that when Louise died she had been suspended from work 'because of Damien'.

2.6.17 Jade thought that the school had got a restraining order[2] against Damien but felt that it had made no difference.

2.6.18 Jade said that her mother had been evicted as a result of Damien continually breaking in to her place. Jade confirmed that this was a private rental.

2.6.19 Jade reported that at one point her mother thought about moving abroad to live near relatives. Louise told her that she was moving her things slowly from Damien's flat to the concierge in the building as part of a plan to get away.

2.6.20 It is worth noting here that MPS reported that concierge staff told them that Louise had left clothing with them on 3 occasions but staff described those situations as being when Damien 'threw Louise out' following arguments.

2.6.21 Louise talked to Jade about going to a refuge but didn't know how to find one. For a period of time she slept in her car in petrol station forecourts as there was CCTV, light and a person for security and as an eyewitness if Damien found her. Jade said it was a sad existence, that her mother never felt safe.

2.6.22 Jade said that her mother did not think anything could be done to stop Damien because the few times she asked for help, it made no difference. Jade said that her mother eventually did not want to call the police, as she did not expect they could help her. She said that the police took statements but did not reach out to her mother.

2.6.23 Jade said that her mother gave up in 2010 and stopped even ringing Jade for help, forcing Jade to ring her. Jade reflected that she did not think that her mother shared everything with her, that Louise tried to protect Jade from the worst of her situation. She said that her mother would not go to her family for protection because it would have put them at risk.

2.6.24 Jade said that what her mother needed was a person, physical contact with someone. A leaflet or a letter was not enough. She knows that her mother was brave enough to leave Damien but she had nowhere to go.

[2] We have been unable to track down the details of this order. It may be that Jade is referring to the restraining order issued at Highbury Magistrates Court on 25 February 2012 that prohibited Damien from contacting directly or indirectly, Louise and from attending her address or place of work, as a result of an incident at the school on 15 December 2011. Or it may align with Louise's colleagues similar account of a 'barring order'.

2.6.25 **Commentary.** *Reaching out to clients who find it difficult to engage with support services.* There is a recommendation addressing this.

2.6.26 Response of services to Damien. Jade repeatedly said that she and her family felt that Damien got away with everything, that there were no consequences for him of his actions. Jade said that she made a complaint to the police when Damien came to her house but 'nothing happened'. Jade knew that Damien breached his tenancy agreement by growing cannabis and sub-letting, but there were no consequences for him. It appeared to the family that Damien walked away from everything and that nothing came from reporting incidents.

2.6.27 Jade felt that Damien manipulated the system, that the system does not work. Damien seemed to be able to run away from the police and get away with everything.

2.6.28 What Jade wants from this review: Jade said that it was too late for her mother now, but that she did not want her mother's life to be lost in vain. She was angry that her mother did not have protection and security. She wanted to know about the role of the police in this situation. She felt that there must be a reason that Damien did not suffer the consequences of his actions.

2.6.29 Further to this, Jade is concerned that she will not be notified of Damien's release from prison. He still has links to Hertfordshire and Jade does not want herself or her family to meet him unexpectedly.

2.6.30 Jade did note that since her mother died, VS, the police Murder Squad and the Family Liaison Officer have been very supportive and have helped her move and offered her counselling. But she does not feel that her mother and her family were protected from Damien during her mother's lifetime.

2.6.31 Further information from Jade on reading the draft: Damien used a fictional story about money owed to him by Louise as an explanation for his harassment.

2.7 Information about Louise and Damien from Louise's work colleagues

2.7.1 On 22 September 2016, the Haringey VAWG Strategic Lead (Strategic Lead) met two of Louise's colleagues. The chair expected that interviews with Louise's work colleagues would take place as part of an IMR from the Pupil Referral Unit (PRU)[3] or an

[3] A Pupil Referral Unit is an establishment in some local authority areas that is specifically organized to provide education for children who are excluded, sick, or otherwise unable to attend a mainstream school, in order to fulfill the responsibility to provide suitable education for children of compulsory school age who cannot attend school *S. 19 of the Education Act 1996).

IMR from Haringey Council's HR department. As these interviews, had not taken place by the summer of 2016, the chair and the Strategic Lead agreed that these interviews should take place independent of those reports.

2.7.2 The Strategic Lead who interviewed Louise's colleagues had not been in post when Louise worked for the Council and had had no other contact with the agencies involved. The chair provided a list of questions to inform the Strategic Lead's interview.

2.7.3 The Strategic Lead provided a transcript of the interview for the chair. This is a summary of the information gained at that meeting. It is worth noting that the colleagues were recalling incidents and events from almost three years before and that we were trying to gain an understanding of Louise's work life rather than pin down details through this interview.

2.7.4 The Strategic Lead met with Jack and Clarissa. She explained why she wished to speak to them, the purpose of a DHR, and that their contribution would be anonymised.

2.7.5 Both Jack and Clarissa said they had known Louise since she started working as a cleaner for the PRU, since about 2001.

2.7.6 They explained that the school at the time was on several sites.[4] Her colleagues report that Louise worked at Victoria Oaks (a secondary school), Cherry Wood (also a secondary school, now amalgamated with the Victoria Oaks site), Morris House (the medical needs PRU with a tuition centre) in Victoria Oaks, and Blue Lanes (the primary school which relocated to a Primary School in 2005 – Louise did not make the move to this new site). These sites were covered by 3 working contracts. Her colleagues believe that Louise also worked at the Victoria Oaks Youth Centre until about 2007, probably as part of a separate contract.

2.7.7 There have been several changes of senior staff at the Octagon while Louise was there and since she died. The head teacher left in March 2012 and was replaced by an interim head until a new head came into post in November 2013. Louise was already suspended when the new head came into post and Louise died in December 2013.

2.7.8 **Louise's work**. Jack and Clarissa said that Louise worked across all four sites. Jack was the manager at the Victoria Oak site. He saw Louise every day, though he did not line-manage her. He also worked alongside her at Cherry Wood for a period. At Cherry Wood, it was often just Jack, Louise and Louise's dad.

[4] All anonymised for publication.

2.7.9 Jack and Clarissa said that Louise was a permanent staff member, not a part-time cleaner or on contract.

2.7.10 Jack and Clarissa thought that Louise had 20 hours of cleaning at Victoria Oaks every week and 20 hours elsewhere. Louise usually worked at Victoria Oaks in the mornings and Cherry Wood after the school had closed for the day, sometimes at 2 or 3 in the morning.

2.7.11 Louise's father helped her in her work. He often came with her to work and did half her hours. If she were contracted for 20 hours at Victoria Oaks, she would do 10 and her father would do the other 10. He would even do the middle of the night sessions with her.

2.7.12 The head teacher knew that Louise's father helped her, but a blind eye was turned.

2.7.13 When Victoria Oaks was closed for refurbishment, Louise had to do all her hours at Cherry Wood. Louise had out-of-hours access there.

2.7.14 Louise occasionally stayed at the Cherry Wood site overnight. They said that she used the site as a sort of refuge when there were incidents between her and Damien. They said that the site was quite isolated and backed onto playing fields.

2.7.15 When Victoria Oaks re-opened, Louise was not given out-of-hours access to that building as before and had to work when everyone else was on-site.

2.7.16 After Louise's father got ill, Louise's life got more difficult. Clarissa recalls that Louise's father was around 86 at the time

2.7.17 Louise then became unreliable at work. She would show up one day, but not the next. She would come to work in the middle of the night.

2.7.18 They said that on several occasions she came to work clearly under the influence of cannabis. She said that she'd been smoking in the car with her friend (unnamed).

2.7.19 Jack said that he'd found Louise's drugs once. Louise was sent home on several occasions because she smelled of weed and the school was a PRU.

2.7.20 They also report that when she was working in the school over the summer of 2013, she made many calls one night. The other workers could see the switchboard light up. Clarissa said that Louise spent an hour and a half making over 100 calls that night, mostly to the same number, but the other person did not answer.

2.7.21 Jack and Clarissa said that when they reviewed the CCTV to figure out what Louise was doing at work, they could see her father doing the cleaning and Louise would be in one

of the rooms without CCTV. If they then found her to ask what she was doing, she would be on her phone and would dismiss the question and say she was just 'doing something'.

2.7.22 The staff were concerned about Louise's father doing this work, considering his age, and suggested he sit down occasionally, but he would not.

2.7.23 Neither Jack nor Clarissa knew of the incident when Damien brought the cannabis plants to school.

2.7.24 **What did they know about Louise**?

2.7.25 The two colleagues said that Louise was good-hearted and amiable.

2.7.26 Louise was very close to her father. They thought that he was the strongest person in her life and appeared to be a stabilising force for her. They did not hear Louise talk about her mother, though they were aware that Louise lived with her for a while.

2.7.27 They thought that Louise's father was clearly a good influence on her. Louise's father would frequently accompany Louise to work and ensure that she was on time. They also said that they would see Louise at weekends, doing her Dad's shopping or taking him to dinner.

2.7.28 Jack and Clarissa said that they never really knew where Louise lived. They described her as living from 'pillar to post': in Hertfordshire, Haringey, Enfield. They said that she stayed with her father sometimes, with her mother at other times. They confirmed that Louise had lived in her car for a while as well. They said that she changed her phone numbers often as well and had a purse full of sim cards.

2.7.29 Jack and Clarissa said that they thought she moved around some of the time as a choice, that she wasn't actually homeless.

2.7.30 They both noted that it was 'bizarre' that when they were asked where Louise lived by the Council after she had died, they could not provide those details even though they had known her for many years.

2.7.31 Jack and Clarissa described Louise as chaotic in her timekeeping.

2.7.32 They describe Louise as a 'ducker and diver'. They saw that she had holidays that would have been difficult to afford on the pay she was making. They also said that there was a period of time where she had a different car every two weeks. One was her father's, but they didn't know where the others came from.

2.7.33 **What did they know about Louise's relationship to Damien**?

2.7.34 Jack and Clarissa said that Louise had known Damien for a long time, since they were 15 or 16. They had been involved with each other for years. They thought that he was always in the background.

2.7.35 Clarissa said that she had never met Damien, but a few of their colleagues had when he came into the building early one morning looking for Louise. Jack could not recall meeting him, but knew what he looked like, so felt he must have.

2.7.36 Jack and Clarissa knew that Damien left abusive phone messages on the school phones. They said he also left abusive messages on their personal phones. They said that he'd taken their numbers from Louise's phone and then used them. He'd leave abusive messages for or about Louise, naming people he thought she was sleeping with, saying that she was a thief.

2.7.37 They said that it was obvious that he was trying to get her in trouble.

2.7.38 Clarissa said that she knew the concierge at Damien's block of flats and when Louise was living there she would leave at midnight saying that she was going out so that Damien did not take the keys and access the school.

2.7.39 Yet Louise brought Damien to Cherry Wood a couple of times. Jack, let it go a few times, but then told her she couldn't continue to bring Damien yet she continued to do it.

2.7.40 When the Victoria Oaks site reopened, Louise's situation appeared to have worsened and it was difficult for her to complete her hours. That led to her suspension in the summer of 2013.

2.7.41 The catalyst for that suspension was Louise bringing a man onto the site late at night. The school had child protection concerns about this. Jack and Clarissa think that the man was Louise's boyfriend, that is, Damien.

2.7.42 Jack and Clarissa also reported that Damien had some land near the Tottenham Hotspur football ground that had been left to him. During matches, he charged for parking there. They understood that when Damien was in prison, Louise took over managing that piece of land. They think this led to a big incident between the two of them.

2.7.43 Jack said that he thought that Louise had been trying to break away from Damien, that she'd met someone else. There were telephone messages on the school phone from Damien that said, 'if I can't have you, nobody will, you don't know what you're getting into.' They think this was around Easter of 2013.

2.7.44 **What did they know about the severity and frequency of the abuse Louise suffered from Damien?**

2.7.45 Louise came to work a few times when it was obvious that she'd been badly beaten. She had bruising to her face, her eyes. One time she'd had her teeth knocked out. On another occasion, she had a cut lip as well as the bruising. On another occasion, her wrist was strapped. She wore dark glasses to hide some of the injuries.

2.7.46 Clarissa reflected that a few times, after Louise had missed work, she came in with clear bruising. It seemed obvious that she had taken time off to let the bruising fade.

2.7.47 Clarissa recalled that Louise went to court (she thought it was Highbury and Islington, but didn't know what the case was) just before she was suspended in the summer of 2013 (NB: reports note that Louise was suspended in November 2013) and came back to work after 17:00 on that day. Clarissa said that there was a great lump out of Louise's face. She did a half hour of work and then left. That summer, Clarissa said that Cherry Wood got cleaned, but Victoria Oaks did not.

2.7.48 **Support provided to Louise**

2.7.49 The two colleagues reported that the PRU had sought a 'barring order' against Damien across several sites because the head teacher had found him lurking outside the building on several occasions when she came to work.

2.7.50 The two said that the barring order had been granted for a year and that when it finished, the phone calls started again. They did not think that he'd breached the order while it was in place.

2.7.51 **Commentary.** *Lack of information about the civil order.* Jade and Louise's colleagues spoke of an order gained by the PRU to keep Damien away from the sites where Louise worked. Initially, this appeared to be a misunderstanding of the restraining order granted by a criminal court on 25 February 2012. But the details provided by the colleagues suggest that this was a different order. The school has no record of such an order and the police would only have known about one if informed by those involved in bringing the case.

2.7.52 Jack and Clarissa reported that the previous head teacher and a manager gave evidence in the case. They were worried about Louise and worried about the safety of the staff.

2.7.53 One day when Louise came to work with two black eyes, Jack told her that this couldn't go on, that it had to stop. Louise said that 'it was my fault as well'. Jack asked how it would be her fault. She said, 'I'm as bad. We just fight.'

2.7.54 The two said that the previous head teacher had offered to help, but Louise had refused.

2.7.55 Louise came into work so badly beaten one day that he put her on a minibus and they went for a drive. He said, 'This can't go on.' She just waved it away.

2.7.56 The staff suggested to Louise that she should vary the times she came to work, but she did not do that.

2.7.57 Jack said that Louise did not want the help. He thought she did not want to admit that she was in a violent relationship or needed help. He was at a loss as to what could have been done when she did not engage.

2.7.58 At a meeting regarding Louise's suspension, Jack said that Louise 'just blanked' them and he found it very difficult. The feeling Jack got from Louise at that meeting was that she just wanted to know how long she had to be there. At the end of the meeting, Jack said to her, 'you know, [Louise], we are here for you'. She said, 'Yeah, yeah. It's okay.' She seemed to want to leave as quickly as possible.

2.7.59 Jack said that Louise was difficult to manage and it was difficult to get her to understand that there were people who would be willing to help her. Clarissa thought that Louise's view was that as she had survived the beatings and injuries up to that point, she could go on a lot longer.

2.7.60 **Did Louise's situation change over time**?

2.7.61 Jack and Clarissa think that their relationship with Louise did change over time. Jack thought this was due to the change in Louise's personal life. Though he thinks she had every right to keep it to herself, he said that it was impinging on her work life.

2.7.62 He said that Louise's problems were a concern to a lot of staff, right up to the head teacher.

2.7.63 Jack suggested that she might have been secretive so that no one would know about some of her activities. They both thought that Louise had a clear CRB and then DBS check.

2.7.64 **Finding out about Louise's death.** Though this was after Louise died and therefore outside the timeframe of this DHR, it is worth noting that Clarissa was notified of Louise's death casually and at the same meeting that staff were told they would be TUPE'd[5] over to an academy trust. The meeting focused on the employment issues.

[5] Provisions for employees when an organization or service transfers to a new employer under the Transfer of Undertakings (Protection of Employment) Regulations 2006

2.7.65 Jack and Clarissa said that when the staff came back to work after Christmas, it was still uppermost in their minds. But they were not given any support.

2.7.66 **What might have helped?**

2.7.67 Clarissa felt that the difficulty was getting Louise to accept help. She said they gave Louise information about 'battered wives' but she was not interested. It seemed the more they said, the more she backed away.

2.7.68 Louise said that she gave as good as she got and that it was her fault. Jack and Clarissa said that 'it doesn't work like that'.

2.7.69 Jack and Clarissa said that Louise did not want their help. They think if anyone could have helped her it would have been her family, especially her father as she was so close to him.

2.7.70 **Commentary.** *Identifying domestic abuse. Damien's* abuse of Louise was clear to her co-workers. They saw Damien's coercive control and jealousy, and the results of the physical abuse. Louise's minimising of the abuse she suffered is clear here in her accepting blame for it, saying that she was as bad as Damien was. Her isolation from others is also clear: in the times she chose to work and in her secretiveness. She may have thought that talking about her situation might have led to problems and greater risk.

2.7.71 *Victim's tactics for managing the abuse.* Louise's tactics for managing Damien and her situation are suggested in her colleagues' account:

(a) Working at night to reduce Damien's access to the schools. She then brought him to work and ignored her manager's direction to stop doing that.

(b) Not sharing information with her colleagues

(c) Her father attending work with her was obviously important in Louise keeping her job, but it may be that it was, as Jade suggested, also a way for her father to protect her from Damien

(d) Louise's use of cannabis

(e) Her peripatetic life – not staying anywhere for long

2.7.72 *Providing effective support. Louise's* abusive relationship was an open secret. Her managers and the head teacher offered advice, signposting, and the use of the school to keep her safe. They allowed her father to help her do her work without comment. Jade noted that the only time her mother was 'free' was at work. Louise's colleagues

reported that the school got an order to keep Damien away from her place of work and therefore away from her, during her work hours, though, as noted above, no record could be found of this order.

2.7.73 Without a policy to record, address and escalate the concerns of staff, without a planned approach to encourage Louise's engagement with support services, to develop a safety plan for her work life, most of these efforts remained acts of kindness rather than an effective approach to helping Louise.

2.7.74 Louise's different techniques for managing her situation would have benefitted from the help and support of a specialist worker. While the order, if there was one, was in force, it might have been a time to have a specialist domestic abuse worker talk to and work with Louise. The school head might also have benefitted from a conversation with a specialist worker about how Louise might be kept safe at work.

2.7.75 The colleagues noted the 'barring order' by the PRU to keep the children who attended there safe from Damien, but no reports to the police. This is returned to in the section on the PRU below.

2.8 Metropolitan Police Service and Hertfordshire Constabulary – Damien

2.8.1 During this DHR, incidents occurred at a number of addresses in Hertfordshire and London.

2.8.2 Damien lived in Haringey and Louise lived in Enfield and worked in Haringey. Louise sometimes stayed with her mother who lived in Haringey. Louise had also lived in Haringey with her ex-partner for a time during the period that this review covers. So, the MPS dealt with several incidents.

2.8.3 Louise also stayed in Hertfordshire during this period of review. She reported living there in 2010 and she sometimes stayed with her daughter or sister who lived there. Her daughter too lived in Hertfordshire, so the Hertfordshire Constabulary dealt with several incidents too.

2.8.4 To understand Damien's effect on Louise's life, the persistence and intensity of his abuse and his offending, the reports from the MPS and Hertfordshire Constabulary are combined in a chronological account of police involvement below. Changes to each police service's working practices are highlighted within the commentary where appropriate.

2.8.5 For both police services, practice around domestic violence has changed a great deal since the first incidents in this report. Early incidents are here to show the nature of Damien's offending which should have informed all future responses to him.

2.8.6 **Damien's criminal record**

2.8.7 The MPS provided a great deal of information about Damien's activities. He was a prolific offender and well known to criminal justice agencies.

2.8.8 Between 16 October 1991 and 19 December 2014, Damien had 32 convictions for 47 offences which included:

(a) 4 offences against the person (1 common assault and 3 actual bodily harm (ABH))

(b) 9 offences against property (criminal damage)

(c) 2 fraud and kindred offences

(d) 6 theft and kindred offences

(e) 5 public order offences (affray, threatening/abusive/ insulting words of behaviour and harassment)

(f) 11 offences relating to police/court/prisons (assault on police, failing to surrender, offences committed on bail and prohibited items)

(g) 4 drug offences (possession, possession with intent to supply and production)

(h) 2 offensive weapons

(i) 4 miscellaneous offences (disqualified driving, no licence and no insurance)

2.8.9 The four offences against the person that Damien was convicted for were all against women.

(a) Damien was convicted on 12 June 2006 for Actual Bodily Harm (ABH). He forced entry into the home of a woman he had been in a relationship with, destroyed her property, urinated on the bed and strangled her. This incident included allegations of rape that are returned to below.

(b) On 12 January 2010, Damien was convicted of common assault when he grabbed Louise's phone when she tried to call the Hertfordshire Constabulary.

(c) On 12 May 2011, he was convicted of common assault against Louise's daughter. This followed a period of harassment of Louise. Damien eventually forced entry to Jade's house, punched her in the face and took Louise's car keys and drove off in Louise's car.

(d) On 23 April 2012, Damien was convicted of common assault when he had an altercation with a neighbour and spat in her face.

2.8.10 In addition, 23 cases were taken to court for 27 offences that did not result in convictions.

2.8.11 Of the offences that did not result in convictions, many related to Louise and they often were closed with 'no evidence offered' by the CPS (the lack of further information about these disposals is returned to in the CPS section below).

2.8.12 The cases that did not result in convictions included these offences against the person (more details are provided later in this section):

(a) The alleged rape during the incidents that led to the conviction for ABH on 12 June 2006. Damien was found not guilty of these rape charges and a charge of affray.

(b) On 12 February 2008, Damien forced his way into the home that Louise shared with her previous partner, armed with a claw hammer, and attacking her previous partner and Jade. No evidence was offered to the court and the case was dismissed.

(c) On 9 April 2010, Damien was in court for an assault on a constable and controlled drugs. He punched the officer when he was stopped in possession of cocaine and cannabis. No evidence was offered and the case was dismissed.

(d) On 23 May 2011, Damien punched Louise. No evidence was offered and the case was dismissed.

(e) On 25 September 2011, Damien assaulted Louise and stole her keys. No evidence offered and the case was dismissed.

(f) On 15 December 2011, Damien damaged Louise's car and assaulted her. The allegation was withdrawn.

(g) On 1 June 2012, 15 May 2012, and 23 July 2012, Damien breached a restraining order and harassed Louise. No further action was taken.

(h) On 3 August 2013, the police stopped Damien when he took Louise's car without her consent and had cocaine. The police did not pursue a charge of possession of drugs because of the small quantity and Damien's denial. No evidence was offered for the taking-without-consent (TWOC) and the case was dismissed on the day of Louise's death, as she was not there to give evidence.

2.8.13 During the review period (10 February 2005 to date of homicide (December 2013)), MPS dealt with 36 incidents involving Louise and Damien across five Borough Operational Command Units (BOCUs).

2.8.14 In Hertfordshire, the constabulary were alerted to 26 incidents regarding Damien and Louise between August 2008 and February 2011. Damien was arrested on 6 occasions in Hertfordshire.

2.8.15 During the review period, Louise, her daughter and other female relatives reported domestic abuse by Damien.

2.8.16 **Damien's violence against women before Louise**

2.8.17 Metropolitan Police Service

2.8.18 MPS provided details on these incidents, though outside the time frame in the terms of reference, because they show a pattern of behaviour that Damien goes on to replicate in other relationships.

2.8.19 **Incidents with P1**

2.8.20 On **4 May 2003**, the police saw Damien carrying a screaming female into an address in Haringey. Damien claimed she was his wife and became violent towards the police. The woman declined to identify herself. Damien was arrested, charged and remanded.

2.8.21 Eight months later, on **25 January 2004**, Damien kicked the hinges off the front door at the same address. The identity of the woman in the previous incident was confirmed and it was also confirmed that she had been in a relationship with Damien. This partner (P1) declined to support a prosecution. She was provided with the details of Hearthstone[6] (Haringey's domestic violence support service). P1 later obtained an injunction against Damien.

2.8.22 Two months after this, on **13 March 2004**, Damien called P1's sister at her home and threatened to hold P1 at knifepoint. He then smashed windows at the sister's address. To escape, P1's sister jumped from a second storey window. Damien pursued her down the street until the police arrived at which point he ran away.

2.8.23 P1 attended the scene and told police that though she had split with Damien a year previously, he had continued to harass her and had threatened her with a knife on one occasion.

[6] At the time, Hearthstone only accepted 'self-referrals', that is, victims that contacted the service themselves.

2.8.24 P1 did not feel it was safe for her to return home. She sought help to be re-housed and to add a power of arrest to her injunction against Damien.[7]

2.8.25 A Separation/child contact issues, Pregnancy/new birth, Escalation, Community awareness/Isolation, Stalking and Sexual Violence (SPECSS) +/ Domestic Abuse, Stalking and Honour Based Violence (DASH)[8] risk assessment was conducted with P1. Her risk was assessed as 'standard' with no heightened risk factors identified. P1 was referred to VS and requests were made for a 'Safe and Sound Alarm' and 'Special Scheme' which required that all calls were treated as urgent. The actions were the same for P1's sister who had been so frightened she had jumped out of a window.

2.8.26 Damien was not arrested until a year later, on 10 May 2005. At that time he was found in possession of a knife. Damien made no comment in interview except to say that he would not contact P1 again.

2.8.27 Due to the delay and that P1 had had no further problems with Damien, P1 was no longer willing to support the prosecution for criminal damage. However, Damien was convicted for possession of the lock knife on 3 October 2005 and sentenced to 28 days imprisonment.[9]

2.8.28 **Commentary.** *Behaviour of the perpetrator*. This case shows Damien's abusive behaviour that he repeats many times in this report:

(a) Damien's violence to police

(b) He terrifies the women

(c) Harassment and threats after separation

(d) Use of weapons

(e) His pursuit of women through their female relatives

2.8.29 *Response of agencies and victim*. These responses are repeated throughout this narrative:

(a) The risk assessment does not recognise harassment.

[7] Since 1 July 2007, the breach of a non-molestation order (a civil order) has been a criminal offence under S.1 of the Domestic Violence, Crime and Victim's Act 2004 that amended S. 42A of the Family Law Act 1996.

[8] Research-based risk assessment tools for victims of domestic abuse. The assessments are checklists of factors most closely associated with future harm of victims of domestic abuse. The outcomes are standard, medium and high risk, each outcome requiring a response tailored to the risk seen. These tools allow the practitioner to exercise professional judgment and assess a situation as high risk even if the checklist suggests that the risk is standard or medium. High risk now leads to a multi-agency response. This was not the case at the time P1 was assessed following this incident.

[9] Length of sentence from Prison IMR and chronology.

(b) There is a delayed arrest

(c) The victim doesn't support the prosecution

2.8.30 Before the case against Damien for carrying the knife came to court, the MPS were called to another incident. The terms of reference for this DHR start from this incident.

2.8.31 On **26 August 2005**, the sister of another partner (P2) called the police to an address in Enfield. When police arrived, Damien was holding P2's arm and refused to let go. When police separated them, Damien ran off. He was chased but lost.

2.8.32 P2 told police that Damien had damaged property and then threatened to punch her. He then ripped off all her clothing and threatened her unless she got ready to go out with him. P2 told the police that Damien had head-butted her on a previous occasion.

2.8.33 Later that night (early on **27 August 2005**), Damien returned when P2 was alone. He kicked open the front door, damaged P2's sister's belongings with a knife stating that he was angry with her for calling the police earlier. He threatened P2 with a knife, slapped her, pulled her hair and strangled her. He threatened to 'slice' her throat and said he would kill her. P2 reported that he then raped her three times, and said, 'I'm going to have it whether you like it or not'.

2.8.34 After the assaults, P2 texted her sister who rang the police. They arrived and found Damien asleep in the bedroom and arrested him.

2.8.35 Damien claimed that P2 consented to the sexual intercourse when interviewed. He was charged with three counts of rape, ABH, two counts of criminal damage and affray. He was remanded in custody.

2.8.36 A 124D, a booklet used by MPS to collect information on domestic abuse incidents, and a SPECSS+/DASH risk assessment was completed but the grade was not uploaded to the electronic crime reporting information system (CRIS), a system that was accessible to all officers, as it should have been and therefore the information was not available to other officers. The incidents were flagged as domestic violence (DV).

2.8.37 P2 was interviewed by an officer specially trained for sexual assault cases. P2 provided evidence in the form of a medical examination, video interview, and photographs of her injuries. Her clothes were seized as evidence. The scene was forensically examined, though it had been tidied. She declined a referral to VS.

2.8.38 Damien declined to consent to allow intimate forensic samples to be taken but supplied non-intimate swabs. He made no comment in interview

2.8.39 On **12 May 2006**, Damien was found not guilty of rape following a trial. On 5 June 2006, there was no evidence offered for the charge of affray and it too was dropped.

2.8.40 Damien was found guilty of ABH and criminal damage on **12 June 2006** and sentenced to 26 months imprisonment.

2.8.41 **Commentary.** *Perpetrator's risk underestimated*. With this incident a pattern of behaviour is established.

2.8.42 The evidence provided by the victim at the time of the assaults makes the result of the rape trial difficult to understand. This incident clearly showed the nature of Damien's response to women that he was or had been in a relationship with. Here he was alleged to have used rape as a tool of control and punishment of a previous partner. The incident reveals the relentless and punitive nature of Damien's offending against women.

2.8.43 Women in a relationship with Damien should have been assessed not as standard or medium risk, but as at high risk of serious injury or future harm, at this point and thereafter. This incident should have informed all future risk assessments of women in a relationship with Damien.

2.8.44 *Multi-Agency Public Protection Arrangements (MAPPA)*. The Criminal Justice Act 2003 provides for the establishment of MAPPA meetings in each criminal justice areas in England and Wales to protect the public from serious harm by sexual and violent offenders. MAPPA meetings are attended by criminal justice agencies and other bodies dealing with offenders to work together in partnership to deal with the offenders and protect the public.

2.8.45 Damien would have been eligible for referral to MAPPA as a Category 2 offender following his conviction for ABH and criminal damage in this case. He would have been eligible for MAPPA until the expiry of his licence on 27 August 2007. After this date, he would have been eligible for referral to MAPPA as a Category 3 offender if he was considered to pose an imminent risk of serious harm.

2.8.46 *Multi-agency Risk Assessment Conferences (MARACs):* MARACs are a multi-agency response to victims and perpetrators of abuse. It asks key agencies to refer victims of abuse that are assessed as being at high risk of serious injury or harm. This assessment is based on an evidence-based risk assessment tool, usually the SafeLives/Domestic Abuse, Stalking and Harassment risk indicator checklist (DASH). Agencies research their involvement with the victims and the alleged perpetrators referred to a meeting and use the MARAC meeting to share information and make a multi-agency safety plan to

help the victim and any children to stay safe. The purpose of the meeting is to ensure the safety of the victim.

2.8.47 *MARACs in Haringey.* MARACs are not statutory responses to domestic abuse and MARACs went live at different times in different places. It also takes time for any process to mature and consistently deliver the intended results. The MPS have records of Haringey MARACs from 2009.

2.8.48 *Support for the victim*. There was little put in place to support P2 after the event. A specialist domestic abuse worker or a witness care referral might have provided much-needed support.

Update- Safeguarding *Strand.* The MPS trialled units to protect and support all vulnerable victims which include victims of domestic abuse.

MPS Service pilot: Steps are being taken to address the siloed approach and to improve information sharing between areas. Work is taking place as part of MPS One Met Model to pilot a new system that will amalgamate current boroughs to create Basic Command Units (BCUs). These will share certain resources and services across neighbouring boroughs to reduce duplication and increase efficiency. BCUs will be led by a Chief Superintendent with appointed Superintendents responsible for; Response, Neighbourhood Policing, Investigation and Safeguarding.

Officers from Community Safety Units (CSU), Sapphire (Sexual Offences) and Child Abuse Investigation Teams (CAIT) will be brought together meaning child, domestic and sexual abuse will be investigated within one command, eradicating duplication whilst combining learning and expertise. Victims will have access to specialist investigators at the earliest opportunity with one investigating officer from start to finish. The status of domestic abuse investigation will be raised so it is recognised as a specialism, working to prevent domestic homicide, targeting the most high harm offenders, protecting victims and potential victims from harm. To test these new arrangements, the MPS is trialling them on two Pathfinder BCUs namely; Camden / Islington, (referred to as the North Pathfinder) and Redbridge / Havering / Barking & Dagenham (referred to as the East Pathfinder). These Pathfinders went 'live' on 16 January 2017 with the PVP teams starting at the end of March 2017.

2.8.49 On **11 June 2006**, the day before Damien was convicted of ABH and criminal damage, and while he was in prison on remand, Damien sent a letter to a woman telling her that her boyfriend had written insulting words about her on the wall at Crown Court. He offered to challenge the boyfriend.

(a) The court confirmed to the police that there was no such message on the wall there.

(b) The woman who had received the letter contacted Pentonville Prison, where Damien was being held, and asked that letters to her be stopped. No further incidents were reported.

2.8.50 **Commentary.** *Behaviour of perpetrator*. This is a strange incident and shows Damien's attempt to manipulate this woman, coupled with a violent intent.

2.8.51 On **11 August 2006**, Damien was referred to MAPPA by probation in anticipation of his release from HMP Pentonville on licence on 25 August 2006.

2.8.52 Information about this process is below in a section on MAPPA (see par 2.18).

2.8.53 **Damien's violence towards Louise**

2.8.54 Metropolitan Police Service

2.8.55 The relationship between Damien and Louise first came to the attention of MPS on **13 November 2007**. This was swiftly followed by another incident the next day and another incident a few weeks later on **2 December 2007**. In these incidents that the police were called to, Damien was causing damage at the Victoria Oaks site where Louise worked: a door was kicked in, a brick was thrown through a window, and threatening messages were left for Louise on the answering machine. In the third incident Damien was seen roaming around the site of the school looking for Louise and had left abusive messages.

2.8.56 These incidents were not flagged as DV. Louise said that their friendship had ended due to Damien's 'erratic behaviour'. Damien said that they were in a 'turbulent' relationship. The messages that Damien left were not adequately recorded on the CRIS.

2.8.57 Damien then reported on **7 December 2007** that Louise had stabbed his foot with a knife causing a small wound. Louise was arrested and denied the allegation, saying that Damien made the allegation as revenge for being reported to the police for criminal damage. Damien was claiming to be in a relationship with Louise and she was saying he was a friend who was infatuated with her. CCTV confirmed that Louise was at work at the time of the alleged assault. (The family recall this happening at a different time. Police records were checked and confirmed the date.)

2.8.58 The false cross-allegation was identified but not challenged or addressed by the police. (MPS Recommendation 2)

2.8.59 **Commentary.** *Behaviour of a perpetrator*. One of the ways that perpetrators obscure information and manipulate the victim is through counter-allegations.[10] At the time, Damien's allegation was identified as false but not challenged. (See more in the next Commentary.)

2.8.60 Louise identified at this time Damien's punitive response to her help seeking.

2.8.61 This continued into the New Year when school windows were again smashed on **16 January 2008** and Damien left phone messages for Louise saying that he 'had had quite enough now. I'm going to go to the police and tell them about you.'

2.8.62 By this time, the police knew that Louise and Damien had known each other for years and had information that they had been in a relationship for a year. But neither Damien nor Louise were contacted about these incidents and they were not flagged as DV. The risk assessments and information gathering (124D and SPECCS+/DASH) were not completed. Though research revealed Damien's criminal history and warning signals, the incident was classed as 'no crime'. No reason was given for this. (See MPS Recommendation 2)

2.8.63 Several weeks later, on **11 February 2008**, Damien left more messages on the school answering machine calling Louise a 'prostitute', a 'slut', and accusing her of sleeping with staff members. Still no DV flag was put on CRIS. Officers attended Damien's home to issue a first instance harassment warning[11], but he did not answer the phone or the door so the warning was not delivered. Damien was on bail at this time for a burglary charge. His bail conditions included a condition requiring him to be at home between 21:00 and 7:00 every night. (See MPS Recommendation 2)

2.8.64 The Criminal Investigation Department were allocated the case but a supervisor there noted that it was unlikely that the calls to the school would be found to be traceable to a specific individual and recorded that ' . . . to spend considerable sums of money and staff hours investigating this telecommunications act offence is disproportionate to the crime alleged'. The supervisor suggested that resources should be directed at 'violent and gun enabled crime and like offences.'

[10] 'It is common for abusers to make or threaten to make false allegations about their victims to the police, social services and immigration authorities or to friends and family'. Accessed in July 2017: http://rightsofwomen.org.uk/wp-content/uploads/2016/03/ROW %C2%AD-Legal-Guide-Coercive-control-final.pdf

[11] A First Harassment Warning alerts its recipient that a complaint has been made against them and that a charge may follow if the conduct complained of is repeated. The Protection from Harassment Act makes it a criminal offence to pursue a course of conduct which amounts to harassment of another person, where that person knows (or ought to know) that the act amounts to harassment, that is, that it causes alarm or distress for the other person.

2.8.65 **Commentary.** *Poor understanding of domestic abuse*. This took place 5 years before Louise was murdered but the supervisor's comments are included as it is indicative of cultural attitudes at the time that the police have been working to overcome to improve their response to domestic abuse.

2.8.66 This response shows the lack of understanding around domestic abuse, harassment and, latterly, the patterns of coercive control. Incidents and allegations were viewed in isolation. This can be seen throughout the police responses that follow, both from the MPS and from Hertfordshire Constabulary.

2.8.67 The police training on domestic abuse at the time included some training on controlling behaviour that was primarily aimed at gathering evidence to support assault charges. Coercive control was not a specific crime at the time and there was no guidance regarding it. However, following the introduction of an offence of controlling or coercive behaviour in S. 76 of the Serious Crime Act 2015 (came into force on 29 December 2015), there is now a College of Policing training package and tools to assist officers in gathering evidence for coercive control. This helps officers understand and identify controlling behaviour. This includes training and tools on identifying perpetrators presenting as victims and identifies making counter allegations as an example of tactics that a perpetrator might use. The MPS has enhanced this with training for all front line staff, specialists and supervisors, titled 'Murdered by my Boyfriend' (based on a BBC documentary of a domestic homicide.) There has been a joint NPCC and CPS Evidence Gathering Checklist in use since the end of December 2014 that also asks for information about counter allegations.

2.8.68 *Holding perpetrator accountable*. Attending Damien's address during the times he was required to be at home under his bail conditions would have provided the opportunity to issue the harassment warning if he was there and arrest him for breach of bail if he was not. It is not clear whether the research was done that would have identified this opportunity.

2.8.69 *Poor understanding of domestic abuse, no safety focus and not holding perpetrator accountable*. The MPS IMR identified that these workplace incidents were managed in isolation and, by not seeing and labelling them as domestic abuse, there were missed opportunities to:

(a) Build the case for the crimes committed and identify the pattern of abuse

(b) Gather information and risk assess Louise and provide safety advice and a safety device

(c) Liaise and share information with the Safer Neighbourhood Team, ASBAT, or the local council to improve Louise's safety while working alone and

(d) Challenge Damien's behaviour in any meaningful way. To look at and understand the impact on Louise of Damien's allegation that Louise had stabbed him. This false allegation showed Louise that Damien could get her arrested and would have aided his control of Louise.

2.8.70 The next day, on **12 February 2008**, police were called twice to the house that Louise shared with her former partner, M1, and her daughter, Jade. The first time Damien came to the house he had caused a disturbance. That time, he was asked to leave and did. The second time Damien had forced his way into the house, armed with a hammer. Louise and M1 said that he had threatened to kill them. He had fought with M1, resulting in them both being injured. Jade had intervened and hit Damien with a baseball bat.

2.8.71 The police understood from the conversations at this time that though M1 and Louise had split up, they continued to share the house. Louise had grown close to Damien but she reported that she was concerned about his abuse of alcohol and drugs and was not in a relationship with him.

2.8.72 Damien was arrested and the hammer recovered. He was drunk and admitted to having taken cocaine two days before. He was taken to NMUH and then returned to custody. The results of his drug test at this time are no longer available. He was seen by a drugs worker.

2.8.73 Damien was charged with aggravated burglary and remanded.

2.8.74 **Commentary**. *Record-keeping.* The prison and probation services' records of Damien's remand periods and releases do not always agree with the police records of releases or incidents. For instance, the prison shows that Damien was released on 2 September for his trial on 3 September, yet there are incidents reported during his time on remand. This created confusion for this review, particularly in 2010 and 2011 when Damien's offending was prolific.

2.8.75 HMPS and the National Probation Service (NPS) input information into the National Offender Management Intelligence System (NOMIS). On a daily basis, information is uploaded electronically to the Prisoner Intelligence Notification System (PINS) to which the MPS have licenced access. PINS allow trained staff to search the whole national prison population for individuals or groups. The responsibility for the accuracy of information about release dates sits with HMPS.

2.8.76 MPS report relying on PINS for locating subjects to manage warrants, tracking offenders, alerting those at risk from offenders. MPS find that on occasion, the information on the system is inaccurate. There is a recommendation for HMPS regarding this.

2.8.77 Louise attended the police station on **8 April 2008** and asked to make a withdrawal statement. This information was forwarded to the Officer in Charge (OIC) who then tried to contact Louise, M1 and Jade without success. No withdrawal statement was taken and the case was listed for trial on 3 September 2008.

2.8.78 Hertfordshire Constabulary

2.8.79 Hertfordshire Constabulary report that on **21 August 2008**, Louise made an emergency call to the police. Damien was kicking at her door (an address in Hertfordshire) and trying to get in. Louise told the police about the incident (February 2008) with the hammer. She said that Damien was a threat to her daughter if he got into the house. Louise said that Damien was on a curfew and should be at his home in London. Damien was there when police arrived and was volatile.

2.8.80 Police National Computer (PNC) checks were conducted on Damien, Louise and Jade and revealed that Damien had a history of violent crime, including; weapons and drugs, that he offended on bail and often failed to appear at court if he was released on bail. They found no information about a curfew.

2.8.81 Damien was at the scene when police arrived and was volatile. This was recorded as a 'non-crime domestic' and risk assessed as 13, which was recorded as medium risk (high risk was 14). Louise was noted as a 'repeat victim'. A note was made to treat calls as urgent.

2.8.82 Louise and Jade went to another address and said they would talk to MPS in the morning to find out what Damien's bail conditions were.

2.8.83 **Commentary.** *Accountability of agencies to hold the perpetrator accountable – investigations not completed.* There is no indication that the police followed this incident up with MPS, despite the information provided by Louise about the incident in February and her understanding that Damien had a curfew. The police research did not show that Damien was due to appear in court in a few days for the aggravated burglary at Louise's house so this intimidation of witnesses was not identified as such.

2.8.84 Damien's behaviour could have been viewed as witness intimidation, but without researching this situation, this was not identified as an option.

2.8.85 Damien might have been detained to prevent a further breach of the peace. This was a lost opportunity to intervene in this abusive situation.

2.8.86 *Changing role of the victim*. It appears that determining whether Damien was under curfew or had conditions was left to Louise and Jade.

2.8.87 *MARACs. Louise* was risk-assessed and identified as a 'repeat victim'. The PNC checks showed that Damien was a prolific and violent offender. Records show that the MARAC began in Hertfordshire in mid-2009 and therefore was not an option for police to refer to for a multi-agency response at this time.

2.8.88 *Update.* Hertfordshire Constabulary's processes have changed significantly since this incident and Hertfordshire Constabulary confirm that a case such as this would be expected to be referred to MARAC.

2.8.89 Metropolitan Police Service

2.8.90 Louise, M1 and Jade were given court warnings the night before Damien's trial on **3 September 2008** but did not appear to give evidence and the case was dismissed.

2.8.91 **Commentary**. *Accountability.* There seems to have been a lapse in communication between the police forces so that Hertfordshire did not know about the imminent case where Louise and Jade were witnesses against Damien. MPS did not appear to know about the call-out in Hertfordshire and so they too missed a possible charge of witness intimidation.

2.8.92 *Changing role of the victim(s)*. Here we have victims, who had been subjected to intimidation by the perpetrator, given court warnings to appear as witnesses to give evidence against him. This perpetrator had a documented history of violence to ex and current partners, especially when they called in the police. The victim had become a witness and therefore a part of a system that was less focused on immediate safety outcomes.

2.8.93 *Investigations not completed*. The MPS IMR reports that research on this case was not completed and the incidents at Louise's place of work were not identified. Despite Louise saying that she was not in a relationship with Damien, he had talked about their 'relationship' when he was arrested and Louise had spoken of their 'friendship'. The threshold for recording domestic abuse had been reached for incidents between them and all incidents between them should have been recorded as domestic abuse after this

time that is a SPECCS+/DASH risk assessment and referral to the Community Safety Unit (CSU)[12] should have been completed. (MPS Recommendation 2)

2.8.94 Two days after the aggravated burglary case against Damien was dismissed (on **5 September 2008**), he was back in court for a number of other burglaries and theft where he was found guilty and sentenced to 10 months imprisonment. The family of Louise report that they thought that this sentence was for the break-in in February.

2.8.95 Hertfordshire Constabulary

2.8.96 Shortly after this, on **12 September 2008**, Damien was back at Louise's door. (The MPS confirm that Damien had served his time for the burglary offences by this date, as time served includes remand periods.) MPS had re-routed an emergency call from Louise that she was being harassed by her ex-partner Damien. They reported that Damien was known to be aggressive and there was a young girl at the address (Jade). Hertfordshire Constabulary noted the sig marker identifying that Louise had been the victim of an aggravated burglary by Damien, that he had attacked her with a hammer, and that there were markers for firearms, weapons and violence. The case was not marked as urgent. It is likely this was because the Hertfordshire Constabulary were not aware of Damien's release. The police then made several attempts to contact Louise but did not get through.

2.8.97 Louise called again to say that Damien was outside her flat, that her daughter and another person had locked themselves in a room in case Damien got in. The police attended.

2.8.98 Shortly thereafter, the incident was closed as Damien had not been seen. The police noted that this was 'not a domestic incident' as Damien and Louise had not been in a relationship. So the Harm Reduction Unit (HRU)[13] was not informed and further investigation was not undertaken.

2.8.99 **Commentary.** *Poor recording and poor understanding of domestic abuse*. The initial report showed that Damien was Louise's ex-partner. The significant markers showed that both women had been the victims of aggravated assault by Damien in the recent past which makes the labelling of 'not a domestic' difficult to understand. The level of fear shown by Jade and Louise should have suggested there was more going on here

[12] The Community Safety Unit provides the second-tier of investigations for domestic abuse.

[13] The Harm Reduction Unit was the second line of investigation for domestic abuse at Hertfordshire Constabulary at the time.

than the police officers knew and led them to ask more questions to better understand the situation. This was a very poor response.

2.8.100 Several weeks later, on **1 October 2008**, the MPS routed a call to Hertfordshire Constabulary from a caller, Nicky, who said that she believed her aunt, Louise, was being held hostage by Damien. In a further discussion with Nicky, she said that she thought that Damien had left now, but that Louise had been held hostage the night before by Damien. She said that Louise had humoured Damien to keep him calm.

2.8.101 When police attended, they found Louise at the address and Damien was not there. Louise reported that she had invited Damien into the house and then given him a lift to London. The family were very upset by the situation and wanted the police to investigate. The risk assessment of Louise showed medium risk and it was recorded as a non-crime domestic. The HRU decided that this was not technically a DV incident and therefore did not require a DV response.

2.8.102 **Commentary.** *Lack of investigation*. The Hertfordshire Constabulary IMR suggests that the police were hamstrung by Louise's 'implausible' account. However there is no indication that the police spoke to neighbours or investigated the incident further. The family's concern, past incidents and Damien's propensity to use violence suggest that it is highly likely that something serious had occurred that put Louise at risk from Damien.

2.8.103 *Poor recording.* This should have been flagged as a domestic incident as Nicky and the previous information the police had agreed that Damien was Louise's ex-partner.

2.8.104 *Training on domestic abuse.* It is worth noting that the immediate risk of reprisals from a perpetrator is often more real to a victim than the likelihood of protection from the police and the courts – a fear likely to have been shared by Damien's many victims as evidenced by their marked reluctance to give evidence in court.

2.8.105 *Behaviour of a perpetrator*. This is a good example of a scene where the information does not add up which is indicative of coercive control. Police are being trained on the new law against coercive control to help attending officers identify such situations.

2.8.106 <u>Another victim – F1</u>

2.8.107 Metropolitan Police Service

2.8.108 A month after having his aggravated burglary dismissed and less than a week after the alleged imprisonment of Louise, on **7 October 2008**, a woman (F1) reported that Damien had become angry when she had turned down his advances and begun dating

a friend of his. He had then damaged her vehicle and threated to kill her when she had rung him up to ask him to pay for the damage.

2.8.109 MPS followed their 'Threats to Kill' policy and advised F1 to go somewhere safe until Damien was arrested. Damien was arrested a few hours later. F1 did not want to support the prosecution and made a withdrawal statement. She was given advice about civil injunctions and was referred to VS, though there is no corresponding date in VS's records (this is addressed in the section on VS).

2.8.110 Damien was issued with a First Instance Harassment Warning and referred to the MAPPA on 10 October, where he was adopted as a 'high' risk Category 3 'dangerous offender', based on this assault. He was discussed at 4 meetings: on 21 October 2008. 2 December 2008, 13 January 2009 and 10 February 2009. This is returned to later in the section covering the MAPPA meetings.

2.8.111 Damien and Louise

2.8.112 Hertfordshire Constabulary

2.8.113 A little over a week later (and two days after Damien had threatened F2 in MPS area) on **9 October 2008**, Hertfordshire Constabulary were called to Louise's address via a 999 call. Damien had broken into the house. The call ended abruptly. The officers arrived quickly at the scene. Damien was in the flat and refused to leave. PAVA spray (an incapacitant spray) was deployed against Damien; he was restrained and arrested on suspicion on burglary. He had taken Louise's phone and removed and snapped the SIM card. (The family recall this happening at a different time. Police records were checked and confirmed the date.)

2.8.114 Damien was charged with criminal damage to a mobile phone. (It is unclear what happened to the burglary charge.) The custody officer refused bail on the grounds that it was likely Damien would not answer bail, that he would commit a further offence and that his detention is necessary to stop him interfering with the administration of justice or investigation of offences.

2.8.115 The risk assessment completed by the HRU showed that Louise was at 'very high risk'. Louise was very scared and Damien had threatened to kill her. The increase in frequency and severity of incidents since Damien was released from prison (date unspecified) were noted. A Crime Prevention Officer was to attend Louise's address and assess her security. A temporary police alarm was installed at Louise's address the next day (the alarms are reviewed a month after installation). Louise was referred to Victim Support Hertfordshire (VS Herts) who would get in touch with her.

2.8.116 The following day, Damien appeared at court and pleaded guilty to criminal damage for this incident. He was sentenced to a conditional discharge for 12 months, £87 costs and £160 in compensation. (The sentence was varied on 12 January 2010.) Louise was informed of Damien's release.

2.8.117 **Commentary**. *Victim safety*. Though no MARAC was available at this time, the police might have completed some safety planning with Louise, talked to her about her options and provide safety advice. There was no record of Louise being referred to a specialist domestic violence worker despite the appropriate high risk (HR) assessment. Louise might have been receptive in the aftermath of this frightening incident.

2.8.118 *Investigations not completed*. Louise was very shaken after this event and this might have been the time to ask more questions about what had happened on 1 October, as Louise was engaging and providing information to the police.

2.8.119 *Update*. High risk investigations are now reviewed at the daily management meetings which are chaired by senior officers.

2.8.120 Metropolitan Police Service

2.8.121 **21 October 2008**, There was a MAPPA meeting about Damien in regard to F1.

2.8.122 On **28 October 2008**, Damien reported that Louise had stolen jewellery belonging to his ex-wife and had refused to return it and had threatened him saying 'don't go to your house or you are dead'. The case was not flagged as DV because he said they were merely friends. The officer noted that there was likely to be more to this situation than was immediately apparent, and followed the procedures appropriate for threats to kill.

2.8.123 When the police went to Louise's address, Jade was there alone and told them that Damien and Louise had split up but that Damien would not leave Louise alone. She said that Louise had stayed in touch with Damien while he was in prison and that there had been a number of incidents since he was released. The police seized several items of jewellery though Jade accounted for them. Louise later went to the police station and gave the same account of the jewellery. When police asked Damien for his ex-wife's address and he understood that they would talk to her separately from him, he said he would contact a solicitor and did not need their help any more.

2.8.124 Further information was gained from Hertfordshire Constabulary around the incidents noted above and that Louise was regarded as 'high risk'. The notes say that Louise 'portrayed herself as someone seeking to leave the relationship and in fear of [Damien]

though she believes the 27 year friendship offers her some protection.' However, the case was not flagged as domestic abuse.

2.8.125 Louise was advised by the police about harassment and injunctions. They confirmed that Hertfordshire Constabulary had installed a panic alarm at Louise's Hertfordshire home. No further action was taken.

2.8.126 **Commentary.** *Behaviour of perpetrator*. MPS note that as this was only 3 weeks after the report by F1 of threats to kill and therefore Damien may have used his recently gained knowledge of the police response to threats to kill to manipulate the police and Louise.

2.8.127 *Poor understanding of risk and holding the perpetrator accountable.* Again, Damien is trying to bring Louise to the attention of the police. The false allegations are not explored with him or addressed.

2.8.128 *Victim safety*. Louise is again identified as high risk and an assessment is made that she is seeking to leave the relationship. She is given advice by the police. This might have been a time when she would have engaged with an IDVA.

2.8.129 On **2 December 2008**, Damien was discussed at MAPPA in relation to the incident with F1.

2.8.130 Another victim: F2

2.8.131 On **6 December 2008**, another woman (F2) called the police. She said she had met Damien in a bar where he had claimed to be a policeman. She'd invited him to her address but became worried when he spoke suggestively. She asked him to leave and he forced himself on top of her. She told him to get off and then she retreated to the bathroom, locked the door and rang the police.

2.8.132 Damien was aggressive to the police when they arrived. F2 was clear that Damien had stopped when she'd asked him to but became scared when he would not leave. No offences were disclosed and no further action was taken, but an intelligence report was created.

2.8.133 The record of this incident was linked to Damien's intelligence record and the warning signals of firearms, drugs, weapons, and violence were noted. But the previous arrests for rape and domestic abuse were not.

2.8.134 **Commentary.** *Behaviour of a perpetrator of domestic abuse.* Damien's behaviour here shows his sense of entitlement. He manipulated F2 by claiming to be something he was not and then responded aggressively when she asked him to leave.

2.8.135 *Poor research*. The alleged rape and domestic abuse – violence against women – did not inform the officers' assessment of this incident.

2.8.136 Incident with Louise

2.8.137 Hertfordshire Constabulary

2.8.138 **On 16 December 2008,** Louise contacted police regarding the theft of her car. She thought that Damien had stolen it during the previous night as they were having on-going problems and he'd been seen outside her house. She said that someone had rung her buzzer after 11pm and she'd ignored it as she was not expecting anyone. She had then received a text from Damien saying that she must have heard the buzzer and to stop playing games.

2.8.139 Further attempts to talk to Louise failed, but she then came to the police station on 23 December 2008 saying that she had found her car in London and had taken it to a scrap yard. She said that there had been a misunderstanding with her ex-partner, Damien, and he had taken the vehicle to be fixed or destroyed and had failed to tell her. Louise provided a retraction statement on 4 January 2009.

2.8.140 Follow-up from incidents with other victims

2.8.141 Metropolitan Police Service

2.8.142 On **13 January 2009**, there was a MAPPA meeting about Damien.

2.8.143 On **10 February 2009**, there was a MAPPA meeting about Damien. MAPPA meetings are discussed in more detail below.

2.8.144 Incident with Louise

2.8.145 Hertfordshire Constabulary

2.8.146 On **12 April 2009**, Hertfordshire Constabulary received 3 calls from Louise's address in Hertfordshire within a 15 minute period: an emergency call; a call cancelling the first call, saying there had been an argument with her boyfriend; and a final call asking for urgent attendance as the caller's mother and the mother's boyfriend were arguing.

2.8.147 Police attended and the incident log notes that this was not a domestic incident. It notes that the daughter does not like her mother's partner and the daughter called the police when the partner came to the flat. The police were told there were no issues between the mother and her partner. The incident was closed with no further action noted.

2.8.148 **Commentary.** *Lack of investigation and concern for safety of victim.* At this point, Hertfordshire Constabulary had been called to incidents between or about Damien and Louise on a number of occasions. There was a sig marker on the address and a history of domestic abuse. They had recorded Louise's great fear of Damien only six months before. Yet there is no record that the parties were interviewed separately or that the police gained an understanding of why Jade had been fearful enough to ring the police.

2.8.149 On **2 May 2009,** Louise rang the MPS to say that Damien had taken her car keys two days before and had refused to give them back and she had seen him driving the car in London. The call was re-routed to Hertfordshire police. Within the hour, Louise had rung again to say that she had her car back and did not need the police. The call-taker heard Louise arguing with another person. The control room rang Louise again later that night and she said that the keys had been taken several days before in London after a row but that she had the car back now.

2.8.150 Though the crime should have been dealt with by MPS, Hertfordshire police should have notified the HRU given the history of domestic abuse between Damien and Louise.

2.8.151 Metropolitan Police Service

2.8.152 Another victim: P3

2.8.153 On **17 May 2009**, the police were called to an address in Enfield by another woman (P3). She said she was an ex-partner of Damien's and said they had not been getting along. She had a telephone call from Damien while she was out, demanding that she return and threatening to smash her windows if she did not. When she did return, a brick had been thrown through her window. The SPECCS+/DASH graded her risk as medium and identified separation and escalation as heightened risk factors, aggravated by alcohol and jealousy. P3 was referred to 'agencies' (unidentified) and VS was notified. There were no witnesses and the case was closed. (MPS Recommendation 3)

2.8.154 **Commentary.** *Understanding domestic abuse.* Intelligence from Damien's treatment of his ex-partners, P2 and Louise, would have supported an assessment of high risk. Damien's response to ex-partners had been seen to be very physically abusive. The Review Panel has been unable to verify when the MARAC started in Enfield. If available, a referral to MARAC would have been valuable. If that was not an option at the time, then the police could have provided an alternative heightened response.

2.8.155 Abuse of Louise

2.8.156 Hertfordshire Constabulary

2.8.157 Again, several weeks later, on **23 May 2009**, Louise made an emergency call to the Hertfordshire police to report that she had rowed with her ex-partner, Damien, and he had taken her car and was headed to London. She wanted to report the car as stolen.

2.8.158 A summary search linked 13 previous incidents and the reports of the car being stolen after domestic incidents.

2.8.159 The police did not manage to speak to Louise to obtain a statement for another day and a half, despite numerous attempts. Louise said that she'd be home after 8pm that night, but police did not talk to her again until the morning of 26 May.

2.8.160 On **27 May**, Louise spoke to an officer and said she had her car back and that she'd rung them in haste. She was reluctant to talk to the police now. The incident log says that the car was not stolen.

2.8.161 **Commentary**. *Good research*. The incidents involving Damien and Louise are now being linked and the theft of the car is being seen in the context of domestic abuse.

2.8.162 *Poor response*. A crime report should have been raised immediately noting a domestic-related incident which would have been flagged up to the HRU. The delays and the changes in information received meant that this incident was never referred to the HRU for further investigation.

2.8.163 *Perpetrator behaviour*. Damien's taking of Louise's car does not appear to be linked to other criminal behaviour. It appears to be Damien's way to punish Louise after an argument.

2.8.164 *Holding perpetrator accountable*. At this point there are 3 incidents that might have constituted a harassment charge but the incidents were not linked in that way.

2.8.165 A few days later**, on 30 May 2009**, a neighbour of Louise's called Hertfordshire Constabulary about an incident at Louise's address where Damien and Louise appeared to be having an argument. Louise was shouting at Damien about 'doing crack'. The neighbour also said that the couple had on-going domestic issues.

2.8.166 The history was reviewed and officers arrived quickly. Damien and Louise were having a quiet conversation when the officers arrived and the incident was closed an hour later with no offences were recorded. The caller was not interviewed.

2.8.167 Fifteen minutes later, the neighbour rang again to say that the male had gone into the house and tried to hit the woman. The woman was now crying.

2.8.168 The same police officers returned and updated the incident log 9 minutes later recording a non-crime domestic that would be submitted to the HRU. Louise and Damien were spoken to separately, described what had happened and said that the neighbour had misinterpreted what she saw, perhaps to get back at Damien who had told her 'where to go'. The police asked Damien to leave and he did so.

2.8.169 **Commentary**. *Poor response*. It was good practice to interview the parties separately, but 9 minutes does not seem enough time to have established what had happened this time, despite having recorded spending almost an hour with Louise and Damien following the first call.[14] Again, the neighbour was not spoken to and there are no observations recorded of the scene or their demeanour.

2.8.170 *Victim's behaviour*. It is worth noting how Louise is trying to manage Damien by discouraging his use of 'crack' and agreeing with him when police attended.

2.8.171 **5 June 2009.** A call from Louise was re-routed from MPS to Hertfordshire Constabulary regarding the theft of Louise's car by Damien on 30 May 2009, the day of the last call-out. The police tried to take a witness statement but could not make contact with Louise. Later that day, Louise contacted Hertfordshire police to tell them that she had her car back and it was no longer stolen. In response to further police enquiries, Louise said that she no longer wished to report the car stolen and would not support any police action.

2.8.172 The police record notes the pattern of Louise reporting that Damien has stolen her car and then retracting the allegation when the car is returned. The report also noted that Louise was a very high risk victim of domestic abuse and the HRU was informed. The original report was replaced with a non-crime domestic report.

2.8.173 On **9 June 2009**, an officer from the HRU contacted Louise about the incident on 30 May. Louise said that she'd had no contact with Damien and did not think she was likely to have contact. She said she did not feel at risk and was provided with safety advice and a contact number to use if she needed help. There is no record that the officer discussed Damien's taking Louise's car as she had reported on 5 June 2009, or the contact she would have had with Damien when he returned the car.

2.8.174 **30 June 2009.** Hertfordshire Constabulary Domestic Violence Officer (DVO) talked to Louise who said that she had not heard from Damien since the last incident and had no concerns. She thought Damien had moved on. Louise did not feel she needed to

[14] Times are based on the timing of entries into the incident log, so are not precise.

complete the risk assessment, so the officer completed it from the previous information and assessed that it did not meet the threshold for referral to the MARAC.

2.8.175 **Commentary.** *Knowledge of domestic abuse and engaging the victim*. It is notable here that on 5 June, Louise thought she was not at risk but the police knowing of other incidents, thought she was high risk. It would have been useful for the police to talk to Louise about the risk assessment they had completed and the implications for her. It is not clear if this happened. The pattern of Damien taking Louise's car after an argument has been established, but this is not seen as a pattern that might be used for an harassment charge.

2.8.176 *Improving processes.* This was good practice to follow up these incidents with Louise. As Louise may be minimising the risk to her which is a common response of victims, the DVO still completes a risk assessment

2.8.177 **6 August 2009.** In the early hours, three emergency calls were received by Hertfordshire Constabulary in quick succession: Louise's sister rang to say that Damien had kicked her door down and stolen her mobile phone, her neighbour rang to say that she was worried that her neighbour was being held against her will and the front door had been smashed, and Louise then rang to say that Damien was at her sister's house and was known to be violent. These incidents were linked and police were dispatched.

2.8.178 When police arrive, Louise's sister then told the police that Damien had left on foot. The police notes record that Louise's sister appeared to be intoxicated and they suggested that she ring the police again when she was sober. There are no notes about the damage to the property or about an interview with the concerned neighbour. The incident was closed.

2.8.179 Several hours later, Louise's nephew rang to say that Damien had returned to his mother's house with a knife, was probably drunk, was 'off his head' and was threatening to smash the door in.

2.8.180 Based on this information, the use of a Taser was authorised. Officers arrived quickly and Louise's nephew said that Damien had left in a taxi. Other officers identified Damien on the street but were advised to await the Armed Response vehicle. The officers tried to speak to Damien but he would not engage. They watched him and saw him put something in a letterbox. Eventually they lost sight of him. There is no record that the police sought to recover the item put in the letterbox.

2.8.181 **Commentary.** *Poor response. Holding the perpetrator to account.* Though the police had linked Damien, Louise and Louise's sister to previous incidents and were aware of

Damien's violence, their response at the scene was poor: they did not record information about the state of the door to Louise's sister's house or interview the neighbour who had reported her concerns in order to help build this case. They did not stop and detain Damien for a search, nor did they recover the item that Damien put in the letterbox though he was reported to have a knife.

2.8.182 Damien was on 12-month conditional discharge for criminal damage in relation to his offence on 9 October 2008. If he had been charged, this could have been taken into consideration by the court.

2.8.183 Officers at the address tried to obtain information from a woman (unnamed), who was very angry, and two men (also unnamed) who were there, one who was too tired and the other refused details. Eventually the woman asked the police to leave and tore up the crime information number they had given her.

2.8.184 The police linked this incident to Louise's address and thought Damien might go there. They closed the case at 5:15, noting that no allegations had been made and that individuals at the scene had refused to provide further details.

2.8.185 In the afternoon, a further emergency call was made to the police by Louise's sister's daughter who reported that Damien had her mother's phone and was making threats to the family. She demanded immediate police attendance. Police attended later that day and obtained witness statements and enough information for a crime report for the offence of aggravated burglary. Louise's sister said that Damien was still in a relationship with Louise.

2.8.186 Early the next morning, officers attended Louise's Hertfordshire address and arrested Damien. He was charged with using violence to secure entry, common assault and theft. Bail was refused on the grounds that he was unlikely to answer bail, he was likely to commit further offences and interfere with the administration of justice.

2.8.187 **8 August 2009**. Damien remanded to HMP Bedford.

2.8.188 **11 August 2009**. Damien released from prison. The reason for this is unclear from the records.

2.8.189 The same day, Louise rang Hertfordshire Constabulary to say that her sister and sister's boyfriend were threatening her. The call handler heard a woman swearing in the background and then Louise hung up. The police rang Louise back and she said that her sister should not be there due to the upcoming court case regarding the incident on 5 days earlier. She said that her sister had left at that point. The police attended, noting

that this was not a domestic incident. Both parties were advised and no allegations made.

2.8.190 **Commentary.** *Knowledge of domestic abuse.* This incident did constitute a domestic incident and should have been treated as such.

2.8.191 *Controlling behaviour.* Damien had threatened Louise's sister and, though Louise had called the police initially to her sister's house on 6 August, she was now in a position where she seems to have felt that she had to take sides.

2.8.192 **On 18 August,** Damien was granted conditional bail by the Court, regarding the incidents on 6-7 August 2009. The victims were informed and steps taken to keep them safe, though what those steps were is not recorded. The incident was identified as a domestic abuse incident as Damien had been looking for Louise when the incident occurred. The investigator contacted VS, though they have no record of this.

2.8.193 **22 October 2009.** Damien failed to surrender to the custody of the Court for the above offences. Police were called to Hertford Magistrates Court regarding witness intimidation by Louise against her sister and nephew. The report states that Louise continuously walked past the witness room where her sister and nephew were waiting to give evidence which they found intimidating. She had told police staff, 'you had better fucking protect them'. Louise later said that this was a misunderstanding and she denied intimidating anyone. She said she was having an argument with her partner.

2.8.194 Louise was charged with S. 4 of the Public Order Act and released on conditional bail. The incident was identified as being domestic-related and the HRU were informed.

2.8.195 **Commentary**. *Good practice*. Informing the victims of Damien's release might have helped build their trust in the system and flagging it as domestic abuse correctly identified the context of this criminal behaviour.

2.8.196 *Consequences for a victim*. According to a 2009 Cabinet Office short study[15], nearly 50% of women in prisons have been the victim of domestic abuse. This incident is a demonstration of how that can happen. Damien went to Louise's sister's house looking for Louise. Louise first tried to protect her sister and rang the police. When Damien was charged, Louise intimidated her family so that they would not give evidence and was prosecuted herself. The intimidation may have been to protect her sister from Damien's anger if she gave evidence, or to protect Damien from a conviction. Either

[15] *Short Study on Women Offenders,* May 2009 by the Social Exclusion Task Force at the Cabinet Office. Accessed on 3 November at: http://webarchive.nationalarchives.gov.uk/+/http:/www.cabinetoffice.gov.uk/media/209663/setf_shortstudy_womenoffenders.pdf.

way, her actions alienated her from her sister, resulting in further isolation for Louise, one of the risk factors in domestic abuse. Louise now has a conviction resulting from her protection of Damien.

2.8.197 Metropolitan Police Service

2.8.198 **9 January 2010**. Police attended Damien's flat to execute a warrant of arrest for his failure to appear at Hertfordshire Magistrates Court on 22 October. They found cannabis factory (20+ plants) there and arrested Damien. A 'crack pipe' and a 'pit-bull style' dog was also found there. The notes show that Damien's 'girlfriend' attended to collect the dog. Damien was remanded in custody until the case on 12 January 2010.

2.8.199 Hertfordshire Constabulary

2.8.200 **12 January 2010.** Damien appeared in court for the offences on 6 August 2009 at Louise's sister's place. He was found guilty of theft from a dwelling, common assault, using violence to secure entry, failing to surrender to custody and breach of a conditional discharge. He was given a 12-month suspended sentence with supervision requirement and a curfew order for 4 weeks with electronic tagging.

2.8.201 Metropolitan Police Service

2.8.202 On **9 April 2010**, Damien had been found parked in Jade's car with another male. Both appeared to be under the influence of drugs. Damien tried to discard two packages that were found to contain cannabis and cocaine. He punched one of the officers in the face and the officer required urgent assistance. Damien was arrested and, following a drugs analysis, he was charged and bailed to appear at Haringey Magistrates Court on 13 June 2010.

2.8.203 Hertfordshire Constabulary

2.8.204 Later that day, Jade made an emergency call to the Hertfordshire Constabulary to report that Damien had taken her keys and driven off in her car. A report was made and forwarded to MPS. Jade declined to report the car as stolen and said she would collect the keys the next day from the police. She found the car had been clamped and was angry.

2.8.205 **10 May 2010.** Jade made an emergency call from her flat to Hertfordshire Constabulary to say that Louise and Damien had been having a row over the phone and that Damien had said he was coming around. Damien had done this before and she and her mother were worried. Jade was advised to call 999 if Damien arrived. Checks were carried out

and officers arrived. They advised Jade and Louise and closed the incident as a 'non-recordable domestic'. There was no 'non-crime domestic' report made and the HRU was not informed.

2.8.206 **Commentary.** 'Non-recordable domestic' is not a category that is used.

2.8.207 Metropolitan Police Service

2.8.208 Twenty minutes later, Damien went to one of Louise's workplaces (Tuition Centre) and left two bags that he said belonged to Louise. Six cannabis plants were in one of the bags. Louise's employers called the police. The manager there said that Damien had been aggressive and reported that he believed that Damien was trying to create problems for Louise.

2.8.209 Damien was due in court the next day for the second hearing on a charge of cannabis production (incident on 9 January 2010). (See MPS Recommendation 2)

2.8.210 The report was not flagged as domestic abuse and a 124D was not completed and there was no risk assessment. Both parties were recorded as suspects but no action was taken.

2.8.211 **11 May 2010**. Damien pleaded guilty to production of cannabis at Haringey Magistrates Court. This offence was committed while Damien was on bail. Sentencing was postponed to 7 June 2010, at which time he was given a non-custodial sentence of a community order, costs and 2 months' curfew/electronic tagging.

2.8.212 Hertfordshire Constabulary

2.8.213 **28 May 2010**. Hertfordshire Constabulary received repeat silent emergency calls routed from the MPS. The calls sounded like a child and an adult talking and appeared to come from a phone associated with Louise's sister's address. The telephone number was called and an officer was sent to the address but no one answered. A text was sent to the phone asking that the person contact the police. An officer returned later that evening and, receiving no response at the door, spoke to a neighbour who said that she had seen the woman who lived at the address in the middle of the day and she appeared safe and well. The incident was closed as the woman being safe and well.

2.8.214 **Commentary.** *Poor research*. The research for this call did not reveal the number of domestic incidents related to this address, or that Louise's sister was a witness in a case against Damien, a man with a history of violence. In the circumstances, this case should not have been closed on the strength of a sighting by a neighbour.

2.8.215 **31 May 2010**. Louise made an emergency call to Hertfordshire Constabulary to report her car stolen by Damien from outside Jade's address, where she was. She said that she and Damien had argued.

2.8.216 Police arrived and took statements. Louise reported that Damien might be drunk and that she had been so frightened of him that she had run out of her home and hidden in the shrubbery. She saw Damien get in her car and drive away. She provided a witness statement and a DASH risk assessment rated the risk as standard. Louise said that Damien would be heading into London. The police recorded damage to a mirror, the theft of £60 and the taking of the car.

2.8.217 **Commentary:** *Risk assessment.* Given that there was a long history of incidents between them, that Louise was so fearful she'd fled and hidden, and the continuing harassment and control Damien was exercising by continuing taking her car after an argument, this should have been labelled as a high risk situation.

2.8.218 *Engagement of victim***:** Louise was very frightened. But time passed and there was little contact with agencies or support and she retracted.

2.8.219 The police made house-to-house enquiries and found two witnesses. One saw a 'black male' throw bags into the road and another neighbour heard a woman scream. Both declined to provide statements.

2.8.220 The Hertfordshire police contacted MPS who said they would attempt the arrest that morning but later reported that they were unable to do this due to lack of resources and cell space.

2.8.221 That evening Louise rang the police to say that Damien had agreed to return her vehicle and that she was going to collect it. She wanted the car removed from the PNC so that she was not stopped. She later rang to say that she had the car.

2.8.222 The MPS asked Hertfordshire police if they still wanted Damien arrested and attended his address to do this. When there was no reply, the incident was closed. Further efforts were made to contact Louise without success.

2.8.223 On **2 June 2010**, Louise called to say that she did not want to pursue the complaint. The operator could hear a male talking in the background but Louise said that there was no one there.

2.8.224 On **6 June 2010** officers attended Jade's address at 19:20 for a welfare check on Louise and found Damien there. He was arrested on suspicion of the offences recorded on 31 May 2010 (damage, theft and stolen car). His solicitor had a prepared statement. The

CPS would not make a charging decision until a retraction statement was obtained. Damien was released on police bail.

2.8.225 Efforts to talk to Louise failed until 11 June 2010 when Louise was noted as rude and uncooperative. Louise said she would not attend court. A further note on 15 June 2010 says that Louise would not talk to the police and the Domestic Violence Unit. The case was discontinued.

2.8.226 **Commentary.** *Holding perpetrator accountable*. The IMR suggests that the statement taken from Louise on 31 May 2010 would have been sufficient to charge Damien but that Louise's reluctance to support the prosecution made success impossible.

2.8.227 *Understanding of domestic abuse*. The pattern of Damien taking Louise's car and then returning it and then taking it again, the fear that Louise talked about when she gave her statement, the sound of a male voice in the background when Louise withdrew her complaint: these are signs that Damien was controlling Louise. The inability of the police to see and pursue the pattern for a charge of harassment shows that they were dealing with each incident individually rather than seeing the pattern of abuse here.

2.8.228 By not seeing the pattern of abuse, the agencies were baffled by her non-engagement and the case was dropped.

2.8.229 **On 1 July 2010**, an emergency call was made to Hertfordshire Constabulary, saying that a big row was happening near them. Police attended and Damien was removed from premises to prevent a breach of the peace. The other parties (male) are not the subject of this review.

2.8.230 Metropolitan Police Service

2.8.231 On **4 July 2010**, Louise reported that Damien had punched and strangled her to unconsciousness after she had collected him from an address in Woodford Green. When she regained consciousness, she ran to a nearby address for help. Louise had marks, bruising to her neck a swollen eye and said she thought she would die. She said he was jealous and controlling. A SPECSS+/DASH risk assessment graded the risk as 'medium' and measures were put in place to protect Louise.

2.8.232 Louise declined the London Ambulance Service. Arrangements were made to take photos of her injuries. Louise said that she'd had enough of Damien's volatile behaviour and was willing to go to court.

2.8.233 Safety measures included a welfare check in Hertfordshire, a panic alarm/special scheme at her Hertfordshire address and advice on injunctions and information about the NCDV[16]. VS Herts was informed so they could contract her.

2.8.234 The investigation that followed Louise's disclosure collected local information and information from other areas. It recognised Damien's criminality, and the couple's history as known to the MPS and the Hertfordshire Constabulary. The conviction for ABH on F2 was identified, though the allegations of rape were not.

2.8.235 The notes show that Louise's support for the prosecution waned a week later. Then Louise said that it was the first time that Damien had assaulted her, that she loved him.

2.8.236 Damien was circulated as 'Wanted' for ABH when the police did not find him at home. He was arrested on **25 July 2010**, charged and remanded in custody. While in custody, Damien said he was depressed but declined health care.

2.8.237 **Commentary.** *Risk assessment.* The assessment of risk here is difficult to understand. (MPS Recommendation 4)

2.8.238 Strangulation is a risk factor for serious harm or death in domestic abuse and is a common method of killing in domestic homicides, accounting for 37% of female deaths by male perpetrators[17]. This is identified in the DASH practice guidelines for first response police staff. In a study published in the US[18], non-fatal strangulation was reported in 45% of attempted homicides and 43% of homicides. Louise should have been identified as at high risk.

2.8.239 *Poor research*. Several serious allegations against Damien were missed in the research.

2.8.240 *Safety of the victim.* When Louise reported the strangulation, she appeared to be ready to assist the prosecution. The notes show her support waned a week later. Damien was not arrested for 3 weeks after this incident. With Damien still at large, it is not surprising that Louise no longer wanted to give evidence against him. Being a witness would have put her at greater risk.

2.8.241 As a high risk victim, Louise should have been referred to MARAC (see section on multi-agency partnership meetings) and Damien re-referred to MAPPA. A MARAC referral includes a referral to a specialist domestic violence worker, usually an IDVA. The IDVA

[16] National Centre for Domestic Violence. This national organization provides a free, fast emergency injunction service to survivors of domestic violence regardless of their financial circumstances and is available on an 0800 number.

[17] Edwards, Susan (2015). *The strangulation of female partners*. Criminal Law Review (12), pp. 949-966.

[18] Glass, N, Laughon, K., Campbell, J., Wolf Chair, A., Block, R., Hanson, G., Sharps, P., and Taliaferro, E., *Non-fatal strangulation is an important risk factor for homicide of women*, in J Emerg Med. 2008 Oct: 35 (3): 329-335. Accessed on 6 November 2016: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2573025/

would have made proactive efforts to contact and advise Louise on how to stay safe. The police provided information but victims often disclose more to IDVAs who have the experience and remit to work with clients over the short to medium term for long-term safety.

2.8.242 Hertfordshire Constabulary

2.8.243 **22 July 2010.** Jade made an emergency call to Hertfordshire Constabulary, saying that Damien tried to contact Louise for 2 hours. When Louise refused to speak to him, Damien had kicked the door, armed with a sharpened spanner. Damien had hit her and her mother and he had then left in her mother's car. She said that Damien was wanted for attempted murder. (Jade was probably referring to the incident when Damien had strangled her mother on 4 July, see 2.8.231 above.) While on the phone, Jade said that Damien had returned and screaming could be heard in the background. Then the line went dead.

2.8.244 Officers arrived swiftly and searched the premises but Damien was not there. It was thought that Damien was heading into London. He was seen on the A10 but he was then lost. The MPS was informed.

2.8.245 A sig marker was put on the address that identified Jade and Louise as high risk DV victims from Damien who was currently wanted by police for serious assault on Louise. It was noted that Damien was extremely violent. Louise was living with her daughter Jade and Damien had been attempting to contact Louise for two hours before this incident on the 22 July 2010. Louise had refused to talk to him and he had arrived, kicked the door in and stormed into the flat with a sharpened spanner. Damien had hit Jade to stop her calling the police, demanded Louise's keys and then driven off.

2.8.246 Witness statements were obtained from Jade and Louise and the risk assessment was increased to high risk following the attack. Police undertook to drive by the property hourly for their protection.

2.8.247 A welfare check was made the next day on Louise at Jade's flat. Louise said that Damien had not made contact and she provided the officer with Damien's telephone number so that the police could locate him.

2.8.248 The investigation was reviewed by a Detective Inspector who recorded that protective measures were to be put in place, including a panic alarm and/or moving Louise to an address not known to Damien. Fast track efforts were recorded to locate Damien. There is no record that Damien was on the PNC as 'Wanted'.

2.8.249 There is a note that Damien was arrested by MPS on **25 July 2010** for the incidents on 4 July 2010 (strangulation of Louise) and for the assaults on 22 July 2010. The Hertfordshire Investigating Officer (IO) planned to arrange a prison visit with Damien the following Wednesday to interview him about the assaults on 22 July 2010. There is no indication that this happened.

2.8.250 **26 July 2010**. Damien remanded in custody.

2.8.251 Louise rang the DVO wanting to know if Damien had been arrested. The DVO notes that she was crying and was afraid. The DVO told her that Damien had been arrested. Later that day the DVO visited and brought two alarms for the women. Louise talked to police later that day and said that she was at her parents' address and that she felt safe there; her father had reinforced the door. There is no note of a referral to MARAC or any specialist service offered.

2.8.252 **Commentary**. *Perpetrator behaviour.* Damien's sense of entitlement is seen here: Louise must respond to him or be punished. His threat to women is clear in his assault on Jade as well as Louise.

2.8.253 *Management of the case.* There was good risk assessment and immediate protection was provided but by not circulating Damien as 'Wanted', officers who dealt with Damien in the future were seriously hampered in their response. This should have been picked up in the oversight of the case. Despite the high risk assessment, there are no indications that the case was handled in a way that reflected that risk by acting swiftly to prosecute the offender or in providing effective support for the victims.

2.8.254 *Safety of victims and lack of multi-agency response.* The immediate safety of the victims was addressed. But the long-term safety was not. It appears that the police are not working within a coordinated community response to domestic abuse. They did not refer the case to MARAC or the victims to specialist support. (MARACs were available in Hertfordshire from at least mid- 2009.)

2.8.255 *Communication between agencies.* It is usual practice for police services to send representatives to interview a suspect who is in custody for another matter in another area. It is not clear why this did not happen in this case. Hertfordshire Constabulary suggests that the MPS did not know that Damien was wanted by them.

2.8.256 On **4 August 2010**, Louise contacted Hertfordshire Constabulary and said that she did not want to proceed with the case against Damien (22 July 2010 assault on her and Jade and taking her car), as she was no longer in fear of him. The Detective Inspector decided to continue with the case anyway. A note on the file shows that by 21 August

2010, Damien had still not been interviewed by the Hertfordshire police, though a request had been made to do so. The Investigating Officer noted that CPS advice should be sought.

2.8.257 Metropolitan Police Service

2.8.258 The same day, on **4 August 2010,** Louise made a withdrawal statement regarding the 4 July assault (strangulation) and this was forwarded to the CPS.

2.8.259 **7 September 2010.** Louise visited Damien in jail.

2.8.260 **9 September 2010**. Damien in court for production of cannabis and failure to comply with the requirements of a community order for a previous sentence. There was no evidence offered for the assault and that charge was dismissed.

2.8.261 **Commentary**. *Holding the perpetrator to account*. From the police record we know that there had been a witness to Louise's distress following her strangulation by Damien. Louise had run to a nearby house when she regained consciousness, and she'd agreed to photographs of her injuries. Damien's risk to Louise was recognised by the court when it remanded him. Even without Louise's testimony, on the information we have, there appeared to be evidence to substantiate a charge for the strangulation. There is more comment on this in the CPS section below.

2.8.262 *Safety of the victim.* When Damien strangled Louise to the point that she passed out, Louise was very frightened and said she'd had enough. But we have seen how Damien punished women who tried to hold him to account or deny him. It is tragic, but not surprising that she withdrew her statements. However, this severe assault should have informed police response and risk assessments from there on. The fact that this terrifying assault was dismissed can only have added to Damien's sense of entitlement and being beyond the law and will have added to Louise's sense of hopelessness.

2.8.263 Hertfordshire Constabulary

2.8.264 **15 September 2010**. The IO moved departments and the case regarding the assaults on 22 July 2010, was handed to another officer to complete. The new IO noted that the prison had not responded to requests for an interview.

2.8.265 Damien was released with bail conditions on this day. The bail conditions required that he reside at an address in Haringey and to check into the police station between 16:00 and 18:00 each Monday and Friday. He missed 2 of these appointments, but did sign in on 24 September 2010.

2.8.266 **Commentary.** *Poor investigation and management*. This was a straightforward case with a statement from Louise and Jade and a suspect in custody, yet two months after the incident, the suspect had not been interviewed. Now that Damien had been released, his bail requirements meant that there were regular opportunities to arrest and interview him for the Hertfordshire assaults on 22 July 2010. If this had happened, conditions could have been added to his bail conditions to prevent him from seeing Louise or entering Hertfordshire. He was still not listed as 'Wanted' on the PNC.

2.8.267 *Not seeing the pattern and not working together for victim safety and to hold the perpetrator to account*. The proximity of the 4 July and 22 July assaults, both severe and frightening, should have been seen as an escalation and the case referred to MARAC.

2.8.268 On **18 September 2010**, around 2:00 in the morning, Jade and a neighbour rang the Hertfordshire Constabulary to report that Damien was trying to get into Jade's flat, shouting that Louise owed him money. Jade said that Damien had just come from prison.

2.8.269 The police were dispatched but the search of the PNC did not show that Damien was wanted for the 22 July 2010 assaults on Jade and Louise. The officers attended the scene and the incident log described the situation as calm and that both parties (Damien and Jade) were spoken to. A comment from Intelligence notes that Damien may be wanted in connection with a crime.

2.8.270 Within the hour, the incident was closed and recorded as a 'standard' risk, non-crime domestic.

2.8.271 Fifteen minutes later, Jade made another emergency call saying that Damien had returned with another man and was kicking the door. The independent witness confirmed this. Officers arrived within 5 minutes and conducted a search but did not find Damien. The PNC checks indicated that Damien was on conditional bail to sleep at his flat in London. Intelligence checks confirmed that Damien was 'Wanted' for the assaults on 22 July 2010. The log notes that Damien had been allowed to leave before this information was received.

2.8.272 **Commentary**. The IMR writer notes that the bail condition to sleep at his flat was not enforceable without a curfew.

2.8.273 *Again, further missed opportunity to hold Damien accountable as a result of the serious oversight in recording on 22 July 2010.* If Damien had been posted on the PNC as 'Wanted', he would have been interviewed and likely charged by this point. Such a

charge would have strengthened the case to keep him in custody and would have precluded these incidents happening.

2.8.274 *Poor risk assessment*. The risk for this incident was reduced to 'low' without rationale and was wrong, both procedurally (see discussion of professional judgement in risk assessment in Analysis below) and professionally, given the seriousness of the charges against Damien, his 'Wanted' status, his propensity to violence and the recent (July) grading of the risk to Louise as very high. (See Hertfordshire Constabulary Recommendation 1)

2.8.275 Two days later, on **20 September 2010**, Hertfordshire Constabulary received an emergency call from a male caller at Jade's address that was discontinued. The telephone number belonged to Damien's phone. Police attended but occupants (no names provided in IMR) were surprised and abusive, saying they did not need the police.

2.8.276 **26 September 2010**. Jade rang Hertfordshire Constabulary to say that Damien would not let her out of her flat and then the call ended. Incidents at 'Shelley Court' were reviewed, but none of the incidents with Damien, Louise or Jade were identified, including the incident from 8 days before where Damien's status as 'Wanted' was noted.

2.8.277 The PNC check highlighted Damien's bail conditions and propensity to violence. It did not show him as 'Wanted'. The incident log shows that Damien was threatening Jade who was 'his girlfriend's daughter' and that he was in Jade's flat. It notes that Damien, Louise and Jade were having an argument in the car park of Jade's building. A neighbour invited them in to another flat to finish the argument. Jade called the police and Louise left in her car. A non-crime domestic incident was recorded as at 'standard' risk. It notes that a risk assessment could not be completed because the parties involved would not cooperate.

2.8.278 **Commentary.** *Profound problems with response regarding research and response to risk*. Complete records and understanding of risk should make all these encounters high risk with support for the victims and referrals to MARAC.

2.8.279 *Risk assessment*. Where there is no information for a risk assessment, the records should state that, rather than mask unknown risks with an assessment of 'standard'.

2.8.280 **27 September 2010**. The next day, Jade's grandfather (Louise's father) made an emergency call to MPS that was re-routed to Hertfordshire as it was happening at Jade's flat. The caller said that Damien had verbally abused Jade and the call-taker could hear what sounded like a domestic incident going on in the background.

2.8.281 Officers attended and found that the incident involved Jade and Damien and that Damien had left. The incident log notes that this was not a domestic because the parties involved are not related and have not been in a relationship.

2.8.282 **Commentary.** *Understanding of domestic abuse and risk*. The Review Panel discussed this and agreed that this incident should have been labelled as a domestic incident because it took place because of the relationship between Damien and Louise, Jade's mother. Damien was looking for Louise. The HRU should have been informed so that it could inform their understanding of the controlling behaviour that Damien was exercising over Louise by arguing with her daughter. The literal interpretation of the statutory definition suggests that the dynamics of power and control were not understood by the officers. (Hertfordshire Constabulary Recommendation 1)

2.8.283 Several days later, on **29 September 2010**, the Domestic Violence Liaison Officer (DVLO) tried to contact Louise after being told by another officer that Louise and Damien were back together. When she could not contact her by phone, she sent a letter to Louise with telephone numbers for an Independent Domestic Violence Advocate (IDVA).

2.8.284 **Commentary.** *Incidents treated in isolation. Victim safety*. This pro-active approach is welcomed; however, it is not clear where the letter was sent. Given the history of Damien's violence and action, sending the letter potentially increased the risk to Louise and was an unsafe action by the DVLO. (Hertfordshire Constabulary Recommendation 1)

2.8.285 *Poor understanding of risk.* This is a clear escalation and Louise's return to Damien can only have increased her risk. It may be that Louise was trying to manage Damien and stop him scaring Jade by returning to that relationship. The DVLO does not appear to have realised that the risk for Louise has increased.

2.8.286 Metropolitan Police Service

2.8.287 On the same day, **29 September 2010,** staff at Louise's place of work saw Damien being aggressive towards Louise and then the two drive off together. The police were called and attended and reviewed the CCTV but saw no evidence of violence. The incident was linked to a Hertfordshire arrest request for Damien (27 Sept incident). The police went to Damien's house and looked for the vehicle but found nothing. An urgent enquiry was sent to Hertfordshire Constabulary to check on Louise's welfare. It was a month before an outcome was recorded (on 27 October) when Louise said there had been a misunderstanding. The police recorded that day that Damien had previously assaulted Louise, but without a reference.

2.8.288 **Commentary**. *Victim safety.* The reason for the delay is not clear, particularly when the police were aware of Louise's place of work and could have checked on her there. The incident was flagged as DV. (MPS Recommendation 2)

2.8.289 *Poor research*. Police research revealed no previous incidents or factors to assist the risk assessment that ranked the risk as 'standard'. VS was notified (29.9.10). A supervisor advised that the incident be flagged as DV

2.8.290 **1 October 2010.** Damien arrested by MPS on behalf of Hertfordshire Constabulary for the aggravated burglary (breaking into Jade's flat and assaulting her and Louise) on 22 July 2010. He was brought before the court on 2 October and charged with burglary at Jade's flat, assaults on Louise and Jade and driving a car without consent. He was remanded on 4 October 2010 but released on 18 January 2011 with bail conditions to live and sleep at his flat in London, to not contact Jade or Louise directly or indirectly, not to enter Hertfordshire until the court case and to report to a local police station twice a week at specific times.

2.8.291 **Commentary.** *Priority of domestic abuse, safety of victim and holding perpetrator accountable.* This sequence of events goes some way to explaining why Louise might have felt there was no hope for her.

2.8.292 **14 January 2011.** The case against Damien for battery (assault on police officer on 9 April 2010) and possession of drugs (Class A & B) went to the Crown Court. The PNC records suggest that the strangulation case (4 July 2010) was also heard that day. No evidence was offered and the cases were dismissed.

2.8.293 **Commentary.** *Holding perpetrator accountable, safety of the victim, priority of domestic abuse, incidents treated in isolation.* It is unclear why no evidence was offered for the strangulation of Louise or the assault on the police officer. A successful prosecution for a violent offence that did not require Louise to put herself at risk by giving evidence might have provided her with some protection. It appears that this case was not seen in the context of Damien's overall offending or in the interests of Louise's safety.

2.8.294 Strategies that address the perpetrator's behaviour and do not increase the victim's risk are recommended, for example victimless prosecutions, tireless police responses to other offending that a perpetrator may be committing.

2.8.295 The PNC records are not entirely clear regarding the charges that Damien faced on 14 January. CPS records of this court appearance would have added to this review and helped the Review Panel to understand why these two cases ended as they did.

2.8.296 **18 January 2011**. Damien released from remand for 22 July 2010 assault on Louise and Jade with conditions. (The IMRs did not have a record of the conditions.)

2.8.297 **Commentary**. *Recording.* HMPS records did not note what those conditions were so we cannot tell whether these conditions should have informed the response on 20 January that followed.

2.8.298 On **20 January 2011**, the police were called to an argument at Louise's address in London between Damien and Louise about money. Damien said that Louise owed him money because she had managed his business (unstipulated) while he was in prison for assaulting her. Damien was intoxicated and was asked to leave Louise's address. The police ensured that he did not have keys to the address. Damien said he would pursue the debt through the courts. Louise said she would apply for an injunction the next day.

2.8.299 The SPECCS+/DASH risk assessment completed at this time rated the risk as 'standard' and the CSU supervisor recorded that there were no risk factors and no intervention required. There was no referral to an IDVA for help with the injunction Louise said that she wanted.

2.8.300 **Commentary.** *Risk research poor, risk assessment poor and safety of victim.* The MPS had information that should have identified heightened risk factors of separation, escalation, isolation, stalking/harassment, strangulation, controlling behaviour, threats to kill, alcohol and drugs in relation to Louise. In addition, Damien had criminal convictions for violent offences, regularly breached bail conditions and had harmed previous partners. Going back to the case of P2, risk assessments for partners of Damien should have been continually high with the corresponding heightened response including referral to a specialist DV worker and a referral to MARAC.

2.8.301 Damien had shown little respect for legal restraints to this point, so it is unlikely that an injunction would have provided sufficient protection for Louise.

2.8.302 Louise was the victim of the crime for which he was bailed. We do not have a record of what Damien's bail conditions were but his actions here and on 3 February below are likely to have breached them.

2.8.303 Less than 2 weeks later, on **3 February 2011**, police again intervened in an argument between Louise and Damien. Though the prison dates do not confirm this, the police understood from Damien and Louise that Damien had just been released from prison. Louise said that Damien had come to her place to demand the money that he said she

owed him. Both Louise and Damien had been drinking and would not answer questions. The police again advised Louise about civil remedies.

2.8.304 **Commentary**. *Safety of the victim*. As both parties were intoxicated, this was a poor time to provide advice. If Louise had been assisted to gain an injunction, then this incident could have been recorded as a breach and Damien could have been arrested and prosecuted. No questions were asked about the debt and Damien's business, or about any efforts he'd made to address his grievance through the courts.

2.8.305 *Release from prison*. A pattern is developing where Damien is released from custody and shortly thereafter tries to find Louise. Yet Louise is not informed of his release despite the risk to her.

2.8.306 On **17 February 2011**, Louise rang the MPS and reported damage to her car and to her mother's front door. Louise reported that she had separated from Damien after the last incident. The SPECCS+/DASH risk assessment gave a rating of 'medium' with heightened risk factors of separation, escalation, stalking/harassment, strangulation, threats to kill and alcohol and drug use.

2.8.307 This incident was flagged as DV and then the flag was removed when the police could not confirm that Damien was the suspect. The case was closed when the police could not contact Louise again.

2.8.308 Louise was living with her mother who was 78 at the time. The current response would have included a Vulnerability Framework Assessment and consideration of a referral to adult social care.

2.8.309 **Commentary**. *Poor risk assessment*. The DASH Guidelines for First Response Police Staff notes that attempts to end a relationship are strongly linked to intimate partner homicide. Women are particularly at risk when leaving an abusive relationship. The DASH risk assessment asks if there has been separation within the last year. In the Standing Together review of DHRs, 10/32 of the victims had left their abuser. Half of these victims had left in the past year and the other half had been separated for longer, suggesting that any separation, completed or intended should prompt more investigation when assessing risk after separation.[19]

2.8.310 *Viewing incidents as separate events and not seeing the pattern. Victim safety.* Again, after the assault on 4 July 2010, any interaction between Damien and Louise should

[19] *Domestic Homicide Review (DHR) Case Analysis at* http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf.

have received a high risk response. The damage followed a long-standing pattern of harassment.

2.8.311 Hertfordshire Constabulary

2.8.312 The same day, **17 February 2011**, a little after 8am, Jade reported her car windscreen had been damaged overnight. She told police that the damage was likely to be caused by Damien because he had also damaged her grandmother's door that night. She was in the process of checking the CCTV from a nearby shop.

2.8.313 A detective advised the control room to send an officer as Damien was on bail and Jade was a witness (for the assault against her and Louise on 22 July 2010) and this could constitute witness intimidation. The CCTV footage from a nearby shop showed a black male wearing a hooded jacket walk to Jade's car and throw something through the windscreen. The offender then disappeared out of view. Though Jade could not identify that it was Damien, she did identify the clothing as his.

2.8.314 Hertfordshire police requested that MPS arrest Damien, a file of evidence was compiled and Damien was put on the PNC as 'Wanted' for this offence, but this was not put on the file until June 2011.

2.8.315 **Commentary**. *Lack of priority for domestic abuse and victim safety. Poor recording and oversight.* June 2011 was after Damien's trial that Jade was to be a witness in, after his sentencing for that and after he had served his brief term of imprisonment. There are no notes about a search of his flat to identify the clothes in the CCTV footage. As he was on bail for serious domestic-related offences, this incident could have been pursued in an effort to remand Damien in custody until the case, providing some peace of mind for Louise and Jade.

2.8.316 Metropolitan Police Service

2.8.317 On **14 April 2011**, the police rang the LAS to attend an incident where a man (believed to be Damien) was on the roof refusing to come down. Louise had reported the incident. The police then cancelled the ambulance when the risk of injury reduced.

2.8.318 Damien was arrested on warrant for failing to appear at St Albans Crown Court on 4 October 2010 (Damien was remanded on this day for another offence) and at Bedfordshire Magistrates on 7 February 2011 (unclear for what offence). He was remanded to St. Albans Crown Court the same day and fined £300 and in default of this was ordered to serve 14 days in prison.

2.8.319 Prison records show that Damien was in prison from 15 April 2011 to 12 May 2011.

2.8.320 **Commentary.** *Threats of suicide are a risk factor.* The fact that Louise called the police suggests that she feared that Damien would be harmed or harm himself. There is a link between suicide and homicide for domestic abuse perpetrators[20] and threats of suicide are a risk factor in domestic abuse.

2.8.321 Herts Constabulary

2.8.322 On **12 May 2011,** Damien attended two different courts where he pleaded guilty in both. He pleaded guilty to common assault and criminal damage for the events of 22 July 2010 (assaulting Louise and Jade) and was sentenced to imprisonment for 3 months. He was also sentenced for bringing a prohibited article into prison (a mobile phone), and for failing to surrender to custody.

2.8.323 PNC notes that, taking account of his time on remand, Damien was released the next day – having served one day. The potential witness intimidation was not considered. Again, Louise and Jade were not notified when Damien was released.

2.8.324 Metropolitan Police Service

2.8.325 On **14 May 2011** Louise attended her probation placement and Damien (who had just been released from prison for an assault on Louise) was there with another man. Damien struck Louise, giving her a black eye. The SPECCS+/DASH risk assessment was 'standard'.

2.8.326 Five days later Louise withdrew her statement. She told the police that she would eventually stay away from Damien 'in her own way, in her own time'.

2.8.327 A week later, she had changed her mind and wanted Damien prosecuted. She gave a further statement to the police. Damien was circulated as 'Wanted'.

2.8.328 A MARAC referral was noted on the file, but there was no evidence of this in the minutes of the MARAC meetings and no referral paperwork was found. (MPS Recommendation 2)

2.8.329 **Commentary.** *Poor risk assessment* given the assault the previous summer. But then a referral to MARAC is noted; suggesting a reconsideration of the risk and then not made.

[20] Campbell et al, 'Risk Factors for Femicide in Abusive Relationships: Results from a multi-site Case Control Study, American Journal of Public Health, 2003 and 'Characteristics of spousal homicide perpetrators. Belgrade. H and Rying, M. 'A descriptive study of all cases of spousal homicide in Sweden 1990-19999'. *Criminal Behaviour and Mental Health: Depression among Perpetrators of Domestic Homicide* (2004).

2.8.330 *Victim safety.* Damien is known to be vindictive when women challenge him and Louise wanted Damien prosecuted for his assault on her. The MARAC and an IDVA should have been offered.

2.8.331 On **27 May 2011**, Louise reported that Damien had shouted through her letterbox and that she was afraid he would return and assault her. The SPECCS+/DASH assessed the risk as 'medium' with heightened risk factors of homicide/suicide (based on the incident in April when Damien was on the roof).

2.8.332 However, Louise was referred to an IDVA, to MARAC and to VS. Louise told officers that she had the details for NCDV[21] and other support agencies.

2.8.333 Damien was arrested on **10 June 2011** for the 14 and 27 May 2011 assaults, charged and remanded to appear on 11 June 2011 at Haringey Magistrates Court. Louise was referred to VS.

2.8.334 On **11 June 2011**, Damien appeared at Highbury Magistrates Court in relation to the offences on 14 and 27 May 2011. The records do not show the result of this court appearance.

2.8.335 Louise's case was discussed at the Enfield MARAC on **15 June 2011**. (See MARAC section below.)

2.8.336 **Commentary.** *Poor understanding of risk***.** DASH Guidelines for First Response Police Staff note that if a perpetrator threatens suicide, there is a heightened risk of homicide. [22] These last two assessments suggest some confusion about MARAC referrals. A MARAC referral is, by definition, someone assessed as being high risk, either through the SPECCS+/DASH, professional judgement, or escalation. Here, Louise should have been assessed as at high risk, so it was good that she had a high risk response with the referrals to an IDVA, MARAC and VS.

2.8.337 *Coordinated community response.* The MARAC response was poor and was a lost opportunity to share information and create a multi-agency plan to help Louise stay safe.

2.8.338 Hertfordshire Constabulary

2.8.339 On **8 July 2011**, Damien was arrested for the criminal damage to Jade's car on 17 February 2011. He was interviewed, denied it and was released without charge.

[21] National Centre for Domestic Abuse. This is a national call centre manned by legal advisors that supports victims of domestic abuse to bring civil cases against their abusers.

[22] Menzies, Webster and Sepejak, 1995; Regan, Kelly, Morris and Dib, 2007.

2.8.340 This was the last contact Hertfordshire Constabulary had with Damien, Louise or Jade.

2.8.341 **Commentary.** This continuing failure to hold Damien to account would have contributed to Louise and Jade's sense that Damien could do as he wished.

2.8.342 *Coordinated community response.* Throughout Hertfordshire Constabulary's account of their involvement with Louise and Damien, there is only one reference to referring Louise or her family to specialist domestic abuse services. VS Herts (later in this report) had no records of any contact with Louise or Jade. There is a recommendation about the police engagement with partner agencies, especially the new IDVA service. (Hertfordshire Constabulary Recommendation 2).

2.8.343 *Update.* As a result of lessons learned from previous DHRs that have occurred in Hertfordshire and nationally, Hertfordshire Constabulary has fundamentally reshaped its response to domestic abuse. Hertfordshire Constabulary launched a specialist Domestic Abuse Investigation and Safeguarding Unit (DAISU) at the beginning of 2016. DAISU investigates all incidents of domestic abuse reported to the Constabulary. As well as providing dedicated resources for investigating violence, coercive or controlling behaviour and other abusive behaviour that can occur within intimate relationships, this team is also tasked with vital work to protect, support and safeguard victims. The staffing levels in the DAISU have increased recently in response to the increase in reports of domestic abuse.

2.8.344 Metropolitan Police Service

2.8.345 On **8 August 2011**, Damien appeared at Haringey Magistrates Court for the incident on 14 May 2011 when he had struck Louise in the face causing a black eye. No evidence was offered and Damien was found not guilty.

2.8.346 **Commentary**. *Lack of information*. Again, the records do not tell why no evidence was offered at court. Louise had told the police and the hospital staff about the assault at the time and there was physical evidence of the assault. In addition, Damien had threatened Louise (the victim and witness) at her home on 27 May 2011.

2.8.347 On **6 September 2011**, Damien went to Louise's address in Enfield and knocked loudly. She rang the police, but made no allegations when they arrived. A SPECCS+/DASH assessed her risk as 'medium'. Louise told officers that she 'was getting used to it'. A VS referral was noted but not made. (MPS Recommendation 3)

2.8.348 **Commentary.** *Research and supervision poor.* Following this contact, the research was again poor and endorsed by a supervisor, resulting in another missed opportunity

to understand the full history of Damien's abuse of women and particularly Louise, and consider a re-referral to MARAC.

2.8.349 On **26 September 2011**, Jade rang the police saying that she'd received a distressed call from her mother saying, 'I need you to help me. I need you to get the police to me somehow'. Louise had told her, 'he has taken me out of the area and I can't take any more. My face has already been smashed up.' Jade believed that 'he' was Damien and urgent welfare checks were made at Louise's and Damien's addresses and the duty officer was informed. When the police found Louise, she said that she'd been punched by Damien but that she was not being held against her will. SPECSS+/DASH was assessed as 'medium'. Damien was circulated as 'Wanted'.

2.8.350 Research identified the history of domestic abuse and the warning signs on the PNC related to Damien. A MARAC referral was raised as an action by a supervisor but not made. (MPS Recommendation 3)

2.8.351 On **11 October 2011**, telephone messages were left at Louise's place of work (Cherry Wood). The messages came from Damien's telephone number. One was unclear, but the other spelt 'C***'. Staff told police that Louise was most likely the intended victim.

2.8.352 The police initially identified this as DV but then took the flag off when they decided it was not clear who the intended victim was. Her employers had taken to varying her routine to help her avoid Damien. Officers alerted the police in Enfield who were investigating the assault allegation from 26 September 2011. (MPS Recommendation 2)

2.8.353 **Commentary.** *Poor understanding of domestic abuse. Incident-focus.* It was clear who the victim was if the police had taken these actions in context. Damien was wanted for an assault on Louise (26 September 2011) and had a history of leaving messages on her workplace phone.

2.8.354 Louise was contacted and provided advice about civil orders and future contact with Damien and information about Hearthstone, the specialist DV provider in Haringey. She was also provided with a DV pack of information that listed specialist organisations in the area, myths and facts about domestic abuse, and practical steps to stay safe.

2.8.355 **Commentary.** *Victim safety*. Louise had received a lot of information by this time. For a perpetrator with these behaviours, a civil order would have little, if any, effect. One is reminded of Jade's statement that her mother needed a *person* to help her.

2.8.356 On **31 October 2011** Damien attended Louise's workplace while she was there. He knocked on a window and asked to come inside. When Louise refused, he continued to knock on the window, accused her of 'sleeping' with someone, called her a 'bitch' and threw stones. Damien then approached another employee who was arriving for work. When he also refused to let Damien in the building, Damien became abusive and accused him of 'sleeping' with Louise. Damien had left by the time the police arrived and he was not at home when they called there. The police noted that Damien's flat was padlocked from the outside.

2.8.357 The risk to Louise was assessed as standard, the incident was flagged as DV, and Louise was given a DV pack again. A 48-point plan was completed but neither a supervisor nor the CSU were consulted. VS were notified.

2.8.358 On **15 December 2011**, Louise attended the Haringey police station early this morning to report an incident at her place of work at the Victoria Oaks site. Damien was waiting for Louise when she got to work in her car. She locked her doors when Damien ran towards her and tried to open a door. She sounded the horn and colleagues then witnessed Damien kick Louise's car, jump on the bonnet, pour beer over the windscreen and pull off the wipers.

2.8.359 Louise returned to her address from her mother's because Damien had threatened to tamper with her electrical supply. She reported damage to her door later that day.

2.8.360 Three days later, on **18 December 2011**, Louise reported further criminal damage to her front door and took refuge in a neighbour's flat and called the police. Damien was found on the roof and arrested for offences against Louise (assault on 26 September 2011 and criminal damage to her car, front door and electrics on 15 December 2011).

2.8.361 In interview, Damien claimed that Louise had driven her car at him. Damien said that the difficulties between him and Louise were due to her owing him another £9,000. Damien said that he thought Louise was 'seeing' someone else and that he got angry and now wanted to end the relationship. There is no record of a discussion of Damien's business and the source of the debt that Damien was seeking to be repaid. There was no record of this information being shared with Probation though Damien had recently been released from prison.

2.8.362 Damien was charged with theft of house keys, assault, and criminal damage to Louise's front door.

2.8.363 There is no explanation for why it took so long (3 days from the 15 December incident) to arrest Damien. Enquiries found that the concierge of Damien's block of flats was

willing to assist by notifying the police of his return, but there is no indication that this approach was considered at the time. (MPS Recommendation 2)

2.8.364 Louise revealed that Damien had tried to lock her in. The risk assessment was 'standard' due to Damien being in custody and this assessment was confirmed by a supervisor. Louise was referred to an IDVA and VS was notified.

2.8.365 The Officer in Charge (OIC) prepared suitable bail conditions in the event that the court released Damien.

2.8.366 **Commentary**. *Incidents in isolation, poor research and poor risk assessment*. These incidents at Louise's workplace were dealt with in isolation and the research was not thorough. They were not flagged as DV and therefore were not reviewed by specialist officers in the CSU. Opportunities to build a harassment case – either of her employer and/or Louise – were not taken. There was no liaison with the Safer Neighbourhood Team, ASBAT or Louise's employers about Louise's safety, lone working, and the use of CCTV or Louise's options in an emergency. These are common activities for CSUs, but they were not implemented here.

2.8.367 Louise's workplace was a school for children with support needs. There is no evidence in the police file that the potential risk to them was identified and addressed. (MPS Recommendation 2)

2.8.368 *Victim safety*. That Damien had tried to lock Louise in is evidence of extreme control and should have made the risk assessment high with the consequent response.

2.8.369 *Good practice*. The OIC's preparation of bail conditions by someone close to the case was good practice.

2.8.370 On **18 December 2011**, Damien was remanded in custody to appear in Haringey Magistrates Court on **23 December 2011** for a bail application. He was successful in his bail application and released. In the risk assessment for one of the incidents on 26 December 2011, the officer noted that one of the licence conditions was not to contact Louise directly or indirectly.

2.8.371 Damien was then bailed to appear at court for the damage to the car pending statements and CCTV evidence. An alarm was put in place at both Louise's home addresses (she was moving) at this time.

2.8.372 **Commentary.** *Victim safety.* If MPS had been notified of Damien's release, consideration could have been given to making emergency plans with Louise. Damien was a prolific and violent offender and could have been referred to MAPPA.

2.8.373 Three days after his release, on **26 December 2011**, the police attended two incidents of domestic abuse at Louise's residence.

2.8.374 In the morning, the windows of an address where Louise was staying were smashed while Damien shouted, 'Get [Louise] out here.' Louise activated her panic alarm, but Damien had left before the police arrived. Louise said that Damien thought she was in a relationship with another man (M2) and had called her saying, 'Are you going to save your Paki [sic] friend?'

2.8.375 The SPECSS+/DASH assessed the risk as 'standard' and Louise was advised to activate her alarm if Damien returned. A police sergeant confirmed the assessment and noted that there was 'little the police could do' and that they had no evidence that it was Damien who had caused the damage. A Detective Inspector removed the DV flag saying this was not a domestic violence incident. M2 said that he was unwilling to support a prosecution and the case was closed. Louise told the police that Damien had been released from prison a few days before and was on a tag with a curfew between 20:00 and 8:00.

2.8.376 A supervision plan was made that included moving Louise to an address unknown to Damien. It also included circulating Damien as wanted if not arrested within 72 hours. These were recorded on the risk assessment. The risk was seen as minimal.

2.8.377 **Commentary.** *Victim safety*. Good practice. Louise had been given a panic alarm and used it on this occasion.

2.8.378 *Identifying domestic abuse. Risk assessment*. The risk assessment was again poor. Damien's behaviour amounts to jealous and controlling behaviour and is a risk factor for domestic abuse. An investigation plan was entered on CRIS by a Detective Sergeant. There was no differentiation between the needs of Louise and M2. (MPS Recommendation 3)

2.8.379 *Holding perpetrator accountable*. Damien had breached his licence conditions here.

2.8.380 That night, Louise received a telephone call from a male she did not recognise (M3) who stated that he knew where she was and would 'blow her head off' and would 'get some boys to kill her'. Louise could hear Damien prompting the caller and rang the police. SPECCS+/DASH was assessed as 'standard', despite noting the risk factors of separation, escalation, isolation, stalking/harassment, strangulation, controlling/jealous behaviour, threats to kill with the additional factors of Damien's cocaine and alcohol use. This assessment was raised to 'medium' by a supervisor.

2.8.381 It was noted that Damien may be in breach of his licence conditions. This incident was linked to the one in the morning.

2.8.382 On **4 January 2012,** Damien was arrested for malicious communications (evening of 26 December) and breach of a Home Detention Curfew (HDC). The police were unable to obtain a statement from Louise about the telephone calls. The case was reviewed and no further action was authorised for the case about the calls. Damien was remanded for breach of his curfew. Though Damien was unemployed, he had £450 in his possession when arrested.

2.8.383 There were no referrals to MARAC for Louise or to MAPPA for Damien to share information and agree a plan. Several incidents mentioned referrals to an IDVA but no outcomes were recorded. (MPS Recommendation 3)

2.8.384 **Commentary**. *Safety of victim, risk assessment/priority of domestic abuse.* These are threats to kill from a perpetrator known to be jealous and controlling, who had just been released from prison and had strangled Louise to the point of unconsciousness 18 months previously. Louise is also a repeat victim. She should have been referred to MARAC and Damien to MAPPA.

2.8.385 On **20 January 2012**, Police attended Damien's home address to arrest him for breach of a HDC at the request of Service Corporation (SERCO). He was not at home. It was identified that Damien had registered a vehicle to Louise's address using a false name. There was a note that Damien was disqualified from driving until 16 February 2012. The vehicle was flagged for Automatic Number Plate Recognition. No outcome was recorded for the curfew breach, nor was a record found regarding the disqualification.

2.8.386 On **24 February 2012**, Damien was arrested, charged and remanded in relation to damage to Louise's car and door on 15 December and 18 December 2011. The following day, on 25 February 2012, Damien pleaded guilty to criminal damage and disorderly conduct and threatening behaviour. There was no evidence offered for the incident on 26 September 2011 and it was dismissed.

2.8.387 **Damien was fined and issued with an indefinite restraining order that stipulated that he must not contact Louise directly or indirectly or attend her address or place of work.**

2.8.388 Breaching a restraining order is a criminal offence and can be punished with imprisonment up to 6 months by a magistrates' court and up to 5 years' imprisonment if the case goes to the Crown Court.

2.8.389 **Commentary.** *Victim safety.* The court issued the restraining order in recognition of the threat Damien posed to Louise. This recognition could have been reinforced by the police through contacting Louise, providing a copy of the restraining order to Louise, researching the situation thoroughly in order to create a risk assessment that took account of all that the police knew, referring Louise to an IDVA and starting risk management strategies in partnership with other agencies through the MARAC and or MAPPA. (MPS Recommendation 7)

2.8.390 Another victim: F4

2.8.391 On **13 April 2012**, the concierge at Damien's block of flats spoke to him following a complaint by a female neighbour (F4) about his noise and that she was afraid of his dog, named 'Gangster'. Damien then banged on F4's door saying that she 'should watch her back'.

2.8.392 On **20 April 2012**, F4 reported an assault by Damien saying that he had put his foot in her front door to stop her closing it, abused her and spat in her face. When police arrived, Damien had left. He returned later and threatened her with a weapon, saying 'this is for you, remember we both live here. I see you every day.' When he was arrested, it was clear he had been drinking. He was charged and remanded.

2.8.393 He appeared in court on **24 April 2012** and was bailed with conditions not to contact F4 or go to the block of flats where he lived and to reside with his mother.

2.8.394 During the investigation, the police discovered that Damien had asked a local shop keeper to dispose of a weapon or machete. Following his hearing, Damien was rearrested and bailed again. No action resulted from this as the shopkeeper could not recall the incident and there was no CCTV evidence.

2.8.395 On **27 April 2012,** Damien was arrested and returned to court. He was imprisoned for breaching the conditions of his bail by returning to his block of flats. F4 was assisted by Haringey Council to move house.

2.8.396 Abuse of Louise

2.8.397 On **13 May 2012**, Damien was released from prison for the incident with F4 and for breaching bail conditions.

2.8.398 On **15 May 2012**, Damien rang the police twice in the early morning, claiming that Louise owed him £400 and had threatened him with a knife. Then Louise activated her panic alarm and called the police to report that Damien had pushed her and threatened to burn her house and car. Police attended

2.8.399 Louise said that Damien had come to her workplace the day before (not in police records) to collect money that he had won on a bet and that she had looked after for him while he was in prison. She had given him the money. She said that Damien had then messaged her insulting messages and called her throughout the night. When she realised that he was outside her address, she went outside to him. He then shouted that he was going kill her, that he would 'go to prison for life', 'do life for you' and 'watch out tonight, I'm coming back with my family', and then pushed her.

2.8.400 Damien was arrested and found to have £973 in cash on him, though he said he was unemployed. Damien claimed to be claustrophobic when questioned and said he was under the influence of alcohol. He was not questioned about the source of the money. (MPS Recommendation 2). Damien was released on bail – there is no note of bail conditions.

2.8.401 The SPECSS+/DASH assessed the risk to Louise as 'standard' (as Damien was in custody) and noted heightened risk facts of escalation, stalking, threats to kill, strangulation, jealousy and alcohol/drugs. A statement was taken in the 124D. Louise agreed to be referred to a specialist agency and VS were informed that day. There was no arrest for breach of the restraining order.

2.8.402 CPS were not consulted until 30 May 2012.

2.8.403 **Commentary.** This assessment did not reflect the risk to Louise at the time:

(a) Damien had breached his restraining order, but he was not arrested for this until 5 June. This should have gone to an Evidential Review Officer and CPS for a charging decision. This was the first breach.

(b) Damien stated that Louise had asked him to come to collect the money and she was trying to get him in trouble, thus acknowledging the breach.

(c) No research informed this risk assessment – the history between the two was not taken into consideration. Louise was a repeat victim.

(d) The risk assessment should have been 'high'. A 'standard' assessment was made because Damien was arrested and taken away. But he was released after the interview, so the safety provided by the arrest was short-lived and provided no protection for Louise. Risk was not re-assessed on his release.

(e) The case should have gone to MARAC.

(f) The risk would have been better managed by charging Damien was a breach and remanding him in custody to appear at court. He was given bail conditions.

2.8.404 **16 May 2012** – the next day. Louise's mother reported that Damien kept coming to her address and calling her in order to find Louise. Louise's mother told Damien to stop coming to the house but he persisted. The police called Damien who denied harassment and said he had attended Louise's mother's house to collect the money that Louise owed him. The police issued a harassment notice.

2.8.405 Louise's mother was noted as vulnerable and an assessment of 'medium risk' was recorded.

2.8.406 **Commentary.** *Victim safety and holding perpetrator accountable*. Damien had breached his restraining order by attending Louise's mother's address and trying to contact Louise indirectly. Therefore this harassment notice added nothing and provided no protection. Once again, Damien had breached conditions or orders put in place to protect Louise and had suffered no consequences.

2.8.407 Two weeks later, on **1 June 2012**, Louise's daughter reported receiving threatening calls and texts from Damien. Damien told her that if she did not speak to her mother for him, 'something serious will happen'. He texted further threatening messages telling Jade that Louise had got him 'nicked' and then saying she should '4 get it I got luv 4 u bt I hate ur mum and u wil c how much bt nt my fault is her' [sic]. He also texted that Louise had picked up £15,000 and police had £400 of it.

2.8.408 **Commentary.** *Victim safety and holding perpetrator accountable.* This was a further breach of the restraining order through indirect, and threatening, contact with another female relative of Louise. No risk assessment was undertaken, nor was the source of the money that Damien spoke of explored though it suggested a motive for the increase in Damien's efforts to contact Louise. (MPS Recommendation 2)

2.8.409 On **5 June 2012**, Damien was arrested, interviewed and bailed for breaching of restraining order on 15 May 2012 and 1 June 2012, and for harassment of Jade through threatening text messages on 1 June 2012. Damien was bailed until 10 July. The CPS was not consulted until 30 June 2012.

2.8.410 **Commentary**. The new bail conditions mirrored those of the restraining order that Damien had been breaching. He had paid no attention to these restrictions. This action was agreed by an inspector and an investigation plan was drawn up. Again, the breach should have been reviewed by an Evidence Review Officer and CPS for a charging decision at the time. (MPS Recommendation 2)

2.8.411 In interview, Damien stated that Louise kept visiting his address and contacting him. He said that Louise wanted to get back together with him and that she owed him £6000 from his car parking business.

2.8.412 Louise confirmed that she went to Damien's address and that she knew there was a court order in place. She gave no reason for this. She was advised not to contact Damien and a special scheme was placed on her mother's address, where she was staying.

2.8.413 Louise enquired at the police station when Damien would be released and if she could take his dog.

2.8.414 **Commentary.** The court order restricted Damien's movements and actions, not Louise's and the focus of police efforts should have been on this and on bringing Damien's breaches of the restraining order before a court. (MPS Recommendation 2)

2.8.415 *Perpetrator behaviour.* It may be that Damien used the dog to extend his control of Louise. We know from reports of the neighbours (in Homes for Haringey information later) that the dog was very frightening. There were a number of occasions when Louise was expected to take responsibility for the dog.

2.8.416 *Victim safety sacrificed. Damien* was re-bailed on 5 occasions regarding the breach of the restraining order. A CSU Inspector authorised these re-bails and Damien was informed by letter. Louise's safety was not prioritised.

2.8.417 <u>Other victims: F5 and F6</u>

2.8.418 Less than 2 weeks after the malicious calls, on **10 June 2012**, police were called to an address in Barnet by two sisters (F5 and F6 who were 17 and 19 respectively. They reported grievous bodily harm (GBH) by Damien. They had met Damien the day before at a club. F6 had invited him to keep her company whilst she babysat her sister's 2-year-old child. F5 was out when Damien arrived but F6 rang F5 to come home when Damien's conversation concerned her. The three then drank alcohol and Damien tried to get F6 to go home with him. He left in a taxi at about 4am. He returned a half hour later and accused them of stealing money from his wallet. They all argued and Damien punched F5 in the face and hit F6 on the hand with a wine bottle. He then found he had the money, apologised, gave them £20 and left.

2.8.419 Neither F5 nor F6 wanted to proceed with an investigation or have Damien warned saying they were worried that Damien knew about F5's child and her address and might return to retaliate. They did not expect to have further contact with him.

2.8.420 The risk assessment was 'standard'. It was noted that Damien was known for the harassment of several young women. A Detective Inspector considered the option of arrest but concluded that the injuries were not serious and that the likely result would be a 'release without charge' and that was likely to aggravate the situation.

2.8.421 The research carried out was not qualified with reference numbers or a summary of incidents so when the case was reviewed by supervisors, the details were not available to them.

2.8.422 **Commentary.** *Poor risk assessment and victim safety*. Damien had just been released from prison (13 May 2012) for spitting at F4 and breaching court bail. He was at the time on bail for 3 incidents of domestic abuse linked to Louise (15 and 16 May 2012 and 1 June 2012). He was the subject of a restraining order to protect Louise that he had breached several times. A risk assessment of 'standard' is very hard to understand.

2.8.423 In the context of his constant harassment and abuse of women, this was an unchallenged escalation of his behaviour. The pattern of threats against women was noted, but did not result in any action against Damien. (MPS Recommendation 1)

2.8.424 <u>Further to incidents related to Louise in June 2012</u>

2.8.425 **14 June 2012.** Damien attended Haringey police station to report that Louise had sent him abusive texts, had come to his flat to challenge him about other women, slapped him and broken his glasses. Damien had no injuries and could not show the abusive texts. A DS reviewed the case and put a plan in place to investigate the complaint and take a statement from Damien, in his role as victim. A non-molestation order was noted but no further investigation was noted. Damien did not attend to provide a statement and the case was closed. Damien was referred to VS.

2.8.426 **Commentary.** *Victim safety*. In these circumstances, the police were obliged to refer Damien to VS under the Victim's Charter. However, this characterisation of him as a victim might have reinforced his controlling behaviour; thinking that he'd somehow got the authorities on his side.

2.8.427 This is the second civil order that is mentioned in the records of this case**.** However, there is no record in the police files of the details of any civil court protective orders. The police only know about civil protective orders if they are notified by those involved. This gap between the civil courts and the police, who are required to enforce the orders, undermines victim safety.

2.8.428 *Update.* As a result of another domestic homicide and the review that followed it, the MPS is looking at a system to link civil protection orders to the police information system. This is a national problem and there is a Recommendation to address this below.

2.8.429 On **26 June 2012** a supervisor raised an action for the Officer in Charge (OIC) to progress the investigation of the breaches of restraining order with the CPS.

2.8.430 Incidents related to Louise

2.8.431 On **10 July 2012**, Damien was due to attend the police station regarding his breach of the restraining order but he was re-bailed to 16 July 2012.

2.8.432 On **16 July 2012**, Damien was due to attend the police station regarding his breach of the restraining order but he was re-bailed to 24 July 2012. The reason noted was that a statement had been taken 2 days earlier and CPS required 7 days to review it.

2.8.433 On **23 July 2012**, Louise's mother contacted police, saying that Damien's dog had been left on her doorstep and she thought this was Damien's way of getting her to contact him.

2.8.434 On **24 July 2012**, Damien was due to attend the police station regarding his breach of the restraining order but he was re-bailed to 28 August 2012. The reason noted was that CPS had conducted a review and issued an 11-point action plan.

2.8.435 On **25 July 2012,** Damien was arrested again for breaching his restraining order. On the same day, the CPS returned an 11-point action plan and Damien was re-bailed to 28 August 2012.

2.8.436 **Commentary.** *Victim safety. Holding perpetrator accountable*. This was the fourth breach of a restraining order put in place by the court to protect Louise. Without enforcement the order offered little protection. The lack of enforcement suggests that Louise's safety was not a priority here. There were no actions taken to further understand the situation. There was no MARAC discussion nor the offer of an IDVA to help Louise manage the risk and her safety.

2.8.437 It is marked that Damien continued to persecute females that he came into contact with – the mother and the daughter of Louise, as well as sisters F5 and F6.

2.8.438 On **17 August 2012**, the police contacted Louise who refused to speak to them, though her mother confirmed that Damien was meeting Louise regularly.

2.8.439 On **28 August 2012**, Damien was due to attend the police station regarding his breach of the restraining order but he was re-bailed to 12 October 2012. The reason noted was that CPS had further enquiries.

2.8.440 On **17 September 2012**, Damien was arrested, charged and remanded to appear in court the next day for a night-time residential burglary. He confirmed being dependant on alcohol and was drug-tested. (The result of the drug test is not noted.)

2.8.441 On **12 October 2012**, Damien was due to attend the police station regarding his breach of the restraining order but he was re-bailed to 3 December 2012. The reason noted was that the case needed further statements and phone examination.

2.8.442 On **1 December 2012**, the OIC recorded that 11 out of the 12 actions set by the CPS had been completed for the case for breach of the restraining order. Though Damien was on remand for the burglary, he was bailed to a further date for the last action to be completed.

2.8.443 On **7 December 2012**, Damien pleaded guilty to burglary and was sentenced to 18 months in prison, suspended for 24 months. A drugs rehabilitation order for 9 months was also issued. Damien was released from custody.

2.8.444 Finally, on **30 January 2013**, a supervisor noted that the offence of harassment had exceeded the 6-month limit for bringing the case to court. It was noted that Louise was not engaging with the police but that they had left a message updating her that they were dropping the harassment case and the breach of the restraining order.

2.8.445 **Commentary.** *Loss of focus on victim safety. Holding the perpetrator accountable.* The MPS IMR states that there are no obvious reasons given for the terminal delays to the case for harassment. Evidence of the first three breaches included police evidence.

2.8.446 The case for harassment appears to have been linked to the case for breach of the restraining order, as there is no further evidence about the pursuit of the breaches case. The handling of this case did not meet minimum standards. There were long delays between updates and supervision. Oversight was poor. Reminders were sent to the OIC and requests were made for updates throughout the period, but the records were not always updated following these requests. No risk reviews were recorded during this long delay. There was no MPS meeting with CPS at the conclusion of the case as to how it could be taken forward. The breach case is returned to in the CPS section below.

2.8.447 *Victim safety*. The objective of the restraining order was missed entirely throughout this period: that of protecting Louise. The police should have proactively managed the risk

that Damien was posing to Louise while these cases were being built. At this time, it would have been difficult for Louise to see the value of engaging with the police.

2.8.448 On **3 August 2013,** Damien was stopped while driving Louise's car in Islington. He provided false information and was in possession of what appeared to be a Class A drug. He was arrested for taking a vehicle without consent, having no insurance, driving without a valid driver's licence. Louise confirmed that she had not given Damien permission to take her car.

2.8.449 A detective constable in the Islington CSU advised against arresting Damien for breaching the restraining order because the police understood that Louise was in a relationship with Damien. (MPS Recommendation 5)

2.8.450 **Commentary.** *Lack of understanding of domestic abuse, safety of victim*

2.8.451 The incident was flagged as DV and a SPECSS+/DASH risk assessment was graded as 'standard'. The details were not uploaded to CRIS. Damien was transferred to Haringey for investigation. Damien was referred to the IOM Unit, as requested (see IOM section below) and remanded in custody to appear at Haringey Magistrates Court a few days later. Damien confirmed that he had consumed alcohol and a drugs test was positive for cocaine. He was referred to a drugs worker. The decision not to charge Damien for the restraining order breach was not revisited in Haringey.

2.8.452 Louise was angry that she had to pay for the release of her vehicle and did not engage with the police after this. On 23 August 2013, she withdrew her allegation and said she did not wish for it to proceed to court.

2.8.453 **Commentary:** *Update on victim safety and holding perpetrator accountable*. In 2014, the policy regarding retraction statements was updated so that now, when victims wish to withdraw allegations, investigators should consider a referral to a CSU supervisor before a withdrawal statement is taken. Supervisors are required to speak to all victims wishing to withdraw their allegations and discuss their options with them. Supervisors are also advised to seek the advice of the CPS on the feasibility of an independent or victimless prosecution. Withdrawal statements need particular information, including the background to the case, the veracity of the original allegation, a new risk assessment that considers whether the victim has been pressured to withdraw, the impact of the incident on the victim and any children, the reasons why the victim no longer wishes to pursue the case, and whether there are civil proceedings underway in relation to the incident. Officers also make an assessment of the victim's response to a continued prosecution.

2.8.454 The assessment and withdrawal statement should be immediately submitted to the CPS and consideration may be given to whether hearsay provisions (CJA 2003) can be applied. If there is a concern that a victim has been pressured into withdrawing, then full information should be presented to the CPS so that a further investigation might be undertaken into other possible offences.

2.8.455 *Recognising Louise as a victim of abuse*. The Vehicle Recovery and Examination Service (VRES) have the responsibility of recovering any lost or stolen vehicles found by the MPS since 13 April 2015. Specifically, this refers to vehicles that have been recorded as lost or stolen on the PNC or confirmed as such after being found or stopped. The VRES Investigation Litigation and Policy Team have confirmed that consideration would be given to fee wavering in cases of domestic abuse, on a case by case basis. The request could be made to the pound manager or by email to VRES - Complaints. This is not widely known and there is a recommendation to increase awareness of this possibility.

2.8.456 **5 August 2013**. This was the last contact MPS had with Damien when he appeared at Haringey Magistrates Court for taking Louise's car without consent.

2.8.457 The police received information that Damien was selling crack on 22 August 2013 and 11 September 2013.

2.8.458 **Commentary.** *Poor investigation. Damien* was an IOM nominal (see below) at high risk of offending and was on licence. These offences could have been pursued and Damien would not have had the opportunity to harm Louise.

2.9 Metropolitan Police Service – Louise

2.9.1 Louise was known to the MPS. Louise's last conviction was on 8 February 2011. She had no convictions for violent offences.

2.9.2 **Commentary**. *Non-engagement*. This detail is included to highlight the number of female offenders that report that they have been victims of domestic violence: 80% of those surveyed in prison; using Offender Assessment System (OASys) risk assessment[23] information showed that 67% of those in custody or managed in the

[23] OASys is the principal assessment tool used with offenders to assess the likelihood of re-offending, the risk of serious harm to individuals, to identify other risks and offending-related needs, to assist with the management of risk, to link the assessment to the sentence or supervision plan for the offender, to recognize the need for other assessments and to measure any change during the sentence or period of supervision. It asks questions about key areas of an offender's life and is used to guide interventions and support and to assess the success of such plans. The areas covered in the assessment are: accommodation; lifestyle and associates; drug misuse; education, training and employability; relationships; emotional wellbeing; attitudes; financial management; alcohol misuse; thinking and behaviour; and risk of serious harm.

community by NPS and 61% of those managed in the community by CRCs indicated that they have been victims of domestic violence.[24]

2.9.3 On **26 October 2006**, Louise reported that her then partner (M1) had punched her neck in front of her daughter (16 at the time) and her daughter's friend when she confronted him about his suspected infidelity. The police began an investigation into the event and a MERLIN[25] was completed. The risk assessment was 'standard'. Louise stayed with a friend for safety. On 3 November 2006, Louise told police that she had been rash to ring them and she did not want M1 arrested. They were reluctant to close the case and the Officer in Charge (OIC) visited Louise again on 25 January 2007 when Louise said she was 'equally to blame' and did not want M1 prosecuted. Louise was told to contact the OIC if she changed her mind.

2.9.4 On **12 February 2008**, the incident reported above where Damien broke into the house and assaulted Damien, Louise and Jade occurred.

2.9.5 Louise visited Damien in Pentonville Prison on **23 April 2008** and stored cannabis in a locker there. She was arrested, interviewed and cautioned as the drugs were for personal use and she had made no attempt to bring them into the prison. Louise declined the offer of a referral to a drugs worker.

2.9.6 On **29 May 2008**, the police were called by Louise to the house that she shared with her former partner. M1 said that he had had an argument with Louise after he came into her bedroom to collect his belongings, but no allegations were made. Louise was very distressed and the police reported that 'she would not calm down'. She was arrested for breach of the peace and removed from the address to a nearby friend or family member where she was de-arrested as the potential for breach of the peace had ended and was unlikely to reoccur.

2.9.7 A DASH/SPECCS+ risk assessment was completed and noted as 'standard'.

2.9.8 **Commentary.** *Investigation.* The incidents with M1 are unresolved. The level of Louise's distress appears out of proportion to the account given to the police. This should have led to more questions being asked to help the officers understand what was really happening in this scenario. Such dissonance between the scene and the emotion in evidence can be a sign of coercive control.

[24] Corston, J. (2007). *The Corston Report: A Review of Women and Particular Vulnerabilities in the Criminal Justice System*, London: Home Office.

[25] A MERLIN must be completed when children are present or in the household where an alleged incident of domestic abuse takes place so that Children's Services are alerted to a child that may be harmed or neglected as a result of the abuse.

2.9.9 *Understanding of domestic abuse*. Police sometimes arrest a person to remove them from a situation, as happened here judging by the de-arrest when she was safely elsewhere. However, for a victim, it can reinforce a perpetrator's narrative that the problem is actually the victim rather than the perpetrator.

2.9.10 **23 August 2013**. This was MPS's last contact with Louise. She withdrew the allegation that Damien had taken her car.

2.10 Crown Prosecution Service

2.10.1 Where a charging request was made to the CPS, the CPS would have advised on decisions to charge Damien, decisions to withdraw or drop prosecutions and to provide advice to the police where Damien was not charged. They would have made decisions regarding cases that might be heard together.

2.10.2 Following the MPS IMR discussion, the Review Panel were keen to look further at some of the cases against Damien that came to court. In particular, the Review Panel wanted to review CPS decision-making in:

(a) Devising and requesting bail conditions

(b) The case for harassment that was timed out in January 2013 and the disposal of the breach of restraining order that occurred at the same time.

(c) The cases that were discharged where no evidence was offered, in particular the strangulation case (4 July 2010) and the assault on the police officer (9 April 2010).

2.10.3 The CPS did not have independent records for this review as the information they held had been destroyed in line with their policies. They were only able to provide information held on the homicide file that was compiled to prosecute Damien for Louise's murder. This was primarily information gained from the police systems so repeats information noted above.

2.10.4 The CPS holds information for 12 months on cases that were not prosecuted successfully. It holds information until the end of a sentence if the defendant is convicted. The time period for retention varies depending on the type of case.

2.10.5 In brief, the police investigate and, following the Director's Guidance on Charging, if the supervising officer considers that there is sufficient evidence for there to be a prosecution in accordance with the Code for Crown Prosecutors, the supervising officer presents the evidence to the CPS. The CPS then makes the decision whether to charge the suspect in accordance with the Code for Crown Prosecutors. If the suspect is in custody, charges can be brought if:

(a) There is insufficient evidence currently available to apply the evidential stage of the Full Code Test; and

(b) There are reasonable grounds for believing that further evidence will become available within a reasonable period; and

(c) The seriousness or the circumstances of the case justifies the making of an immediate charging decision; and

(d) There are continuing substantial grounds to object to bail in accordance with the Bail Act 1976 and in all the circumstances of the case it is proper to do so ('the threshold test').

2.10.6 If the suspect is on bail, then the 2 stages of the 'full code test' need to be satisfied:

(a) Is there sufficient evidence for a realistic prospect of conviction, and

(b) Is it in the public interest to proceed.[26]

2.10.7 If the defendant is charged on the threshold test then the case must be reviewed under the full code test as soon as reasonably practicable.

2.10.8 **Commentary**. *Lack of evidence and information*. The CPS policy on information retention reduces its value to this process as decisions that are taken by CPS cannot be reviewed. As the court case is the penultimate step in the criminal justice process, it is important to understand what information was utilised and what decisions were made and by whom. For instance, were the cases that show as 'no evidence offered' a CPS decision based on the victim not wanting to give evidence or a court decision based on the witness not appearing? Did the CPS propose the bail conditions suggested by the police?

2.10.9 *Victim safety*. In trying to understand what might have happened that stopped the restraining order from being prosecuted in 2012, the chair had further correspondence with the CPS London Deputy Chief Crown Prosecutor. He explained that, in general, where there was a breach aligned with a new offence, the evidence would relate to both. Therefore, from a CPS point of view, the disclosure of information to the defence needs to be coordinated so that information is not revealed before the investigation is completed. It is therefore usually better to pursue both cases at the same time. However, if the breach would be likely to lead to a custodial remand, the breach might be pursued immediately. This would have seemed sensible in this case, but without records we cannot analyse what happened here. We can only see that numerous

[26] *The Code for Crown Prosecutors*, January 2013.

breaches of an indefinite restraining order, put in place to protect Louise, were not pursued at court.

2.10.10 As noted in the commentary in the police sections above, a successful prosecution that did not require Louise giving evidence would have provided welcome protection for her. Evidence was collected at the time of the strangulation in July 2010 and a police officer was the victim of the assault in April of that year. The breaches of the restraining order in the 18 months before Louise died had police witnesses. We cannot understand why those cases were disposed of with no evidence offered without information from the CPS. We cannot understand the CPS's part in the prosecution of domestic abuse in this case.

2.10.11 The Review Panel understands that the CPS is reviewing its policy on retention of documents and there is a Recommendation that addresses this.

2.11 London Community Rehabilitation Company – Damien

2.11.1 Damien was known to the London Probation Trust at the time of Louise's death. Since then, the probation services have been reorganised. Probation services are now delivered by two services. The London Community Rehabilitation Company (LCRC) works with offenders in the community who present a low to medium risk of serious harm and who have been sentenced to a community order, a suspended sentence order or released on licence from prison to serve the rest of their sentence in the community. Under the Offender Rehabilitation Act 2014, the LCRC continues to supervise ex-offenders for 12 months after release from prison. The National Probation Service (NPS) works with offenders presenting a high risk of harm to others. Offenders seen by LCRC can be moved to NPS oversight if the risk assessments increase.

2.11.2 The LCRC has provided the following narrative. As the probation services have been re-structured, it is important to note that the narrative relates to the actions of the staff and management of the London Probation Trust at the time of the incidents described.

2.11.3 Damien was first known to the probation service in 1997. There were six recorded events between then and the start date for this review.

2.11.4 Since 2005, LCRC has records of eight events, two of which involved probation. The other six events were either stand-alone curfews or periods of imprisonment for less than 12 months and therefore did not have any probation involvement. There is further information in the notes of other criminal justice agencies participating in this review.

2.11.5 **5 June 2006 – Assault occasioning ABH of P2**

2.11.6 Damien was found guilty and sentenced for ABH and was found not guilty of rape. He had been on remand since 30 August 2005, that is, since he was arrested for this assault and alleged rape of P2 on 27 August.

2.11.7 The pre-sentence report following the conviction identified that Damien presented a high risk of serious harm to known adults, predominantly current and future intimate partners.

2.11.8 **Commentary.** *Identifying risk of the perpetrator*. P2 was a previous partner when Damien assaulted her. The evidence suggests that Damien was a risk to women, not just current or future intimate partners.

2.11.9 A Victim Liaison (VL) officer from probation was assigned to the victim in this case and P2 engaged with the VL.

2.11.10 As a result, the VL and the Offender Manager (OM) identified further licence conditions for Damien.

2.11.11 The licence conditions added by the OM were comprehensive and included addressing his alcohol problems, permanently residing at a location deemed suitable by his OM, to complete the Integrated Domestic Abuse Programme (IDAP), non-contact conditions with the victim and two members of her family and an exclusion zone to protect the victim.

2.11.12 **Commentary.** *Good practice*: The value of the victim's engagement is clear and the conditions address the victim's safety and the perpetrator's behaviour.

2.11.13 *Keeping safety of victims central.* The only additional condition might have been to disclose to his OM the name of any intimate partner. A breach of this condition could have led to him being recalled to prison.

2.11.14 The sentence was for 33 months in custody.[27]

2.11.15 As Damien had been on remand for 9+ months, he was released on licence on 25 August 2006.

2.11.16 **Commentary.** *Further information.* Offenders who are on licence are supervised by probation officers. A breach of licence conditions may result in the offender being returned to prison immediately or they may be given a warning for the first and second time. If an offender breaches a third time, they will be recalled to prison.[28]

[27] This is another incident where the criminal justice agencies have different information. LCRC records say 33 months and HMPS and MPS have records that say 2 years imprisonment.

[28] http://www.offendersfamilieshelpline.org/

2.11.17 At the time, Damien's assessment as high risk of harm meant that he was allocated to an OM within a Public Protection Team in the Probation Service with responsibilities for such offenders. (This team no longer exists.)

2.11.18 Damien was able to apply for a HDC and did so. The OM completed an assessment for this on 21 July 2006 and determined that Damien was not suitable for Home Detention.

2.11.19 **Commentary**. *Further information*. The LCRC IMR writer was not able to access this file and therefore could not provide a reason for this decision, though it is worth noting that Damien's mother initially agreed to Damien being released to her address, but then rang back to say that she thought Damien ought to stay in prison until his conditional release date.

2.11.20 There was no Offender Assessment System (OASys) risk assessment completed with the HDC report, which would have been best practice.

2.11.21 **Commentary.** *Accountability of agencies*. The completion of an OASys risk assessment would have helped with the management of the case in that it would have provided a record of the OM's thinking about suitability for release, risk management planning on release and any issues surrounding the perpetrator's housing.

2.11.22 Prior to Damien's discharge, the OM attempted to check the suitability of the housing that Damien intended to occupy. At the time, protocols were not in place to allow the sharing of information between Housing and the OM without the prisoner's consent, which Damien did not provide. There is now a standard protocol that allows information sharing in these situations for the purpose of reducing reoffending.

2.11.23 Two OASys risk assessments were completed by two different prison staff (on 17 and then 24 August 2006) and prior to Damien's release. The reason for two is not clear and they gave different results. One showed Damien as low risk of serious harm to known adults and the public and medium risk to staff in custody. The other showed him as medium risk of harm to known adults and low to everyone else.

2.11.24 **Commentary.** *Differing assessments*. This could indicate that Damien was manipulative and presented differently to different people. It also raises a concern that two professionals assessed the risk differently. Regardless of this outcome, Damien was overseen by the Public Protection Team who looked after high risk offenders.

2.11.25 *Update.* The assessments of those in custody has changed since 2007. A Basic Custody Screening Tool (BCST) 1 and 2 are completed on arrival at prison. A BCST3 is completed 12 weeks prior to release by resettlement teams across the country. This

is a mandated service for CRC and NPS cases. The BCST3 is complemented by a resettlement plan to address the needs identified. These processes are closely monitored by the Ministry of Justice as part of the contract that the CRCs hold.

2.11.26 Damien was released on licence on **25 August 2006** and his sentence expired on 27 August 2007. Damien was seen on his release date and, at the time, a home visit was required within 10 days for high risk offenders. But this did not happen.

2.11.27 **Commentary.** *Victim safety.* As Damien was assessed as posing a risk to current or future partners, a home visit would have provided an opportunity to understand Damien's living arrangements, his relationships and the level of monitoring he would need. It would have helped to identify individuals potentially at risk.

2.11.28 Probation completed another assessment[29] that determined that Damien was a high risk of serious harm to known adults and also assessed as a medium risk of serious harm to the public.

2.11.29 This latest risk assessment and the sentence of more than 12 months in custody meant that Damien was referred to MAPPA. Damien was reviewed as a Category 2 offender and level 2. That is, he was subject to multi-agency management at regular meetings of MAPPA. The MAPPA process is covered in a later section of this report. High risk cases are not managed by LCRC now, but by the NPS.

2.11.30 Because he was on licence, Damien could have been re-referred to MAPPA at any time during his licence period, that is, up to 27 August 2007. He also could have been referred as a Category 3 offender if considered to pose an imminent risk of serious harm.

2.11.31 **Commentary**. *Behaviour of perpetrator*. Notes on the exchanges between Damien and OM are indicative of his sense of entitlement and manipulation:

(a) Damien would not consent to the exchange of information between his OM and Housing, but turned up for probation appointments when he wanted something.

(b) In their discussions, Damien appeared to feel that he was entitled to money or travel warrants from the service. He took little responsibility for his own choices and actions or how he might change his situation.

[29] This third risk assessment is likely to have been started before Damien's release but the records were likely 'locked' by the prison while they conducted theirs.

(c) Damien claimed that an alternative property found for him was not suitable because it was too close to his ex-partner's brother's house, but provided no information to support this.

2.11.32 Damien should have reported weekly to his OM. His attendance was so poor that he was close to recall in January 2007. However, there were no reports that Damien contacted P2 or infringed the exclusion zone.

2.11.33 The requirement to attend IDAP was dropped in January 2007 as Damien's OM and the IDAP programme tutor agreed that Damien was unsuitable for the following reasons:

(a) Minimal acceptance of violence during the index offence

(b) Damien was adamant that he had not been abusive at any other time

(c) Failure to disclose the details of a new partner, which is a requirement of the programme

(d) Lack of motivation

(e) Lack of time to complete the programme before the licence expired.

2.11.34 There was no information gained from MAPPA meetings noted in the current LCRC file.

2.11.35 Despite this, the OM made a decision to change the frequency of meetings with Damien to fortnightly in January 2007.

2.11.36 **Commentary.** *Accountability of agencies, holding Damien accountable.* The licence conditions were not enforced. This lack of engagement limited opportunities to address Damien's adjustment to life in the community, his alcohol issues and his abuse of women. During those missed visits, probation could have undertaken work with Damien to get him ready for the IDAP programme in the future.

2.11.37 Given the information above, it is clear that the risks Damien posed had not been addressed at the time the frequency of meetings was reduced. There is no risk assessment or intelligence checks on file that precedes this decision. It appears that this decision was taken due to elapsed time on licence.

2.11.38 *Victim safety.* We know from the MAPPA minutes from the 21 November 2006 meeting that a new partner was identified (the name is not on the file). There should have been a discussion of how to manage this and this should have been recorded; if details of his new relationship had been requested and not provided, then a home visit would have been advisable to gather further information. This was not done.

2.11.39 It would also have been good practice to conduct a Community Safety Unit (CSU) check or Borough Intelligence Check on Damien's address to see if there had been new call-outs and the identity of the new partner.

2.11.40 The combination of a lack of an investigative approach by the OM and poor recording suggest that Damien was able to avoid providing information and avoid undertaking significant pieces of work; both of which would have helped to address the harm that he presented.

2.11.41 In **April 2007**, Damien's period on licence was reviewed. His risk to the public was reduced to low and the risk to known adults was reduced to medium.

2.11.42 **Commentary.** *Risk assessment*. The behaviours of Damien that kept him out of the IDAP programme do not support a reduction in Damien's risk assessment.

2.11.43 Until the end of Damien's licence, his engagement with probation from this date was practically non-existent. He missed appointments, claiming to be sick; he provided two sick notes without proper diagnoses that signed him off for 13 weeks at a time; the OM did not check these with the GP; home visits were re-scheduled several times. A risk assessment during this time noted Damien's pattern of non-attendance.

2.11.44 Over the course of 8 months, the OM saw Damien once, at his home and with his manager.

2.11.45 Damien's licence expired on 27 August 2007. Policy required an OASys assessment to be completed 8 weeks before the licence expired, that is, at the end of June 2007. This was not done until 15 November and was of poor quality. There is no synopsis of Damien's progress during the sentence.

2.11.46 **Commentary.** *Accountability of agencies.* There is nothing on file that supports the apparent lack of management of this perpetrator. There is no specific policy about how sickness absences are managed but there is an expectation that proper evidence is provided, challenges are made and programmes adjusted to encourage compliance.

2.11.47 An OASys assessment provides a useful reference point for any future sentences and its absence is likely to have had an impact on future assessments.

2.11.48 **7 December 2012 – burglary**

2.11.49 Damien received an 18-month sentence, suspended for 24-months for the burglary on 28 August 2012. The order required a medium intensity drug rehabilitation requirement (DRR) and 24 months supervision. As Damien was on remand at the time of the sentencing, he was released from court.

2.11.50 A breach of such an order requires the offender to be brought back before a court. The court can then add additional conditions or, if the breach is serious enough, it may decide to re-sentence the offender which may include a prison sentence.[30]

2.11.51 Pre-sentence report[31]: The pre-sentence report notes that Damien admitted to previous domestic abuse but attributes this to his use of drugs. The report notes that the perpetrator is in a 'stable relationship' and that this is a protective factor, despite noting that the circumstances of the offence include relationship problems. The report author noted an incident when Damien was at court: Damien rang Louise to pick him up and when she could not, he became loud and angry (noted in MPS report as well).

2.11.52 The incident at court was not discussed with Damien or Louise and there is no alteration to the assessment of Damien and Louise having a 'stable relationship'. There is no mention of the indefinite restraining order issued by the court on 25 February 2012 to protect Louise from Damien. There was no plan to address this as part of a risk management plan for Damien. There was no referral to MARAC.

2.11.53 **Commentary.** *Victim safety and gendered understanding.* For a man who uses violence against women, the definition of a 'stable relationship' may be a relationship where the woman is too afraid to leave.

2.11.54 On **15 January 2013.** Damien was taken onto the Integrated Offender Management (IOM) cohort in Haringey. There is a section on this process below. IOM is used for individuals assessed as posing such a serious risk of reoffending that a multi-agency approach is needed to manage him or her.

2.11.55 DRR: The DRR assessment also noted relationship issues being significant in his drug use and offending.

2.11.56 The DRR required a minimum of 8 hours contact a week. From 1 January 2013 to 18 February 2013, Damien attended 23 appointments, predominantly with drug services for group work, drug testing and meetings with his key worker. In those weeks of twice-weekly testing, Damien tested positive for cocaine three times.

2.11.57 DRR Court Reviews were conducted in February, April, May and June of 2013 to monitor Damien's progress. The second and third review comment on the reduced contact during the period due to illness. Damien's attendance had dropped off by April and the

[30] http://www.offendersfamilieshelpline.org/

[31] A pre-sentence report is a prepared by a probation officer after a perpetrator has been found guilty or has pleaded guilty. The report looks at the circumstances of the perpetrator and offending history to provide a pre-sentence report which is used to assist the court in determining an appropriate sentence.

judge urged Damien at that review to stop using drugs and to 'move towards a drug-free life'.

2.11.58 Supervision order: A supervision element of the order required a level of contact that is sufficient to deliver the sentence plan and monitor changes in dynamic risk factors. Damien had his induction appointment on 13 December 2012, but was not then seen again until 31 December.

2.11.59 An OASys assessment and sentence plan was required within 20 days of commencement but did not happen until 11 November 2013, the following year, and about six weeks before Damien killed Louise. The notes from that appointment state: 'Damien has a history of dishonesty and using violence . . . acknowledged that his long-term partner has been staying . . . Damien has demonstrated a willingness to use violence to achieve his own ends and has had difficulty managing his temper . . . Damien has disclosed that he was unhappy in his current long term relationship and there were indications that he had been abusive to his partner on previous occasions. In terms of risk Damien has also indicated that he is more likely to offend and use drugs when he is experiencing difficulties in his relationship.'

2.11.60 This assessment would have required information about Damien's relationships and the completion of a Spousal Assault Risk Assessment (SARA). A SARA was not completed and so more information about Damien's relationship was not gathered. Damien's behaviour at court towards Louise in December 2012 and the restraining order were not addressed. All this information would have provided evidence for strategies and plans to manage Damien's risk to Louise.

2.11.61 **17 July 2013**. A warning letter was sent by the OM to Damien.

2.11.62 On **1 August 2013,** Louise accompanied Damien to a supervision appointment to confirm his reasons for missing previous appointments. He had missed 39 appointments by this time. Louise was not spoken to directly on that occasion.

2.11.63 **Commentary.** *Accountability of agencies*. This significant delay and poor practice would have had a substantial impact on how Damien was managed as there was no agreed plan for his rehabilitation and the risk to Louise was not being identified or addressed.

2.11.64 *Safety of victim.* Despite the known risks to Damien's partners, Louise was not engaged by probation, nor were his risks addressed in supervision. More importantly, Louise's attendance with Damien was a blatant breach of Damien restraining order. Yet no action was taken.

2.11.65 Damien's engagement. Damien's contact became intermittent with both the DRR and the OM. Damien did not attend any of the scheduled supervision appointments after his 28 November 2013 appointment with the Brent Enfield Haringey Mental Health Trust (BEHMHT) up until the time of Louise's death. It appears from the records that he had telephone supervision during this time as a result of a lengthy sick note he had.

2.11.66 Damien's OM discussed Damien's non-engagement with his supervisor. They agreed that if it continued (time-line unclear) that Damien would be breached. The supervisor asked that Damien be required to produce a sick note. This was not produced.

2.11.67 Breach proceedings would have led to him being recalled to prison.

2.11.68 On **2 December 2013** a (male) person attended on his behalf to explain that Damien was 'not in a good place', had damaged his cartilage and was unable to attend.

2.11.69 On the same day, breach proceedings were begun.

2.11.70 The police and probation went to Damien's home on **17 December 2013** to talk to him and he was not at home, despite having missed appointments due to health problems.

2.11.71 Management of Damien: There were 4 OMs during the course of Damien's supervision order and up to the time of Louise's death.

2.11.72 **Commentary.** *Poor case management and supervision.* Having 4 Offender Managers would have undermined any attempt to build a relation with Damien, though his lack of attendance may have had a greater impact on this. The lack of an OASys assessment and active management plan for Damien also would have meant that the handovers would have lacked an in-depth understanding of Damien's situation and risk.

2.11.73 The management of this case was poor. The LCRC IMR noted six occasions during the timespan of Damien's supervision order when an OASys assessment should have been completed and was not. It appears that Damien's successful avoidance of engagement by means of repeated medical certificates in 2007 was repeated in 2012, right up to the time of Louise's death. Poor supervision of the OMs meant that these lapses were not caught and addressed.

2.11.74 *Perpetrator behaviour. Victim safety.* It is common for domestic abuse perpetrators to blame their abusive behaviours on their substance misuse[32]. This often deflects

[32] Neville, L and Sanders-McDonagh, E, 'Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs' (London, Middlesex University, July 2014), regional analysis of West Midland homicides found that just over half (n=7; 54%) of the thirteen cases involved multiple factors (mental health issues, drug use/and or alcoholism) and/or dual diagnosis. Similarly, they note that alcohol and mental health emerged as an area of concern for both victims and perpetrators, leading them to conclude that this cluster of issues should be recognised as an alert.

services from addressing the abuse to supporting recovery. The victim can get lost in that shift of focus. [33]

2.11.75 *Silo working. Role and safety of victim.* The OM did not take an investigative approach to understanding Damien's relationships. OMs at the time would have been expected to undertake Integrated Domestic Abuse Programme Accelerated (IDAPA) training. The knowledge that OMs gained through that training about risk factors and assessment tools should have impacted on their management of Damien. This is not seen in the file or in any referral to MARAC. When information about Damien's relationship was revealed, there was no attempt to address Louise's safety. The role of Louise as a stability factor seems to have blinded the probation officer to the risks that Damien posed to her.

2.11.76 *Accountability of agencies – to hold Damien accountable*. Damien's Supervision Order was clearly unworkable. Damien's non-engagement meant that Damien should have been breached and subject to recall proceedings.

2.11.77 *Accountability and priority of domestic abuse*. There was not a domestic abuse policy in place within London Probation Trust at the time. LCRC is now developing a strategy for managing domestic violence, including identifying risk factors and expectations of how these are challenged, reported and addressed through multi-agency work.

2.11.78 *Multi-agency approach.* Damien was a very difficult offender to manage. Despite the criticisms of the OMs and the supervision above, it is important to note that individual practitioners cannot carry the responsibility alone for holding perpetrators accountable and keeping victims safe. It requires a co-ordinated community response.

2.12 London Community Rehabilitation Company – Louise

2.12.1 On **8 February 2011**, Louise was sentenced to 80 hours unpaid work under a community order for shoplifting. At a post-sentence assessment, Louise was asked about her circumstances, including employment commitments and health issues. A placement at a primary school in north London was agreed to be appropriate.

2.12.2 **Commentary.** *Help for victims*. The LCRC IMR writer noted that the forms are still vague around domestic abuse. The forms used in the placement now have questions around safeguarding, placements within mixed-gender groups and mental health. As a result of

[33] *Domestic Homicide Review: Common themes identified as Lessons to be Learned*, (London: Home Office, 19 November 2013): in cases where 'the victim and/or the perpetrator had complex needs which could include domestic violence and abuse, . . . alcohol, substance misuse and mental health illness . . [that] domestic violence and abuse was not always identified because agencies were focusing on addressing, for example, the mental health or substance misuse.'

the continuing changes in LCRC and the creation of a female-only cohort, the forms will be revised to create opportunities for domestic violence to be discussed and more female-only projects to be explored further.

2.12.3 When attending for her Unpaid Work commitment, Louise was assaulted on **14 May 2011**. An Unpaid Work supervisor identified Damien as one of the perpetrators. The police were called and a senior manager informed and attended the site, completing an incident report. The senior manager then tried to contact Louise, without success, to see if she was okay. She was then informed that she should not attend the following week but report to a manager instead. There is no indication that further questions were asked or Louise's safety addressed.

2.12.4 There is currently no domestic abuse policy within London CRC. There is a recommendation about this.

2.12.5 **Comment.** *Link between female offending and domestic abuse.* We do not know if Louise's offending was linked to Damien's abuse, but the percentage of female offenders that report having suffered domestic abuse is significant.[34]

2.13 Haringey Action Group on Alcohol

2.13.1 Damien was a client of Haringey Action Group on Alcohol (HAGA) once before the death of Louise.[35]

2.13.2 Louise was not known to HAGA.

2.13.3 HAGA is the alcohol-specific community treatment service in Haringey. It offers a range of interventions, both structured and unstructured, for residents of Haringey affected by alcohol misuse themselves or through family and friends.

2.13.4 At the time of Damien's engagement in 2013, HAGA had partnered with WDP to provide after-care services for people with drug problems. This new service was called RISE. This programme dissolved in December 2013 as drug and alcohol services were transformed as a result of changes in the Health and Social Care Act 2012 which moved Public Health into Local Authorities and changes in the commissioning of substance misuse services.

2.13.5 These changes reduced the amount of information that the IMR writer could access.

[34] Corston, op cit.

[35] Gilchrist et al, 2003, p. 17: In a study of 336 convicted domestic abuse offenders, 48% of offenders were alcohol dependent.

2.13.6 Damien's engagement with RISE took place during the 'tender' window in the last months of 2013, that is, while the organisation was preparing and submitting bids for future funding.

2.13.7 Damien received a suspended sentence order for 24 months on 7 December 2012 for the offence of burglary in a dwelling. The order had a Drug Rehabilitation Requirement (DRR) (medium intensity) and 24-months supervision.

2.13.8 Damien was released from HMP Pentonville on 10 December 2012. He was referred to HAGA on **21 January 2013**. He attended the second appointment offered and was assessed by a HAGA worker, perhaps standing in for a WDP worker who usually completed these. (This worker has since left WDP.)

2.13.9 An assessment and treatment outcome profile was completed and a personal development plan was made. The goals were to complete a curriculum vitae (CV) and training in setting up a business, reduce his cannabis use, train in peer support, attend key worker sessions and the CV workshop.

2.13.10 There was no risk assessment attached to the file as would have been expected. There was no discussion of domestic abuse noted. The HAGA worker was unaware of Damien's criminal history and the restraining order, though the DRR referral should have been a prompt to ask for more information. This suggests issues with communication and information-sharing within RISE and between the WDP and HAGA teams.

2.13.11 Damien's brief file shows there were several missed appointments that were later covered by a sick note, a revision of the development plan and an indication that Damien attended a food hygiene course in June 2013. Damien was discharged from RISE on 17 June 2013. It appears that Damien was continuing to work with his keyworker at WDP but that the work was hampered by Damien's health, as evidenced by the sick notes.

2.13.12 **Commentary.** *Link between alcohol and domestic abuse.* The study of the DHRs that Standing Together has chaired show that in 56% of the deaths, the perpetrator had problems with alcohol.[36]

2.13.13 *Update on services.* The IMR notes that since 2013, HAGA has reviewed its core training plan and, in addition to the domestic abuse and safeguarding training already in place, has added Domestic Violence Intervention Programme (DVIP) training for working with

[36] Sharp-Jeffs, Nicola, and Kelly, Liz, 'Domestic Homicide Review (DHR) Case Analysis', (June 2016), p. 11. The report can be found at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf.

perpetrators and MARAC training. HAGA have also improved their assessment and risk management training. HAGA reports improved confidence of staff following these training events.

2.13.14 The initial assessment that HAGA now uses has additional questions to identify abuse and initiates conversations that should support early interventions and prevention.

2.13.15 HAGA has updated its organisational policy and procedure around domestic abuse and safeguarding – most recently in June 2015.

2.13.16 *Risk management.* It is important that substance misuse agencies respond to non-engagement with services by those on licence. This case shows the link between non-engagement and increasing risk.

2.13.17 *Coordinated response.* While working with perpetrators of domestic abuse, it is important for substance misuse agencies to have an active relationship with organisations working with the victims and with the multi-agency groups addressing safety and perpetrator behaviour.

2.14 The Grove – Specialist Drug Service Haringey

2.14.1 The Grove was formerly the Drug Advisory Service Haringey. It now provides specialist drug services across the borough of Haringey, including criminal justice interventions and Community Care Assessments (CCA).

2.14.2 At the time of Louise's death, Haringey Substance Misuse Service was provided by BEHMHT and DASH in partnership with Blenheim CDP (Blenheim).

2.14.3 Most of the substance misuse services in the borough were provided by DASH (including community care assessment for detoxification and rehabilitation services) alongside these services.

(a) Community Recovery Initiative (CRI) that provided the criminal justice elements of treatment and

(b) WDP who provided the DRR programmes. WDP is a non-statutory provider of addiction treatment and offers support and treatment for patients involved in the criminal justice system.

2.14.4 All services had an agreed information-sharing protocol with the IOM team.

2.14.5 At the time DASH worked within the BEHMHT policies on domestic violence and training and had its own operational guidelines. The data system was the electronic recording system for drugs and alcohol services (RIO).

2.14.6 Referring agencies would provide agreed information to DASH with the referral (organisations were not using the same case management systems then). Then DASH would provide the assessment and a panel, comprised of senior managers from all substance misuse services in the borough, would sit each week to hear the assessments presented and take decisions based on the thoroughness and appropriateness of the assessment.

2.14.7 Following Damien's trial in December 2012 for burglary in August 2012, he was sentenced to 18 months suspended for 24 months and a DRR of 9 months, non-residential.

2.14.8 Damien was referred from WDP, for an assessment as part of his DRR. The organisation had no contact with Louise.

2.14.9 Damien was discharged by RISE on 17 June 2013 and said he was concerned about his increasing drug use. A referral from WDP was received by DASH on 24 June 2013. Damien requested consideration for residential rehabilitation for his drug use problem. His assessment notes he is of Caribbean ethnicity, in a relationship and with no children. He says he has been using £80 of crack cocaine a day since he was 27 (he was 42 at the time) and £25 a day of cannabis. He reported feeling depressed and anxious and showed interest in an Abstinence-Based Treatment (ABT) and was referred to DASH for assessment. The report did not note any intravenous drug use, any previous history of violence, any restraining order and nothing about domestic abuse. That Damien was well known to the criminal justice agencies and IOM was not noted in the original referral.

2.14.10 The DASH worker did not complete the assessment for the residential ABT because Damien's erratic engagement and obvious unsuitability for the programme was apparent. Only rough notes were added to the electronic system, RIO. There is a recommendation about this.

2.14.11 On **25 July 2013**, Damien was assessed by a BEHMHT community psychiatric nurse (CPN) as part of the police liaison team following his arrest for breaching the restraining order. Damien was aggressive with the police on arrest. The CPN accessed RIO to confirm that Damien was not known to specialist mental health services but do not appear to have informed the police.

2.14.12 Damien did not attend his DASH appointments on 30 July 2013, or 7 August 2013 and then rang requesting an appointment on 12 August 2013. He was given an appointment for **21 August 2013** which he attended and the community care assessment began for an ABT day programme. He did not attend his next appointment on 23 August 2013 but came to his appointment on **24 September 2013**.

2.14.13 During this second meeting, Damien told the DASH worker that he'd been remanded for a year in 2007 for rape and kidnap but was eventually acquitted. The worker contacted the IOM to identify the risk history, which was then recorded on RIO.

2.14.14 The IOM Team shared the following information with the DASH worker: Damien had 29 convictions for 41 offences including common assault, violence to enter premises, robbery, possession of an offensive weapon; that Damien was subject to a harassment order [sic] prohibiting contact with an ex-partner was disclosed, but there was no specific mention of domestic abuse or the victim's name. Haringey Probation assessed him as 'medium risk towards staff and professionals'.

2.14.15 Damien was sporadic in his attendance at individual and at group community-based ABT sessions between **25 September and 7 November 2013**, though nothing was recorded on RIO. Damien attended an ABT group at DASH on 7 November 2013 and he was offered a further appointment to complete the CCA a few days later, but did not attend this.

2.14.16 His discharge planned for mid-November was deferred after the Haringey Probation Service requested that he should be offered a further opportunity to engage. He did not use this opportunity and did not appear motivated. Damien attended this appointment on **28 November 2013** and requested a day programme rather than a residential programme. He was offered other appointments to complete the assessment.

2.14.17 On the day of Louise's death, Damien's assessor discussed the case in supervision and a decision was taken to discharge him from the community care process, leaving him with the option to re-engage or be re-referred in the future. The DASH and WDP workers knew that Damien was in touch with other criminal justice agencies in the borough. The IOM team was informed of the discharge.

2.14.18 **Commentary.** *Updates on service delivery*. Service-related issues that contributed to the lack of success with Damien include the following and have been addressed in the following ways:

(a) Lack of reciprocal access to clinical and risk information. Information was shared between agencies, but risk was not highlighted. DASH gathered information to assess

and manage risk but they did not know all there was to know about the risk posed by Damien. This information was held by the IOM agencies.

(b) Lack of clarity and integration of case management, leading to a lack of joint care-management and clear accountability. There is now a shared case management system across the substance misuse services and integrated care plans across providers

(c) Lack of formal CCA documentation. At the time, only patients that were thought to be suitable for ABT had written assessments that were presented to the Panel. Those that were unsuitable like Damien (lack of motivation and poor attendance) only had rough notes as they were not going to be taken to the Panel. There was no electronic link made to emails or other correspondence between DASH and IOM. Now Grove CCA staff complete the assessments and present all cases to the Review Panel for scrutiny and risk review. Where clients do not complete the assessment, what has been done is uploaded to the information system for future reference so there is as full a record as possible.

(d) At the time, substance misuse services were not active part of the multi-agency arrangements around domestic abuse, but they are now. There are now closer links between DASH and the criminal justice pathways, including probation and the IOM process.

2.14.19 BEHMHT, Blenheim CDP and HAGA won the contract to deliver Haringey substance misuse service beginning in January 2014. The new service specification includes:

(a) Universal case management systems, with common access

(b) Closer links between DASH and criminal justice pathways, including probation

(c) Integrated care plans cross service providers in the borough.

(d) This weakness in information-sharing is now relieved by the shared data base used by all the providers. DASH and Blenheim have combined into The Grove and use a data base called ILLY along with all substance misuse providers across Haringey. The Grove operates to Trust policies on DV and Blenheim staff use DV policies issued by their organisation. DV training is mandatory and joint training has been delivered by MARAC staff.

2.14.20 There is now a multi-agency clinical governance meeting to address issues raised by serious incidents, among other things. It reports to the clinical governance group and is chaired by the Consultant Psychiatrist for Substance Misuse lead.

2.15 Her Majesty's Prison Service

2.15.1 The IMR for HMPS was provided by the prison where Damien is currently being held.

2.15.2 Damien was in HMPS custody on 10 occasions during the period covered by this review. However, due to a change in computer systems and the destruction of records in line with the Data Protection Act, there are very few records relating to Damien's time in prison. The records held by the prison repeats information seen in other IMRs.

2.15.3 There were few interventions possible with Damien when he was in prison, as most of the time he was on remand.[37]

2.15.4 The pre-sentence report prepared before Damien was sentenced for the ABH and criminal damage regarding P2 (alleged rape) noted that the risk from Damien was greatest when he was in a relationship. It also noted that Damien would not have enough time on licence to complete the IDAP, the programme used for domestic abuse offenders at the time.

2.15.5 The record shows the when Damien was remanded on 27 July 2010, he was a MAPPA nominal, that is, his case was being managed through the MAPPA process. There is more on this in the MAPPA section. This alert was made inactive on 26 April 2011.

2.15.6 Damien complained about the treatment of Louise on 7 September 2010 when she came to visit him in prison (he was on remand for assaulting and strangling Louise). She was searched and then placed on closed visits. He also complained about his risk level and sharing a cell. His complaints were not upheld.

2.15.7 The prison was not aware when Louise visited that she was the victim of Damien's assault. The prison does not have a policy for addressing the situation when victims visit the men who have abused them.

2.15.8 When Damien was on remand for burglary to HMP Bedford on 4 October 2010, alerts were made active on 5 January 2011 that he was a risk to the public.

2.15.9 The prison records had a pre-sentence report written on 14 April 2011 in relation to a common assault and criminal damage case (unrelated to Louise). The report was inadequate in that it dealt with a previous offence of cannabis production and had not

[37] Remand is pre-trial detention for those accused of crimes. Remand is most likely where: the defendant has been convicted of a serious crime in the past or is currently charged with a serious crime, the police think that the defendant may not appear for their court hearing or commit another crime before the trial, the defendant has a history of not complying with the terms of bail. If the defendant is convicted and sentenced to time in custody, the time already served on remand is set against the custodial sentence to determine how long the offender is required to remain in prison.

been updated to provide any information on the assault or criminal damage and had no information about the victim.

2.15.10 A risk to females was noted on 6 September 2012 while Damien was on remand to HMP Pentonville. The risk flagged applied to female prison staff, that is, to managing him in prison.

2.15.11 On 19 November 2012, Damien was discussed at a Violence Reduction Board following an assault on a member of staff and on another prisoner. The Board decided that Damien represented a low risk of further violence, despite Damien denying the assault. The notes show that Damien now understood the implications of violent behaviour.

2.15.12 **Commentary.** *Risk assessment*. This reduction in risk seems to be aimed at managing Damien in prison rather than providing any meaningful understanding of Damien's offending and addressing it.

2.15.13 A report written following Damien's conviction on 7 December 2012 for burglary indicated that Damien would not be referred to MAPPA and indicated no concerns in relation to breach of trust.

2.15.14 There is a note that Damien was released from court, following his time on remand. Anger management was noted as work still to be undertaken. This may be a narrow response to the incident in prison, but anger management is specifically identified as inappropriate in situations of domestic abuse as the problem to address in stopping domestic abuse is the need to control the victim, not the perpetrator's lack of control of his temper.[38]

2.15.15 **Commentary.** *Poor research*. The HMPS IMR notes that the post-conviction report showed no concerns in relation to breach of trust, despite 11 recorded breach convictions at the time.

2.15.16 Both of these reports show an incident-focus and a superficial understanding of the nature of Damien's offending overall. Any interventions based on these reports were likely to be inadequate.

2.15.17 On the day that Damien killed Louise, he was due in court for sentencing for driving without a licence, using a vehicle whilst uninsured and failing to surrender to custody.

2.15.18 **Commentary.** *Unavailability of interventions. Damien* spent a good deal of time on remand because of his absconding and the risk he posed. While on remand and until a

[38] Gondolf, E. and Russell, D (1986) 'The Case Against Anger Control for Batterers', Response, 9:3 pp. 2 – 5 and at https://www.biscmi.org/documents/Anger%20Control%20For%20Batterers.html.

trial, all defendants are considered innocent and therefore interventions that address their offending are not appropriate. By the time Damien was convicted, he had usually already spent a significant proportion of his sentenced custody time in prison. This was most graphically illustrated on 12 May 2011 when he spent a day in prison following his conviction for common assault on Jade and Louise.

2.15.19 The HMPS reported to the Review Panel that offenders on short sentences are highly unlikely to be able to access accredited DV interventions, though there are many available across the prison service (See **Appendix 4**). Often domestic abuse convictions result in short sentences and therefore the intervention programmes do not appear to match the opportunity for intervention.

2.15.20 Some prisons do offer non-accredited interventions that address domestic abuse but as these are not accredited, the content and criteria are difficult to ascertain.

2.15.21 HMPS also noted to the Review Panel that if there were high levels of concern about an individual offender, it would be possible to refer them for one-to-one work with a suitable professional. If motivation to change was an issue, one-to-one work to address that could also be provided.

2.15.22 The prison records appear process-focussed for managing Damien in prison rather than understanding him in a wider context, addressing his offending and understanding his relationships. There appear to be missed opportunities to intervene when he was in prison.

2.15.23 *Coordinated response for victim safety*. There is an opportunity for agencies to engage with the victim while the perpetrator is being held and the victim is therefore safe. This is best done through a coordinated effort between the prison, local police forces, and IDVAs.

2.15.24 *Commitment of HMPS***.** In discussion with the Review Panel, it became clear that these systemic weaknesses are not unique to this case and require a commitment of HMPS to develop policy and practice to address domestic abuse by prisoners and provide opportunities for their victims to access help.

2.15.25 *Update. Better co-ordination.* Over the last 6 months, a new initiative has been launched in London where every High Risk or High Harm-rated prisoner who is scheduled for release is reviewed by a multi-agency panel, chaired jointly by NOMS, probation and the police. At this meeting, all the issues of every High Risk and High Harm prisoner being released in London are discussed. MAPPA subjects are excluded as the MAPPA process is thought to be effective.

2.15.26 *Update: Accountability.* There is a National Offender Management System review in the HMPS. The aims of the review are:

(a) To bring improvements in quality and outcomes of offender management

(b) To support rehabilitative cultures and a strength-based approach which will bring improvements for prisons and staff; and

(c) To bring NPS and Public Sector Prisons closer together.

2.15.27 The new model is being implemented in 11 pathfinder prisons in the summer of 2017. This model transfers accountability from the community to custody for NPS prisoners. The model is still being developed – especially the case management aspects – and is expected to roll out between the summer of 2017 and December 2018. It will change the workings of the NPS and HMPS.

2.15.28 In the model, all prisoners will be allocated a Prison Officer Key Worker who will have 45 minutes per week with each prisoner to support and coach them. The Senior Prison Officers will assist the work and Prison Governors will be responsible for offender management across the establishment.

2.15.29 **Commentary.** *Accountability.* These changes provide the opportunity to address offenders' abusive behaviours with the offender and to create safety plans and link to support services for offenders and for their victims when they are released. There is a recommendation that addresses this.

2.16 Multi-agency work around Damien

2.16.1 The following information is a compilation of information gained from individual agencies and from the IMRs provided by the different processes: MARAC, MAPPA, ASBAT, and IOM.

2.17 Multi-Agency Risk Assessment Conference (MARAC)

2.17.1 A MARAC is a meeting where statutory and voluntary agencies those who have contact or statutory responsibility for the victim, perpetrator and/or their children, meet to share information about high risk situations of domestic abuse and develop an action plan to address the risk that the victim is facing.

2.17.2 MARACs are not statutory responsibilities.

2.17.3 A referral to a MARAC should be accompanied by a referral of the victim to a specialist independent domestic violence adviser, an IDVA, who represents the victim's views at the MARAC as well as insuring that any plans developed at the MARAC are safe for the

victim and reporting back to them on that meeting. IDVAs provide short to medium term support to victims of domestic abuse to create safety plans to reduce their risk, stabilise their situations and develop long-term plans for safety.

2.17.4 The case was heard at the Enfield MARAC on **15 June 2011** following an assault by Damien on Louise and him threatening her at her home. The only action from the meeting was to see if Louise was visiting Damien while he was on remand for assaulting Louise as she left a probation work placement. Records do not show if this action was completed.

2.17.5 The MPS records and Solace Women's Aid records note a second MARAC for Louise in October 2011 following an assault. The search of Enfield MARAC records did not show this second MARAC.

2.17.6 **Commentary**. *Poor research and response to victim safety. Lost opportunity for multi-agency approach.* Minimum standards of research were not met. There were no cross boundary checks and the research did not go back far enough. Five incidents were discovered (strangulation, argument, argument about money, the recent damage to Louise's mother's front door and Louise's car, and Damien shouting through the letterbox). The research missed the assault on Louise, the abusive relationships with P1 and P2 and the general risk Damien posed to women. (MPS Recommendation 3)

2.17.7 *Blaming victim and not holding perpetrator accountable*. This action focuses on Louise's behaviour rather than on Damien's and the point of this is unclear. This could have been an action to create an opportunity at the prison for Solace to talk to Louise about her options, as this was one of the few times where Louise appears to want to take a case to court. But this opportunity was lost.

2.17.8 *Risk assessment*. The SafeLives DASH risk identification checklist is a standard tool for assessing the risk of future serious harm or death for victims of domestic abuse. It has 24 questions and acknowledges that risk changes over time and therefore is an indicator rather than a full assessment of risk. Referrals to MARAC are based on:

(a) Visible high risk – where the number of 'yes' answers to these questions equals 14 or more

(b) Potential escalation – where the number and pattern of police call-outs suggests that the abuse is escalating

(c) Professional judgement – where the professional involved has serious concerns about a victim's situation even where the information disclosed by the victim does not meet the criteria above.

2.17.9 Based on the information provided by agencies in this review and by Louise's daughter, the chair completed a DASH for Louise, inserting Damien's name for clarity. This does not show information known at any one time, but instead shows the information as it accumulated throughout agencies' involvement with Damien and Louise. It does suggest that a conversation with a specialist worker might have been able to draw this information from Louise to identify that she as at high risk. The score here is 21 and the threshold for referral to MARAC is 14 on the DASH, or through professional judgement or visible escalation.

No.	Risk	Yes	No	Don't Know	Notes
1	Recent injury?	X			On many occasions
2	Frightened?	X			She said she was following the strangulation
3	What are you afraid of? Further injury/violence To whom?	X			Following the strangling incident
4	Are you isolated from family and friends	X			Jade's report and that of colleagues
5	Are you feeling depressed or feeling suicidal?	X			Jade's report
6	Separated or tried to separate within the past year?	X			
7	Conflict over child contact?		X		
8	Does Damien constantly text, contact, follow, stalk or harass you?	X			
9	Are you pregnant or recently had a child?		X		

10	Abuse happening more often?	X			5 breaches of restraining order in the 5 months after it was made on 25 February 2012
11	Is the abuse getting worse?	X			
12	Does Damien try to control you or is he excessively jealous?	X			Accusations against fellow workers and friends
13	Has Damien used weapons/ objects to hurt you?	X			
14	Damien threatened to kill you or someone else and you believed him?	X			
15	As Damien attempted to strangle/choke/suffocate/ drown you?	X			4 July 2010
16	Does Damien say or do things of a sexual nature that make you feel bad or physically hurt you or someone else?	X			Police information based on alleged assault in 2005
17	Threats from other people?	X			Damien waited for Louise outside her probation placement with another man on May 2011
18	Has Damien hurt anyone else?	X			Neighbours, Jade, previous partners
19	Damien mistreated an animal or pet?			X	Gangsta?
20	Are there financial issues?	X			Police call-outs regarding a debt that Damien thinks Louise owes him

21	Has Damien had problems with drugs/alcohol/ his mental health	X			Problems with drugs and alcohol noted in Damien's probation assessments
22	Has Damien attempted suicide?	X			Incident on the roof in May 2011?
23	Has Damien broken bail/an injunction/court order?	X			
24	Does Damien have a criminal history?	X			
	TOTAL	**21**			

2.17.10 *Opportunities for referral to MARAC.* There were 25 incidents in Hertfordshire that related to the relationship between Damien and Louise. There were 36 incidents in the MPS area regarding them. That is 61 incidents in the space of 73 months.

2.17.11 The number of call-outs over time and professional judgement that linked the incidents understood the punitive nature of Damien's abuse and his unmanageability should have had Louise back at MARAC every time there was an incident, particularly after the assault involving strangulation on 4 July 2010.

2.17.12 As noted previously, MARACs are not statutory requirements, so they began and matured at different times in different places. MARACs were running in Haringey from at least 2009, in Enfield from August 2005, and in Hertfordshire from mid-2009. The incidents recorded by the police in both areas should have informed their assessment of risk, leading to referrals to MARACs when they became part of the domestic abuse response in both areas.

2.17.13 *Update*. Operation Dauntless, undertaken by the MPS, aims at developing a more robust system for identifying repeat victims.

2.17.14 This is addressed in the Recommendations for the police services.

2.18 Multi-Agency Public Protection Arrangements (MAPPA)

2.18.1 MAPPAs were established by The Criminal Justice Act 2003 to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. MAPPAs are comprised of local criminal justice agencies, that is, police, probation and the prison, and other bodies dealing with offenders who have a duty to cooperate as

needed. The MAPPA is not a statutory entity, but a platform to coordinate the information and activities of agencies with responsibilities for public protection and offenders.

2.18.2 The basis for referring an offender to MAPPA is that he or she is a registered sex offender, has a conviction for a specified offence[39], or is thought to be a dangerous offender, that is, has been cautioned, reprimanded, warned or convicted of an offence that indicates that he or she is capable of serious harm and required multi-agency management at level 2 or 3.[40] The MAPPA Panel then decides the level that the offender will be managed at. In this case, Damien was a category 2, level 2 (see **Appendix 2**). In general, an offender is referred to MAPPA when he or she is particularly difficult to manage. Damien's drug taking, prolific offending, violence, his non-engagement and his disregard for interventions suggest that he was difficult to manage.

2.18.3 At the MAPPA, the partner agencies agree a plan to manage the offender and the risk they pose. When the action plan is complete and the MAPPA partners feel that there is nothing else they can do, the case devolves to a single agency to manage but can be re-referred at any time for a multi-agency approach.

2.18.4 Damien qualified for MAPPA, following his conviction and sentence for 26 months for ABH and criminal damage in June 2006. He was eligible as a Category 2 offender under probation until his licence expired on 27 August 2007. This conviction also meant that police could have referred him to MAPPA at any time as a Category 3 offender. (MAPPA categories are shown in **Appendix 2**).

2.18.5 **11 August 2006**. Damien was referred to MAPPA in Haringey by probation as a 'high' risk Category 2 offender in anticipation of his release from HMP Pentonville on 25 August 2006 on licence.

2.18.6 **29 August 2006.** MAPPA meeting. Those likely to be at risk from Damien were identified (including the ex-partner, her mother and sister and future partners) and situations that might increase risk were considered. Probation provided licence conditions and requested that any new relationships be disclosed to them. Eight actions were agreed and completed by the police to place a special scheme[41] at P2's addresses and conduct weekly intelligence checks.

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[39] Specified offences include murder and offences specified under Schedule 15 of the Criminal Justice Act 2003 who received a qualifying sentence or disposal for that offence, and those subject to a Disqualification Order for an offence listed in Schedule 4 of the Criminal Justice and Court Services Act 2000.

[40] MAPPA Guidance 2012, version 4, section 6: Identification and Notification of MAPPA Offenders

[41] This would have prioritized call-outs to this address.

2.18.7 **21 November 2006**. MAPPA meeting. This was in connection with the conclusion of the rape trial. Police shared information about Damien's conviction for ABH and the method used in the alleged rape of P2. Police disclosed the name of Damien's new partner, but the details are no longer available. Seven of the eight actions were completed and four more were added to the plan. It was agreed that Damien was still high risk, but should be managed at Level 1, that is by a single agency and in this case, probation.

2.18.8 **21 October 2008**. Damien's MAPPA category 2 status had expired in June 2008 (linked to the expiration of a licence period). But MPS had referred Damien to MAPPA as a 'high' risk Category 3, Level 2 offender due to F2's allegations of assault and threats to kill on 7 October (F2 had declined Damien's advances). He was adopted as a 'dangerous offender' due to the risks he presented and the lack of intelligence about his relationships. The actions raised from this meeting were concerns of rent arrears, notifying Damien of the referral and a safety plan around the victim. The last two actions were for the police.

2.18.9 An officer who had been involved in the F2 case described Damien as 'scary'. She noted that he was hostile when he was being processed in custody and had tried to 'chat her up' and made several inappropriate comments.

2.18.10 **Commentary**. *Poor research and incident-focussed.* The research did not identify eight incidents between Damien and Louise, including the criminal damage at the school (November and December 2007), the aggravated burglary at her home, the worries that she was being held hostage (January through October 2008), By this time, Damien had harassed Louise at her work place, assaulted her in her home, and her family had reported that Damien had held her hostage. But there is no acknowledgement of the active threat that Damien posed to Louise.

2.18.11 Probation noted superficial compliance and Damien's request for a drug intervention programme. The recordings of actions (by the police) were not as clear in 2008 as they were in 2006.

12 January 2009. Police attended Damien's address to notify him that he was a MAPPA subject. Louise was at his address. Police then identified Louise's home address and that she had a daughter, Jade.

2.18.12 **13 January 2009.** At this meeting the risk management regarding F2 was recorded as completed. Again, the incidents between Damien and Louise were not discussed, nor the new incident with F3 on 6 December 2008. Though the police shared Louise's name at this meeting, no risk management plans were made for this relationship (or plans to

establish the nature of the relationship at this time) and police did not seek authority to share Damien's history of violence with Louise. This possibility existed at the time and has been reinforced by the introduction of the Domestic Violence Disclosure Scheme introduced in March 2014. There is an update of Damien's allegations of theft against Louise, but this is considered to be malicious on Damien's part. The next discussion was to be at the February MAPPA meeting.

2.18.13 The minutes of the meeting in February 2009 were not made available to the IMR writer. There were no further MAPPAs for Damien in Haringey.

2.18.14 There are no records for MAPPA review of Damien in Hertfordshire.

2.18.15 **Commentary.** This was a serious lost opportunity that might have made a difference in this case.

2.18.16 *Coordinated community response/ multi-agency approach*. Damien's behaviour in 2010 through to Louise's murder in December 2013 appeared to be unmanageable. He manipulated the system, did not engage with interventions, and breached the restraining order many times. The risk he posed was not being managed effectively and therefore it is disappointing that he was not referred again to MAPPA.

2.18.17 As noted in the LCRC and prison sections of this report, there is an imperative for agencies to work together, particularly when they are managing the risk of such violence and prolific offenders as Damien. MAPPA could be used more regularly and effectively in managing violent domestic abuse offenders.

2.18.18 **Update on improvements to the MAPPA process.** The administration of MAPPAs in London has improved since 2009. There is now a dedicated MAPPA administrator. The London MAPPA Strategic Management Board has focussed on raising the standard of risk assessment and the multi-agency risk management planning.

2.18.19 The most recent guidance (2012) requires the discussion of cases prior to release and recommends 6 – 8 months before release. The IMR writer reported that this was happening in the majority of cases.

2.18.20 The links between MAPPA and MARAC have been made explicit and the minutes of a MAPPA meeting in April 2015 confirm this.

2.19 Haringey Integrated Offender Management

2.19.1 Integrated Offender Management (IOM) is a nationally recognised approach as a key to reducing crime and reoffending. This approach brings together a number of stakeholders to supervise, manage and positively impact on the criminal activity of

offenders within the community. It aims to help partners reduce crime and reoffending, improve public confidence in the criminal justice system and tackle the social exclusion of offenders and their families. The IOM seeks to achieve this through enforcement, persuasive compliance and supportive offender engagement.[42] IOM is not a statutory requirement.

2.19.2 IOM cohort offenders typically are those at the highest risk of reoffending and/or risk of harm to local communities. The IOM responds to these with an intensive package of intervention, including an increased level of contact from a range of responsible agencies.

2.19.3 At the time, the Haringey IOM Unit consisted of police officers, probation officers (London Probation Trust at the time), drug intervention programme and treatment services and substance misuse organisations (St Giles at the time). It was a virtual team with links to the Council and partner agency support services.

2.19.4 On **7 December 2012**, Damien was sentenced to 18 months, suspended for 24 months for burglary and theft from a dwelling, with a requirement for supervision (24 months) and a DRR (Medium Intensity). He was adopted as an IOM nominal on **15 January 2013** as a 'Red' offender that is one at high risk of re-offending with an Offender Group Reconviction (OGR) Scale of 72%, following his conviction on 7 December 2012.

2.19.5 **Commentary.** *Perpetrator behaviour*. The IMR author reported that a score of 50 – 75 on the OGR with convictions for robbery or burglary lead to the 'Red' rating. He noted that Damien was not as prolific an offender as others with that rating, but the variety of offending was notable.

2.19.6 During this time, Damien was supervised by an IOM probation officer and an IOM police officer and he was referred for the DRR. The supervision requirement for Damien was to report for supervision twice per week: once to his probation officer and once to the police officer allocated to him. He also had to report twice a week to substance misuse services: once to the drug intervention programme and one with the Recovery Services. Damien was tested twice a week for drugs.

2.19.7 The IOM management of Damien was through monthly meetings (virtual meetings as the team members were not co-located) where these officers would review information on Damien's attendance for supervision, compliance with the DRR and intelligence by his supervising officers. Any action required would be agreed here.

[42] Information from https://mappa.justice.gov.uk.

2.19.8 Information from the supervision sessions should have been put on the probation system and the police's intelligence system, Crimint. MPS found no record of supervision by the police (this should have been added to the probation file and Crimint). There is no record of information shared by the police or shared with them through the monthly IOM meetings.

2.19.9 In December 2012, Damien had 29 convictions for 41 offences. The areas of concern identified for Damien regarding risk of harm and risk of re-offending are listed below. The IMR author noted that the variety of concerns is unusual.

(a) Offending

(b) Relationships

(c) Substance misuse

(d) Employment, Training and Education (ETE)

(e) Lifestyle and attitudes.

2.19.10 Damien was identified as posing a medium risk of harm to known adults including current/future partners. The IMR author reported that officers from police and probation who were working with Damien at the time say that it was well known that Damien was in a relationship with Louise, that the relationship was not stable and that there was a protection order in place. They also understood that Louise was appealing against this order (though they had not spoken to her about this).

2.19.11 There were no flags for DV at the time. There are only 2 notes involving Louise; when Louise attended supervision with Damien on 1 August 2013, and when the Offender Manager saw an argument between Damien and Louise outside the probation office on 15 August 2013. Louise was not spoken to directly on either occasion and these obvious breaches of the restraining order were not pursued.

2.19.12 **Commentary**. *Poor research.* The notes do not show the assault on Louise on 14 May 2011 at her probation placement or note the abuse Damien gave Louise on the phone when he was at court on 7 December 2012.

2.19.13 The IOM notes show that

(a) Damien's history of violence and chaotic drug use were also well known.

(b) Damien consistently tested positive for cocaine use and admitted on a number of occasions that he used crack cocaine.

(c) Damien's records show that on a significant number of occasions Damien either failed to attend or there is a record of 'acceptable non-attendance' and no records of corroboration of reasons proffered for his non-attendance.

(d) Damien consistently failed to attend both his sessions for substance misuse, with no investigation or actions. By not attending, Damien was in breach of his supervision requirements.

2.19.14 Damien was discussed on **6 February 2013** at an IOM meeting and at each of the monthly meetings until Louise's death. Damien's failure to attend or engage was regularly discussed, as were his positive tests for drug use. The records of these meetings are minimal and show few actions undertaken to address these issues. His behaviour and compliance continued to deteriorate up to the time of Louise's death. Damien talked about the deterioration of his relationship with Louise, money and benefit concerns and they knew of his increasing drug use. The IOM officers would have known that these factors meant that the risk of his re-offending was increasing. Damien should have been subject to breach proceedings prior to Louise's death.

2.19.15 Damien was not seen by either the IOM probation or police officers after 28 November 2013. On **2 December 2013** an unknown male attended the appointment; saying that he was a relative of Damien's and that Damien was 'not in a good place at present' and had damaged his cartilage.

2.19.16 The last attempt at contact was on **17 December 2013**, two days before Louise died, when the IOM probation and police officers attended Damien's home address and did not find him there, despite his recent excuse that he was unwell and immobile.

2.19.17 **Commentary.** As noted in the LCRC section, Damien had disclosed that he was unhappy in his relationship and there was evidence, such as the indefinite restraining order, that he had been abusive to Louise in the past and posed an on-going risk to her. In such circumstances, professional judgement should have led to a MARAC referral.

2.19.18 Despite good information-sharing and an understanding of Damien's lack of compliance, the lack of partnership standards and procedures meant that the process failed to manage Damien and the risk he posed.

2.19.19 The errors and weaknesses in the IOM system seen in this case are

(a) The insufficient management oversight and joint case management systems.

(b) Each organisation followed its own practices and there were no agreed common protocols or understandings about the number of breaches of supervision that should lead to breach proceedings being brought,

(c) No common IOM DV policy

(d) Lack of investigation into reasons for absences and no oversight of actions and whether they were completed

(e) Inadequate recording of intelligence, including other multi-agency reviews of this situation

(f) Poor records of IOM meetings

(g) Inadequate response to the information they were given and knew about Damien's relationship with Louise

(h) No engagement with processes or agencies with a speciality in domestic abuse – no MAPPA, MASH, MARAC, or IDVA service was noted in the files.

2.19.20 **Changes in the IOM system since Louise's murder**

2.19.21 The IOM IMR author provided an update on the substantive changes in the IOM system since the events detailed above. The IOM now includes dedicated IOM LCRC and NPS probation officers, IOM police and drug intervention officers and they are co-located within a single team. IT systems allow all partners access to information held by other partner agencies. Information is shared in real time about non-compliance.

2.19.22 The partnership now includes additional partner agencies such as a dedicated prison officer in Pentonville Prison and links to support agencies for mental health, substance misuse, housing, vulnerable adult's teams and others.

2.19.23 There is now both line management of the officers and case management of the work with offenders. The IOM Operational Manager manages the multi-agency staff and the IOM procedures; line manages the LCRC officers, and has management responsibility and oversight of all IOM cases. The IOM Strategic Lead or Operational Manager attends domestic violence multi-agency meetings.

2.19.24 The IOM operational meetings are held every two weeks and clearly record decisions, including recall, breach and enforcement. Activities are coordinated between agencies responsible for offenders in prison, preparing to return to the community and as they re-enter society.

2.19.25 There are now standard procedures for issues like non-compliance, e.g. where there are 3 or more trigger events (e.g. non-compliance, positive drug-testing), a meeting is held to take decisions.

2.19.26 The recommendations in the Conclusions and Recommendations section for the IOM address issues raised by this review and not dealt with by the restructured IOM processes.

2.20 Victim Support – Hertfordshire

2.20.1 VS Herts searched their records and report that between 2 December 2005 and December 2013, there was no involvement with Louise.

2.20.2 Hertfordshire Constabulary note that on 10 October 2008, Louise was referred to VS Herts after Damien broke into her flat, took her phone and broke her sim card. (Police used PAVA spray to subdue Damien when they arrived.) The police risk assessment was 'very high'.

2.20.3 On 18 August 2009, Hertfordshire Constabulary note that they contacted VS Hertfordshire. This was after a domestic incident where Louise reported being threatened by her family. There was no further note on this.

2.20.4 **Commentary.** *Support for victims*. It appears that VS Herts did not get referrals relating to the domestic abuse incidents in Hertfordshire. As a new IDVA service has been commissioned in Hertfordshire in the course of this review, the recommendations that address this lack of support for victims is aimed at Hertfordshire Constabulary and the county council.

2.21 Victim Support – London

2.21.1 Throughout the time covered by this DHR, it was VS policy to try to make contact 3 times before closing a case referred to them. This appears to have been followed in this case.

2.21.2 It was also VS policy that, where contact could not be established, that the case was referred back to the police CSU or referring agency. There is no evidence in the VS case management system that this policy was followed on this occasion.

2.21.3 **Commentary.** *Update: systems improvement.* A number of incidents where VS do not have records of police referrals made to them, or were unable to establish contact with the victim, were noted above and in the accounts below. The new case management system that VS launched in January 2017 addresses some of the weaknesses of the previous processes. The new system imports all referrals from the police and creates a case for them. Where referrals are incomplete, that is, are missing essential information,

they are reviewed manually. If still found to be incomplete, the referral is sent back to the police to alert them to this. They then supply the missing information and re-refer. In addition, VS also now support all victims of crime so that where domestic abuse is enacted through criminal damage, say, VS would still offer support and therefore may be able to identify domestic abuse in crimes not initially presenting as such.

2.21.4 On **8 October 2008**, VS were notified of Damien's threats to F2 following his damaging her car. There is no record that contact was attempted or made.

2.21.5 **Commentary**. *Poor recording*. If the crime was not flagged by the police as domestic abuse, VS would not have attempted contact as motor vehicle crime was not supported by VS at the time.

2.21.6 On **5 July 2010**, Louise was referred to VS. This was the occasion where Louise picked Damien up in her car and he then punched her and strangled her to unconsciousness. VS tried to ring Louise on four occasions; twice on 9 July 2010 and twice on 14 July 2010. The case was closed on 14 July 2010.

2.21.7 **Commentary.** *Understanding the effect of domestic abuse on victims*. Damien was a jealous and controlling partner. In such cases, victims often find it risky to answer calls from unknown numbers or have answering facilities for their phones as it can be used by the perpetrator as evidence of infidelity. A more varied approach to such victims would get a better response rate. To assist this, officers should gather as much information as they can about ways and times to contact victims safely.

2.21.8 Agencies often withhold their numbers when attempting telephone contact with victims to protect the victim's confidentiality and safety. This is an important safety measure but for some victims, this may reduce the likelihood of making telephone contact.

2.21.9 *Risk assessment*. The strangulation to unconsciousness should have alerted the VS worker to the high risk that Louise faced and a referral to MARAC should have been made. The case should have been referred back to the police when no contact was established.

2.21.10 There was one occasion in 2010 (29 September 2010) and 6 occasions in 2011 (20 Jan, 3 Feb, 17 Feb, 27 May, 31 October, and 18 December) when MPS notified VS of an incident where Louise was the victim and VS has no record of these on their case management system.

2.21.11 **Commentary**. *Poor communication systems*. It appears that these referrals were not picked up via the daily automated data transfer process between the police and VS. VS

report that there are various reasons for this, including insufficient or poor data quality, unsupported crime types (like vehicle theft as noted above), or the absence of a DV flag on the referral.

2.21.12 *Update. Monitoring referrals.* There are now 4-weekly case reviews for all DV caseworkers and IDVAs as part of VS's working towards Leading Lights accreditation of its DV work. SafeLives Leading Lights accreditation reviews case files and requires referrers to be updated, particularly where no contact was established. This feedback loop helps ensure that referrals made are received and acted upon.

2.21.13 On **14 May 2011**, Louise agreed to a referral to VS and a referral was made the same day. Damien had met Louise after her probation work placement and struck her in the eye. VS was notified the next day. VS called Louise on 17 May 2011 and got no answer. Another caseworker rang on 19 May 2011 and Louise declined support.

2.21.14 On **15 December 2011**, VS were notified again of Damien harassing Louise at work and then damaging her front door. A VS worker called Louise on 16 December 2011 and did a DASH risk assessment with her. The score was 13. VS left a message for the OIC saying that Louise wanted a panic alarm. VS also emailed the OIC about the alarm. The VS worker noted that Louise declined emotional support so the worker texted the VS contact details in case she changed her mind and closed the file.

2.21.15 On **27 December 2011**, Louise accepted referral to VS following threats to kill her from an unknown male, being audibly prompted by Damien. A VS caseworker called on 3 and 4 January 2012 and twice on 6 January 2012 and then closed the case.

2.21.16 **Commentary.** *MARAC referral*. This referral, following on so closely from the previous should have triggered a referral to MARAC based on professional judgement. This would have provided a valuable back-up to police systems.

2.21.17 *Victim safety.* Risk is dynamic and a client that is 13 on the risk assessment is already high risk and may reach the MARAC threshold shortly. Practical safety planning should have been offered to Louise.

2.21.18 *Update.* VS now provide 3 different levels of domestic abuse training:

(a) For Victim Contact Officers (VCOs) who make initials calls to victims, training is provided to enable them to undertake initial assessment of victims' needs, risk level (using SafeLives DASH) and initial safety planning, including local referral routes. They shadow other workers as part of their training on contacting victims of domestic abuse.

Their training is refreshed every 6 months. When VCOs have not been able to establish contact with a victim, they alert the initial referrer.

(b) For service delivery teams who support victims up to 13 ticks on the SafeLives DASH, a four-day training course is provided that includes these topics, among others: Victims' Code of Practice, domestic abuse, listening skills, hidden biases, disabilities, vulnerable and intimated victims/witnesses, criminal injuries compensation, building resilience, dealing with difficult behaviour, data protection safeguarding children and adults at risk. Where risk has escalated, the worker and the manager decide on whether the case should be referred to MARAC, IDVA service or a specialist domestic violence organisation.

(c) For VS IDVAs who support high risk victims of domestic abuse, a SafeLives IDVA qualification is required. This is a 12-day course leading to a Certificate in Domestic Abuse OCNLR Level 3.

2.21.19 On **15 May 2012**, VS was informed that Damien had pushed Louise and caused criminal damage at her house. Two calls were made by VS on 17 and 18 May 2012 and another on 23 May 2012 but no contact was established. The case was closed on 23 May 2012.

2.21.20 On **18 June 2012**, VS received a referral for Damien after he reported that Louise had sent threatening texts and come to his flat, challenged him about other women and slapped him. The police research noted that Louise had a non-molestation order in place (this may have been the indefinite restraining order) against Damien. A Victim Care Unit worker rang Damien on 18 and 19 June 2012 and, after a final call without successful contact on 21 June 2012, the case was closed.

2.21.21 **Commentary.** *Victim safety*. At the time, as Damien reported a crime and wanted to be referred to VS, the police would have had to refer him.

2.21.22 *Update. Screening for perpetrators*. At the time, there was no way to screen for perpetrators based on previous referrals or having provided support to the partner of a new referral. No harm was done in this instance because contact with Damien was not established. Following a review of processes by SafeLives, VS now has a perpetrator screening tool which is used with all male DV service users and all DV self-referrals.

2.21.23 The VS perpetrator screening tool has been part of the VS domestic violence service delivery operating instructions since July 2012 and included in subsequent updates, adding the toolkit in June 2014. All VCOs and service delivery teams receive training on this when they attend their DV training.

2.22 GP – Louise

2.22.1 In Hertfordshire, GP services are commissioned by NHS England (Central Midlands).

2.22.2 The Maples Health Centre in Hertfordshire provided GP services to Louise.

2.22.3 Louise attended the GP surgery 15 times between 7 April 2009 and her last appointment there on 29 July 2013. Louise complained of tiredness a great deal and had a history of anaemia. There were no underlying chronic conditions identified through the GP's care.

2.22.4 On **5 July 2010**, Louise attended the surgery and reported that her husband had assaulted her the previous night and that he'd tried to strangle her. The GP recorded the injuries and treated her for them and provided pain relief. The GP noted that the police were involved.

2.22.5 The GP saw Louise again several weeks later when one of the injuries had formed into an abscess. The GP gave Louise further treatment and requested that Louise have an x-ray and blood test.

2.22.6 These are the only indicators of domestic abuse in the GP records.

2.22.7 **Commentary**. *DV is everyone's responsibility*. It is common for agencies and professionals to delegate responsibility for helping domestic abuse victims and holding perpetrators accountable by recording that the police are involved. This case makes clear the number of reasons that victims find it hard to engage with criminal justice processes, and the increased risk for those victims who do.

2.22.8 Strangling is a high risk factor in domestic abuse. If the GP had been trained in domestic abuse, s/he might have identified this and asked further questions to gain more information. Louise might have felt able to talk about the abuse in a health setting in a way that she could not in a criminal justice setting. Louise told several agencies that she was very ready to leave Damien at this time.

2.22.9 As noted elsewhere in this report, every agency has a unique role in identifying and responding to domestic abuse. There are recommendations for Hertfordshire County Council to review and address the provision for victims presenting to GPs.

2.23 GP – Damien

2.23.1 The Chair of the Review, Haringey CCG and NHS England (London) struggled to get Damien's GP at St Johns Road Surgery to engage with this DHR. The GP was a sole practitioner and retired during this DHR. He provided the information and analysis himself initially and then commissioned someone else to provide some additional material, but the quality of the result was not sufficient for analysis by the Review Panel.

2.23.2 The Review Panel was keen to have this information because Damien had used sick notes to excuse him from the considerable number of interventions he was required to attend by the sentence of the Crown Court following his conviction for burglary and theft in December 2012.

2.23.3 The statistics compiled by the GP do provide some interesting information. Damien attended the GP surgery 35 times between 10 February 2005 and 25 November 2013. On a number of occasions, Damien was referred on for cardiology appointments, blood tests and ultrasound investigation of his complaints of chest pain, being short of breath, and abdominal pain. Some appointments he kept, and some he missed without explanation.

2.23.4 On 16 occasions, Damien was given a medical certificate. Between 10 April 2012 and 25 November 2013, Damien was given 8 medical certificates, all for chest pain, depression and abdominal pain. No secondary treatments or further investigations were offered during this time.

2.23.5 As noted elsewhere in this report, Damien's medical certificates were not questioned by the agencies he presented them to and the GP was not contacted for more information. It would have been useful for the LCRC and substance misuse services to understand any underlying pathology and prognosis for Damien's health concerns. It would also have been useful for the GP to be aware of Damien's use of the certificates to excuse him from engaging in supervision and rehabilitation.

2.23.6 **Commentary.** *Training for GPs*. IRIS stands for Identification and Referral to Improve Safety and is a domestic abuse training and support programme based in GP practices. The core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is primarily aimed at helping women who are experiencing domestic abuse from a current or ex-partner or adult family member, yet also provided information and signposting for male victims and for perpetrators.

2.23.7 The London Borough of Haringey and Haringey CCG have jointly commissioned NIA to develop the IRIS model across 25 GP practices (this is about half of existing practices)

across the borough. The project is funded for 3 years by CCG and commenced in June 2016.

2.23.8 IRIS is a general practice-based domestic violence and abuse training, support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. An advocate educator is linked to GP practices and works with the local clinical lead to co-deliver training to practice.

2.23.9 *Information for GPs*. In the chair's experience, GPs often need information and guidance to help them understand their role in DHRs and especially their legal position and responsibilities regarding information-sharing in this context.

2.24 Homes for Haringey

2.24.1 Homes for Haringey are an arm's length management organisation (ALMO)[43] set up in 2006 to manage Haringey's council housing. Homes for Haringey manage about 16,000 tenancies and 4,500 leasehold properties.

2.24.2 When Homes for Haringey took over in 2006, the Council's staff and tenancy records for the housing service transferred to the organisation.

2.24.3 Louise was not a council tenant in the period of time covered in this review.

2.24.4 Damien was a tenant of Haringey Council from August 1994 until 2006 and then of Homes for Haringey. During the period under review, he was a sole and secure tenant in a flat in Haringey.

2.24.5 All tenancy management staff were trained on domestic abuse in 2013. Homes for Haringey report a close working relationship with the domestic violence team at Hearthstone, Haringey's domestic abuse service.

[43] An arm's-length management organization (ALM)) is a not-for profit company that provides housing services on behalf of a local authority.

2.24.6 Damien as a tenant. Damien became a council tenant in 1994 when he left prison. There are notes of a number of communications between the Housing Manager and prison and probation officers about Damien and his housing.

2.24.7 There are many notes regarding Damien and his housing benefit, sorting his benefits when he is in prison, and rent arrears. In addition, there were a variety of notes, letters of warning and successful injunctions taken out by Homes for Haringey. Homes for Haringey worked closely with the ASB Team to manage Damien as a tenant.

2.24.8 For the purposes of this report, we will focus on Damien's anti-social behaviour and Homes for Haringey's responses to that.

2.24.9 There were 2 occasions when Damien reported that his front door had been broken by the police and needed emergency repairs.

2.24.10 Damien was abusive/threatening to neighbours. There is not much information about the threats to neighbours in Homes for Haringey's report. Such information would be useful to record even if the ASB Team are recording it and taking the action forward. The two organisations have different remits and the information recorded is for different purposes.

2.24.11 Damien had a dog named 'Gangsta' that neighbours found threatening. There were several complaints from neighbours about Damien walking the dog without a lead. Homes for Haringey wrote to Damien about this on 11 October 2011.

2.24.12 **13 and 20 April 2012**: Damien threatened a neighbour, spat at her and then threatened her with a weapon after finding she too had complained about the dog. In particular, she complained that he had let the dog off its lead in a communal area, making it difficult for her to get to her flat.

2.24.13 The police were informed and attended and interviewed the tenant. Damien was charged with common assault and released with bail conditions not to contact the victim or go to this flat and to stay with his mother.

2.24.14 Homes for Haringey moved the tenant out of the building in response to this incident.

2.24.15 Damien was abusive to staff. Concierge staff work alone in the block. Damien threatened Homes for Haringey concierge staff on a number of occasions: 22 January 2005, 3 February 2005, 3 July 2009, 3 September 2009, 25 April 2012, and 9 June 2012. Staff reported all incidents promptly, as was required, and managers responded quickly by writing to Damien, reminding him of his tenancy agreements regarding nuisance, annoyance and harassment. Tenancy management instructed their legal team to start

proceedings against Damien for threatening behaviour on 3 September 2009. The staff were well aware of the options available to them and took appropriate actions.

2.24.16 Sometimes Damien's threatening behaviour followed actions by the council that he did not like. These council actions included removing his car when it was on a single yellow line, starting to remove his car, informing him of restrictions on where he parked his bike, and eviction proceedings.

2.24.17 On **22 October 2008**, a Senior Housing Manager attended a MAPPA meeting and recorded that it was not appropriate for lone men or women to attend Damien's flat and suggested that a warning flag was put on Damien's file. There is no record that this flag was reviewed which would have required a further consideration of the risk that Damien posed.

2.24.18 Staff reported feeling very vulnerable when they had contact with Damien and Homes for Haringey note that Damien used racist and abusive language towards both men and women. Two of the three staff interviewed for the IMR had been moved out of the management of Damien's building following incidents with him as they were very shaken.

2.24.19 Staff also reported feeling very vulnerable when they had contact with Damien and did not get feedback on actions being taken against him by Homes for Haringey. He remained in the building.

2.24.20 **Commentary**. *Safety for women.* It appears that the warning flag on Damien's file was a warning for staff. As with the prison information, a warning that a person poses a threat to staff should cause the organisation to reflect on the threat that person might pose to their intimate partners and friends.

2.24.21 The MAPPA discussion noted above followed Damien's damage to a car and threats to kill F1 for dating a friend of his rather than him. Homes for Haringey recorded that Damien was a threat to men as well as women.

2.24.22 Actions against Damien. Damien was a secure tenant and Homes for Haringey actions against him were focused on enforcing the terms of his tenancy agreement and Homes for Haringey's Health and Safety Strategy.

2.24.23 **Commentary.** *Update*. *Holding the perpetrator accountable and keeping staff safe*. Homes for Haringey also have a Flagging Abusive and Potentially Violent Clients' Policy. Homes for Haringey have a Lone Working Policy, a DV and staff policy and safety strategies in place for dealing with aggressive tenants in order to protect staff at work.

2.24.24 A without notice injunction was granted against Damien on **25 September 2009** prohibiting Damien from assaulting, harassing, using or threatening to use violence against any employee, agent or contractor of the Council. It also prohibited Damien from causing a nuisance and annoyance. The notice had a power of arrest and was in force until 24 September 2010.

2.24.25 An eviction for rent arrears was to be held in February 2013, but Damien applied for a stay of eviction and was allowed to remain in the property and pay rent arrears gradually.

2.24.26 Information about Louise. There were a number of references to Damien's girlfriend and partner. Several entries in March – May 2008 referred to the 'tenant's girlfriend' and described how she was involved in paying Damien's rent while he was on remand. There is a note referring to his inconsiderate parking of his car on 17 February 2009 and waiting for 'his partner' to come down and move the car, to his 'girlfriend' moving his car on another occasion. On 3 October 2012, Louise called Homes for Haringey on Damien's behalf, but staff would not discuss his situation with her. She told them that Damien was in prison. The next day, Louise attended his stay in executing the possession order hearing on his behalf, though the judge would not accept her as a proxy. She supported Damien at his later stay in executing the possession order hearing on 8 February 2013.

2.24.27 In interview, some of the Homes for Haringey staff identified Louise as Damien's girlfriend and knew that she visited regularly. On one occasion when Damien had threatened staff, Louise had restrained him. One of the concierge staff had informal conversations with Louise who had told her that she wanted to get out of the relationship. Louise told them that Damien had been to prison for 'attacking her'.

2.24.28 The staff member did not share what they knew of Louise's situation with their manager because she did not have her consent to do so. The other tenants on the floor where Damien lived did not make any complaints and Louise was not a tenant, but Homes for Haringey acknowledge that there was a safeguarding issue here as Louise had shared sensitive information with staff.

2.24.29 **Commentary**. That Louise trusted the concierge enough to talk about her relationship with Damien is significant and speaks well of the staff. As noted elsewhere, Louise did not engage for long with staff.

2.24.30 *Safety of victims*. After Louise's death, the MPS spoke to concierge staff at Damien's block of flats. Staff described Louise and Damien's relationship as volatile with arguments and 'play fighting' where Louise would push and slap Damien. Staff reported

storing Louise's clothes on three occasions when Damien had thrown them out of his flat. They reported that three years before this (in 2010), they had seen bruises on Louise's face that she explained had been caused by Damien. The MPS IMR noted officers recorded that '*The Homes for Haringey report says that staff are aware of the domestic violence protocol and the referral process.'*

2.24.31 *Holding and sharing information*. In the course of this review, Homes for Haringey were surprised about the amount of information that other agencies had about Damien. Knowing more would have helped them in dealing with his threats to staff and other tenants. At the same time, they dealt with incidents of abuse from Damien that they did not report to the police. Homes for Haringey are part of the MARAC and attended a MAPPA meeting about Damien. More of these multi-agency meetings to share information might have helped them all. It would also have assisted Homes for Haringey perhaps to see their role in helping Louise.

2.24.32 *Update*. *For staff.* Since the incident, the staff's awareness of domestic violence has considerably improved as has their understanding of how to report concerns regardless of whether the victim and/or perpetrator are tenants. It is the responsibility of staff to raise concerns with their manager or the Safeguarding Officer. There are posters across all offices promoting the reporting of any concern and providing the details of the Safeguarding Officer.

2.24.33 An improved surveillance CCTV system was installed in 2014 that links all the blocks in that area. Staff report that this additional tool helps to give staff confidence.

2.24.34 Staff involved in this case are now aware of a counselling service that is available to all Homes for Haringey staff.

2.24.35 Safeguarding training includes training on DV and is a rolling programme for all front line staff (Repairs, Concierge, and Estate Services).

2.24.36 A safeguarding group within Homes for Haringey has been established. If staff know of a safeguarding issue, they can provide a concern form to identify this and the Tenancy Management Staff will have a responsibility to investigate it. This primarily for tenants, but clearly states what the process is for dealing with reports about a non-tenant.

2.24.37 The Safeguarding Group meets quarterly to discuss serious reviews and share information from different teams

2.24.38 *Update. For victims*. Housing Related Support is funding an additional housing IDVA post. The role is a strategic time-limited resource to support the development of an

enhanced housing response to domestic violence and abuse. The goal is to develop pathways between housing and partnership services in the London Borough of Haringey. The post will develop a project with Homes for Haringey and its specialist domestic abuse service Hearthstone to deliver accreditation to DAPA[44]/DAHA[45] standards for the housing service, identifying community resources, promoting access to homelessness prevention and developing a culture of commitment to a strengths-based victim, survivor focus leading by example.

2.24.39 Since the incident, Hearthstone, the council's domestic violence and advice centre is now part of Homes for Haringey Housing Demand areas of work. As a result, Homes for Haringey report that there is better awareness of their work among staff.

2.25 Anti-Social Behaviour Service

2.25.1 The Haringey Anti- Social Behaviour (ASB) Service investigates complaints regarding anti-social behaviour[46], including racial harassment, nuisance, etc. affecting residents of the borough, and housing management issues for Homes for Haringey. The service does not investigate allegations of domestic violence, but refers alleged perpetrator activity to Homes for Haringey and victims to Hearthstone. The ASB Service sits within Community Safety and Environmental Services within the Chief Operating officers Directorate.

2.25.2 Possession proceedings. A suspended possession order was obtained in June 2011 for rent arrears by Homes for Haringey. The possession order was sought based on rent arrears and supported by evidence from the ASB service of threats made by Damien to residents and concierge staff and information regarding his offending behaviour.

2.25.3 Following this, the ASB Service was involved in obtaining a Warrant to Execute the Possession Order in June 2012 as Damien had not paid off his arrears in compliance with the Order. Damien was due to be evicted on 9 October 2012.

2.25.4 Damien applied for a stay of eviction that resulted in the eviction being suspended pending a court hearing. Following several delays, the case was heard in February

[44] DAPA is a Domestic Abuse Prevention Advocate

[45] DAHA is Domestic Abuse Housing Alliance. This is a partnership between Peabody, Gentoo and Standing Together that delivers accreditation services to support and improve the practice of housing providers. See http://www.peabody.org.uk/resident-services/safer-communities/domestic-abuse/daha.

[46] Anti-social behaviour is defined as 'Behaviour by a person which causes or is likely to cause harassment, alarm or distress to one or more persons not of the same household as the person.' (Antisocial Behaviour Act 2003 & Police Reform and Social Responsibility Act 2011).

2013 when the court upheld the appeal by Damien. The ASB team report that the criminal activity and the ASB did not persuade the court. Though an appeal process was available, this was not pursued as there had been no further complaints about Damien by his neighbours.

2.25.5 Anti-social behaviour. The ASB team investigated two separate complaints against Damien in April 2012. Their role was to gather information to support an action by Homes for Haringey for eviction of Damien for rent arrears with supporting information on Damien's anti-social behaviour.

2.25.6 One was from a resident of the block (F4) to whom Damien made threats to kill (covered in the MPS report, 13 and 20 April 2012 and in Homes for Haringey section above) and then returned with a machete and made further threats. Damien was found guilty of this offence and sentenced to 4 weeks in custody, but released as he had served 16 days on remand. The resident was moved for her safety.

2.25.7 An injunction with power of arrest was granted against Damien from 13 June 2012 to protect residents and staff that lived and worked in his block until the following April 2013. This forbade Damien from engaging in 'threatening conduct, assaulting, molesting, harassing or threatening to use violence against any resident or employee of the housing block'.

2.25.8 The second complaint was by an immediate neighbour about threats to her and her partner.

2.25.9 The police shared information with the ASB team at their request when they were preparing their case to evict Damien. They shared information about his assault on F4, his arrest for burglary, his being remanded in custody for burglary and his sentence for burglary and details of the restraining order.

2.25.10 The ASB suggest that there are areas to improve in their information exchange with the MPS and in their awareness of violence against women and girls; general awareness, safeguarding procedures and relevant processes and procedures and how they fit into them. For instance, noise complaints, aggressive and controlling tenants, might be indicators of an abusive situation.

2.25.11 **Commentary.** *Update.* Since Louise's death, the ASB Team have reviewed their investigative process and now use a detailed checklist that includes direct questions around domestic violence and domestic abuse when speaking to complainants and those complained about.

2.25.12 The ASB Team is considering the need for an ASB Team domestic abuse or VAWG policy separate from Homes for Haringey's and the Council's. As Homes for Haringey's procedure is very narrow and the Council does not have a policy, a recommendation has been added to this effect.

2.26 Haringey Council and the Pupil Referral Unit

2.26.1 Louise was employed by Haringey as a cleaner at local authority schools. She worked at all four PRU sites until one closed and then she worked across three. Between 13 November 2007 and 15 December 2011, the police were called 7 times to Louise's workplaces as a result of Damien's actions.

2.26.2 Though Haringey Council employed Louise, she was managed on the sites by staff of those schools. The PRU reported that they had sent all the information they had to the Council just after Louise's death.

2.26.3 There was some delay in getting information about the incidents at the school from Haringey Council Human Resources (HR) department and/or the PRU as a result of this and the information eventually obtained from Haringey HR was very brief.

2.26.4 The report from the HR department recorded that Louise was an employee of Haringey Council from 23 July 2001 to the time of her death.

2.26.5 Louise was suspended from work on 20 November 2013 due to allegations of gross misconduct. The allegations were:

(a) Failure to submit a Criminal Records Bureau check. Louise had not provided the school with a copy of her DBS check and would not fill out forms to carry out a further check.

(b) She had allowed unauthorised persons onto the school premises. It was alleged that Louise had allowed a 'stranger and a dog' onto the site in the very early hours of the morning.

(c) Unauthorised absences

(i) Louise had failed to show for work on 7 August 2013 and 2 September 2013;

(ii) Louise had falsified records to show that she had completed her full hours;

(iii) Louise had arrived late for her shift on another occasion.

2.26.6 Haringey had sent a letter to Louise on 17 December 2013, inviting her to a meeting on 9 January 2014 to discuss these allegations. Louise had previously accepted all these allegations.

2.26.7 Louise had told the head-teacher at the time that she had 'personal problems' but was reluctant to discuss these further.

2.26.8 After Louise's death, her colleagues told the police that they had had concerns about Louise as they said that she often had marks or bruises.

2.26.9 It appears that the staff at the school did not formally escalate the concerns within the school or to Haringey Council about Damien's criminal damage at the school, his threatening messages for Louise, his bringing cannabis plants to the school, his assault on Louise in front of staff. The concerns for Louise expressed by her manager and appreciated by her daughter (noted in the daughter's report) were not recorded and formally addressed.

2.26.10 Many of the allegations against Louise could have been evidence of a controlling relationship.

2.26.11 **Commentary.** *Policy and practice around domestic abuse*. We know from the colleagues' interview that Louise had individual support at the school. The school may have obtained a court order forbidding Damien from coming to the school. But the concerns were not escalated to the council and there was no policy in place for staff to know what the appropriate response to Louise should be in this situation.

2.26.12 *Safety of the children.* Though Louise's colleagues and daughter recalled that the school had obtained a court order barring Damien from the school sites for a period of time, no evidence could be found to corroborate this. Therefore it remains unclear whether actions were taken to safeguard the children who attended the schools from Damien who often harassed Louise there.

2.26.13 <u>Haringey's Internal Review</u>

2.26.14 Haringey undertook an Internal Review soon after Louise's death, completing it and reporting in February 2014. The following teams or departments were involved in the case:

(a) ASBAT

(b) Homes for Haringey

(c) Drug and Alcohol Action Team (Commissioned services: HAGA, DASH, WDP)

(d) Offender Management Unit (comprising Probation, Police, Community Safety Team, DAAT, Gang Exit Unit)

(e) Haringey Council's Human Resources

2.26.15 The findings were a result of an examination of agencies' involvement and the discussions that followed. The themes and findings were:

2.26.16 Communication, procedures and discussions, which took place between departments and with external agencies

(a) Communication between ASBAT and Homes for Haringey was very good.

(b) Effective communication between agencies now involved in the OM team was less clear.

(c) An issue was discussed in relation to the information sharing from the Police to ASBAT when they are investigating a case: for example, it does not include intelligence, or where a report has been received but no charge made. This may lead to gaps in information that would be useful to ASBAT.

2.26.17 Co-operation between different departments and with agencies in relation to the case:

(a) Again, between ASBAT and Homes for Haringey in specific relation to Damien, this was very good.

(b) An issue was raised by Homes for Haringey during a wider discussion on how they respond to cases of proposed eviction (e.g. for rent arrears) where there are children or vulnerable adults in the household. Homes for Haringey stated that it can be difficult to gain the full involvement of Children's and Adults' Social Care in these cases, despite the possible risk it puts children/vulnerable adults in. It was felt that a protocol for these cases would be a useful development.

2.26.18 The opportunity for departments to identify and assess domestic abuse risk:

a) For ASBAT this was limited as they were unaware that Damien had a partner for some time; and when they became aware, there were no indications of any domestic violence/abuse.
b) HR felt that there may have been an opportunity for Louise's management and colleagues to identify domestic violence/abuse.
c) A risk assessment should have been completed on Damien at the beginning of his Drug Rehabilitation Referral order; this was not done, and was a missed opportunity to identify persons associated with Damien, specifically Louise, as possibly needing support.

d) There was discussion on the need for all departments and teams to be clear on how they perform their 'duty of care' to children and (vulnerable) adults, specifically those who may be associated with someone who has been identified as violent / threatening / perpetrating anti-social behaviour. For example, through the use of a checklist covering issues such as mental health, domestic violence, drug and alcohol issues, and exploring who else is in the household / associated with the individual in the case.

e) This last point also applied to the Council's 'Violence at Work' policy in relation to any persons posing a threat to staff.

2.26.19 Departmental responses to any identification of domestic abuse issues:

(a) This is only relevant to the OM Team, where greater attention should have been given to Damien's violence and abuse against Louise: a MARAC referral should have been considered, and possibly made.

(b) Other areas recognised that more could be done to proactively identify victims of domestic violence, in cases where the known individual is identified as violent or threatening.

2.26.20 Departments' access to specialist domestic abuse agencies:

a) The discussion demonstrated that this was patchy across the departments.

b) All departments knew of the Hearthstone service; however pathways through to the service relied on explicit disclosure from a victim who then accepted a referral.

c) ASBAT outlined how they can at times receive third party information about a domestic violence victim, and are unclear on what their response should be. This is particularly problematic where the disclosure is made concerning a private tenant (as with Homes for Haringey tenants there are useful reasons, e.g. property check, which can be used to enter the property and explore the disclosure further, where safe to do so). Guidance should be developed.

d) DAAT are aware of the difficulty for drug and alcohol agencies to identify and respond appropriately to perpetrators of (alleged) domestic violence, which has at times led to inappropriate referrals; development of training is underway to address this.

a) The training available, on domestic abuse issues, to the departments involved

a) There was no routine / regular training accessed by any of the departments.

b) DAAT and OM will be undertaking training on domestic violence, specifically on identifying and responding to perpetrators.

c) The discussion revealed that wider awareness was required, in addition to specialist training, across the council, supported by policies and procedures.

b) The response of departments / organisations on discovery of Louise's death

a) Homes for Haringey have very clear processes in place to respond to this type of incident, and these were followed in this case.

b) It is not clear why the link with Community Safety was not followed up on by those in the Council / Police who knew of the incident.

2.26.21 **Commentary.** The action plan that flowed from this internal review has not been completed and was last updated in June 2015. This is disappointing in that it does not show that making the changes identified in this admirably early exercise has been prioritised by the Council.

2.26.22 Despite the fact that Louise was an employee of the Council and the circumstances of her death were known for some time, Haringey still does not have a domestic abuse policy. This is addressed in the recommendations below.

2.26.23 *Update*: Haringey Council's 2015 – 2018 Corporate Plan's 'Clean and Safe' objective makes tackling VAWG a priority. VAWG forms part of the local partnership's approach to improving health, safety and wellbeing. The Health and Wellbeing Board, Local Safeguarding Children Board and Safeguarding Adults Board contribute to this agenda. Oversight of the delivery of the action plan that flows from this DHR is the responsibility of the CSP with monthly oversight by the Statutory Officers' Group.

2.27 Solace Women's Aid

2.27.1 Solace Women's Aid provides VAWG services across 21 London boroughs, ranging from advice and advocacy services to refuge accommodation and therapeutic support.

2.27.2 Solace searched its database and found that Louise had been referred to Solace's Enfield IDVA service by MPS on 28 May 2011 and on 12 October 2011. Both times, first contact was attempted within 24 hours.

2.27.3 MPS referred Louise to Solace and to the MARAC on 28 May 2011 with a risk assessment of 'medium' with heightened risk factors. Two weeks before Damien had

met Louise as she left her probation appointment and hit her. On 27 May 2011, he had attended her address and shouted at her through the letterbox.

2.27.4 Solace could not be sure that the telephone number they had been given was safe, so they did not leave a message or text. They attempted contact 8 times: on 31 May, 2 June and 3 June 2011. The case was closed on 3 June 2011 as no contact had been made and the police were informed. The case was heard at MARAC on 15 June 2011.

2.27.5 After Damien assaulted her on 26 September, MPS referred Louise to Solace's Enfield IDVA service and MARAC again. MPS provided Solace with a safe telephone number to ring and text Louise.

2.27.6 Solace attempted to contact Louise by calling and texting on 18, 20, 21, 25, 27, 28 October 2011 without success. It is usual practice to book an appointment to complete a risk assessment with clients. An appointment was booked for 18 October but Louise did not attend or contact the service. There was no opportunity to leave a voice message. Final text was sent on 28 October 2011, advising that they would not be ringing Louise again, and providing contact details for Solace and other support agencies.

2.27.7 The police were informed that contact had not been made on both occasions and requests were made for alternative contact numbers if they were available or if there was another agency with which the victim was engaging.

2.27.8 **Commentary.** *Safety of victim***.** The Review Panel discussed the difficulties of engaging victims that they could not consistently contact. Review Panel members identified a number of ways that their agencies had been successful doing this. There is a recommendation about gathering this experience into guidance for agencies.

2.27.9 Solace made recommendations for their service that clients that do not engage be discussed in supervision to consider alternative routes of contact.

2.28 London Ambulance Service (LAS)

2.28.1 On **7 December 2007**, following an emergency call from the police service a fast response unit and an ambulance was dispatched to Damien's address. A 37-year old male, Damien, had been stabbed.

2.28.2 On arrival, the ambulance crew were told that Damien has been stabbed on the sole of his left foot by his partner. The wound was small and superficial and not actively bleeding.

2.28.3 Following an assessment of his injury, Damien was taken to NMUH and a handover of care was completed to pass Damien to the hospital staff.

2.28.4 **From MPS IMR***:* on **12 February 2008**, the LAS were called to the house that Louise shared with her ex-partner and Jade. Damien was conveyed to the NMUH.

2.28.5 On **25 January 2011**, following a 999 call, a fast response unit and an ambulance were dispatched to an address (Louise's address) where a 40-year-old male, Damien, had fallen down a set of stairs and incurred a chest and rib injury. The male was alert.

2.28.6 On arrival, Damien was outside the property and was taken into the ambulance for assessment. Damien explained that he was having an argument with his girlfriend and was about 6 steps up from the bottom when he fell onto the right hand side of his chest and slid down the stairs. Damien explained that he had been drinking alcohol earlier that day.

2.28.7 Damien was found to be alert and orientated and was holding the right side of his chest. Damien had no abnormalities on palpation, but was in pain when he inhaled. Damien had no other injuries and Entonox was administered for pain.

2.28.8 When Damien became agitated and refused to engage with the ambulance staff any further or to be taken to hospital, he was advised to make his way to hospital.

2.28.9 On **14 April 2011**, police called the ambulance to attend Damien at the same address. He was on the roof and refusing to come down. The police then cancelled the ambulance before it arrived.

2.28.10 On **14 May 2011**, an emergency call was received to attend the address again. A 40-year-old female, Louise, had been assaulted and was seriously bleeding from a head injury.

2.28.11 An ambulance was sent and the police attended. On arrival, LAS staff were told that Louise had been assaulted by her ex-partner and punched once in the face. She did not lose consciousness.

2.28.12 On examination, Louise had a bruised and swollen left eye and a cut above her eyebrow, approximately 1 cm. Her vision was not compromised and there were no obvious factures or tenderness on palpation around the eye. No other injuries were found.

2.28.13 Louise was taken to NMUH, and her care was handed over to hospital staff.

2.28.14 The final call-outs were in relation to Louise's death.

2.28.15 **Commentary.** *Policy and procedure*. The notes from the call-out on 14 May 2011 do not record any response to the disclosure of domestic abuse.

2.28.16 Since July 2016, the LAS has a Domestic Abuse Policy and Procedure that identifies indications in a victim's behaviour and in injuries. It provides a flowchart of what to do following a disclosure of abuse from a patient or staff member and allegations of abuse against a staff member.

2.29 North Middlesex University Hospital Trust – Louise

2.29.1 NMUH serves those living in Enfield and Haringey and the surrounding areas, including Barnet and Waltham Forest. The hospital has a large Emergency Department (ED), seeing about 500 patients a day. Louise, Jade and Damien attended the ED on several occasions.

2.29.2 On **20 April 2010**, Louise presented to the ED with an injured right shoulder and complaining of severe pain. An anterior dislocation was diagnosed. The shoulder was relocated on the second attempt. Louise said that she had fallen and attended with her partner (no name noted). There is no evidence that Louise was questioned further about the source of the injury and she was discharged home with a follow-up appointment at the fracture clinic the next day. There is no record that Louise attended the next day.

2.29.3 **Commentary.** *Assault?* There was no report to the police or other evidence that this dislocation was the result of an assault. However, Damien's attendance suggests that it might have been. It is common for abusers to attend health appointments in order to control the victim's disclosure of information.

2.29.4 Damien was in court on this day, 20 April 2010, on a charge of production of cannabis. There are a number of occasions when Damien assaulted Louise around the time of court hearings.

2.29.5 *Missed opportunity*. NMUH identify this as a missed opportunity to offer help to Louise. The parties were not separated and further questions were not asked about the incident that led to Louise's shoulder being dislocated. There is limited documentation from both the triage nurse and the ED doctors.

2.29.6 A week later, Louise attended the ED again with abdominal pain, vomiting and diarrhoea. Tests done showed a urinary tract infection and Louise was discharged home with appropriate medication. The case notes indicate that Louise was a 'smoker of frequent weed'.

2.29.7 On **14 May 2011**, LAS brought Louise to the ED. The LAS crew briefed the ED staff on the history of the incident that led to the injury; that Louise's ex-partner (Damien) had punched Louise in the face. The police had been called. Louise's eye was slowly closing up. The triage nurse placed Louise in a cubicle and took a history that corroborated information from the LAS team. The nurse went to get some pain relief and when she returned Louise had left. She was called on the tannoy system but did not respond.

2.29.8 NUMH note that it is not normal practice to follow-up with patients that leave without treatment who are alert and orientated. They note that police were at the address and aware of the situation.

2.29.9 Damien had been released from HMP Bedford the day before (or the day before that, records differ).

2.29.10 On **28 June 2012,** Louise attended the ED, complaining of chest pain for the last four days. She did not report any recent trauma or long journeys. Following examinations, she was discharged home.

2.29.11 **Commentary.** *Everyone's responsibility.* Every agency has a responsibility for stopping domestic abuse. Though the police were aware of the assault on 14 May, this case shows that a criminal justice response alone is not sufficient to keep victims safe. Victims often find health services easier to disclose to than criminal justice agencies.

2.29.12 *Victim safety.* Again, Damien appears to have harmed Louise after leaving custody. Better communication between the criminal justice agencies and specialist domestic abuse service could prepare victims better to stay safe.

2.29.13 *Update.* NMUH note that there is now a domestic violence lead for the ED and that training is booked. The Trust has guidelines for recognising domestic violence and methods of gathering histories from patients.

2.29.14 NMUH determined that domestic violence training needs to be introduced for all clinical staff at the hospital with priority given to ED staff to enable them to identify injuries and symptoms indicative of domestic abuse. Methods of separating probable victims from their alleged perpetrators are required so that victims can speak freely. The unique role of health staff should be emphasised so that asking questions is not left to other organisations. The current guidelines are aimed at maternity unit staff and should be expanded to encompass all staff across the Trust.

2.29.15 The Trust notes that there is no resourcing for additional training and specialist posts – indeed the IDVA service that used to work at the hospital has been withdrawn.

2.30 North Middlesex University Hospital (NMUH) – Damien

2.30.1 On **12 February 2008**, Damien was conveyed to the hospital after breaking into the house that Louise shared with her ex-partner and Jade. He claimed to have taken cocaine two days before and had superficial cuts to his eyes and nose, suffered fits of shaking and was violent/aggressive and uncooperative.

2.30.2 On **26 January 2011**, Damien presented at the ED, complaining of rib pain on his right side. He said he had fallen down steps at a train station (see information in LAS section above where he attributed the pain to falling down steps during an argument with Louise).

2.30.3 On **27 August 2013**, Damien presented at the ED with a broken bone in his hand following what he described as being surrounded by a group of youths and having to fight to defend himself and his girlfriend. (The version of events provided to LCRC was about a pick-pocket that started a fight with Damien and Louise had become involved too.) Damien's hand was strapped and pain-relief was provided. He was booked to attend the fracture clinic the next day but did not attend.

2.30.4 On **3 December 2013**, Damien attended the ED with a painful right knee. Damien reported that he had twisted his knee while going downstairs two weeks previously. After tests, Damien was discharged with pain relief and referred back to his GP.

2.31 Other specialist support – Louise

2.31.1 Hearthstone provided Safe Homes Sanctuary for victims of domestic abuse at the time. This scheme provides a number of home safety improvements. Now a London Fire Brigade member joins the Crime Prevention Officer when they visit the homes of victims to discuss safety measures.

2.31.2 It is possible that Louise was signposted to Hearthstone at the time when incidents occurred in Haringey. Hearthstone only took self-referrals during the time covered by this DHR. This has now changed so that they take agency referrals.

2.31.3 The records do not show that Louise contacted Hearthstone during her ordeal.

3. Analysis

3.1 Key issues around domestic abuse identified in this review/Lessons to be learned from this review

3.1.1 Introduction

3.1.2 The commentary on the actions of different agencies is in the sections above so that this section could be used to step back from individual incidents and gather the common factors and themes from this long narrative and identify lessons that should be learned. There are a number of notable efforts by individuals to help Louise, but overall these were buried under individual, systemic and cultural weaknesses in the response of agencies.

3.1.3 The responses to Damien and to Louise show a poor understanding of domestic abuse. Damien's behaviour was not identified as that of a domestic abuse perpetrator consistently and, without identifying the controlling aspects of his behaviour, he was allowed to continue largely unhindered in his activities. Louise was not responded to as a victim and the possible reasons behind that are addressed below.

3.1.4 The responses also show a 'silo' approach to working with Damien that focuses on the responsibilities, goals and culture within each organisation. So opportunities were missed to work more holistically and with other agencies.

3.1.5 A focus on incidents disguised the patterns of abuse. As noted by Evan Stark, 'focusing on incidents of severe violence trivialise[s] the strategies used to entrap . . . millions of women . . . leaving them unprotected.'[47]

3.1.6 Finally, through all the effort and time spent finding, arresting, prosecuting and working with Damien, there was a glaring lack of focus on the safety of Louise. Securing her safety was only likely to be delivered through a coordinated community approach to domestic abuse.

3.1.7 <u>Poor understanding of domestic abuse</u>

3.1.8 There are three significant events that should have led to a step-change in the response to Damien.

[47] Stark, Evan, *Coercive Control: How Men Entrap Women in Personal Life* (Oxford University Press, 2009), Introduction.

(a) The shocking assault and alleged punitive rape of P2 in 2006 should have identified Damien as a violent high risk perpetrator of domestic abuse thereafter requiring a suitably calibrated response to further incidents, including the cases being reviewed at MARAC once MARACs were introduced.

(b) The strangulation of Louise to unconsciousness in July 2010. Strangulation is a significant risk factor on its own for a future homicide and should have made Louise a high risk victim of domestic abuse from that moment onwards. This would have brought her to the attention of MARAC and the partner agencies regularly and given the IDVAs more opportunities to make contact.

(c) The issuing of an indefinite restraining order in February 2012. This provided the opportunity for immediate intervention, an arrest, for any contact between Damien and Louise. Damien's many breaches were not brought to court.

3.1.9 Seeing the patterns of abuse

3.1.10 Viewing events with an understanding of domestic abuse would have shown the following:

(a) *Damien's coercive control*. Showing up at Louise's workplace, regularly taking her car after arguments, requiring her to look after his dog, the family allegations that he had imprisoned Louise, his trying to lock Louise in, his jealous accusations of her ex-partner, male colleague and friend, are all evidence of Damien exercising coercive control of Louise. It may be that Louise's intimidation of her family members (October 2009) when they were witnesses against Louise was also the result of his control of her.

(b) The new law (Serious Crime Act 2015) codifies coercive control as a criminal offence and the training of police officers on this new law should improve their identification, investigation and evidence-gathering for these crimes.

(c) *Misogyny*. The assaults, intimidation and harassment of Damien's victims extended to their female relatives: their mothers, sisters and daughter. His sense of entitlement included them and he threatened her through them. Domestic abuse is a gendered crime. It is largely perpetrated by men against women and women are more likely to suffer long-lasting harm as a result of it.[48] Though Damien was violent to men as well, his violence towards these women was vindictive and retaliatory.

[48] Povey, D. (Ed.), Coleman, K., Kaiza, P., Hoare, J. and Jansson, K. (2008) Homicides, Firearm Offences and Intimate Violence 2006/07 (Supplementary Volume 2 to Crime in England and Wales 2006/07). Home Office: Statistical Bulletin 3/08

(d) *Isolation*. Damien's behaviour and Louise's secretiveness eventually led to the isolation described by her daughter and colleagues.

(e) *Damien's manipulation of agencies*. Damien tried to develop a narrative with agencies about his relationship to Louise. He said she had stabbed him, stolen jewellery from him and owed him money. He delivered cannabis plants to her place of work and said they were hers. He created a 'tit for tat' view of their exchanges that did not alter in the face of evidence of serious abuse such as his strangling her to unconsciousness in the summer of 2010. Abusers know that accusing the victim helps to disguise their abuse. Damien became so confident that agencies would not challenge him that he brought her to a probation appointment when there was an indefinite restraining order in place preventing him from contact with her.

(f) Damien also avoided interventions designed to address his behaviour through regular unchecked medical certificates. His manipulative behaviour was not seen as such, or as extending to those around him.

3.1.11 Failure to identify Louise as a victim of abuse. This is a common weakness in the response to domestic abuse.

(a) *Louise minimising and normalising Damien's behaviour.* Louise did not say she was a victim and tried not to appear vulnerable. She minimised the harm to her. She told her work colleagues that she was as bad as Damien. She apologised to the police and said that she had acted too hastily when she called them. She told the police that their '27-year friendship offered some protection.' She said she would leave 'in her own way, in her own time'. She also said that she was 'getting used to it.' This minimising can lead to victims underestimating the danger they are in and to agencies taking their lead from the victim and minimising it too.

(b) *Barriers to engagement.* She had her own encounters with the police that may have shaded her view of them and discouraged her from engaging for example, her use of cannabis, and her intimidation of witnesses in October 2009. These incidents might have also discouraged agencies from trying to engage her more fully.

(c) Louise managed Damien in ways that kept the abuse from sight and made Louise difficult to contact. The concierge recounted how Louise had calmed Damien down when his car was threatening to be towed. She moved around and stayed with friends and relatives which would have made it difficult for him to find her. She left his flat in the middle of the night so that he would not take the keys to the school while she slept. There were 10 different addresses linked to incidents between Damien and Louise. The

police were called to a number of incidents where Damien was threatening her family in his search for her. She slept in her car to limit his access to her.

(d) Louise also managed Damien through the police. She called the police when the threat was too great and she was fearful and needed immediate help. But she then withdrew her statements. This would have helped to calm him down again. She tried to get him to reduce his drug-taking which was linked to his violence: there are several incidents noted when they argued about his drug-taking.

(e) This pattern of repeatedly calling the police and then withdrawing her statement suggests abuse and should have been seen as such.

(f) Research shows that the most common safety strategy for a domestic abuse victim is to demonstrate devotion to the abuser. For this safety strategy to work, she has to openly ignored and rejected all the help she is offered.[49] This not only blocks access to help, but can lead to attitudes of frustration and victim-blaming by agencies.

(g) *As examples*: the Hertfordshire Constabulary IMR, and the MARAC notes supplied show an annoyance with Louise, especially when her actions frustrate their goals. Rather than seeing the implausibility of an account by Louise as a trigger for more investigation, the writer suggested that she was 'not prepared to give an honest account', and later as 'not being entirely truthful', and their attempts being 'frustrated by the actions of Louise in her reluctance to engage with the police and not support a prosecution.' The MARAC action suggested monitoring Louise's behaviour, as if she were responsible for Damien's actions. The pursuit of the breach of the restraining order was dropped 11 months and many breaches after it was granted because Louise was no longer supporting it.

(h) *Victims who do not engage need an enhanced response.* In Louise's case, this could have included getting information to her through her employer, doctor's appointments, or through her daughter who was involved. It might have included using her probation appointments as an opportunity for an IDVA to talk to her. Damien's custodial periods would have presented an opportunity for safe contact with Louise, a time to build trust with her by providing information; e.g. about the progression of the case, Damien's movements, or Damien's previous convictions. Police or IDVAs contacting her to ask what she needed and to provide information rather than just to obtain information, might have helped to build trust. This extra effort has resource implications.

[49] Monkton Smith, J. with Williams, A. and Mullane, F. (2014) *Domestic Abuse, Homicide and Gender* : *Strategies for Policy and Practice.* London: Palgrave Macmillan (2014) p. 106 – 9.

(i) Other way to support and protect victims who do not engage would include taking cases against the perpetrator that do not include the victim. This can be victimless prosecutions, which will be easier with the body-worn cameras being introduced across the MPS areas. But it can also mean taking cases to court that do not involve the victim but might result in incarceration or oversight of the perpetrator. In this case, that might have been the assault on the police officer that was dismissed with no evidence offered.

(j) Review Panel members report all of these actions have been done in the past. It is suggested that this wealth of experience is pulled together into a planned Co-ordinated Community Response (CCR) strategy for addressing abusive situations where the victim finds it difficult to engage with agencies.

3.1.12 The result of not identifying Damien as a perpetrator and Louise as a victim is that some incidents were not logged or flagged as domestic violence. For the police, this meant that some incidents missed a second level of scrutiny and the expected domestic abuse response. It also meant that incidents could not be linked and therefore the patterns were missed.

3.2 'Silo' working and narrow-focus

3.2.1 Different agencies have different values, expectations and goals. Hester's Three Planet article[50] highlighted how agencies involved in domestic violence have such different structures, orientations and approaches to the work.

3.2.2 To different agencies and at different times, Louise was 'a stable influence' (probation), a criminal justice researcher (responsible for tracking down any bail conditions, police), responsible for his behaviour (loss of private tenancy because Damien broke in so many times, reported by Jade), an unreliable employee (her employer), an uncooperative witness (police and CPS when cases were dropped or not pursued without her evidence), and his alibi (probation again).

3.2.3 The agencies asked her to play a role in meeting their own agency-specific responsibilities. They did not have systems in place to keep her safe while she did so. This may be because they were not trained to identify those risks and respond to them, or because their agencies' goals took precedence.

3.2.4 Damien was identified as a violent man by the police services, prison, probation and Homes for Haringey, but these services did not see that Louise was his regular victim.

[50] Hester, M. *The Three Planet Model: Towards an Understanding of Contradictions in Approaches to Women and Children's Safety in Contexts of Domestic Violence*. British Journal of Social Work (2001) 41, 837-853.

3.2.5 Though individuals responded to Louise's plight, such as her colleagues, the concierge at Damien's building keeping her clothes for her, the DVLO making follow-up visits; the systems on the whole did not. There was no systematic attempt to get her help through the school; the police did not disclose the nature of Damien's offending against women to Louise; and she was not discussed at multi-agency meetings. She was not supported to find a better safety plan than staying with him.

3.2.6 The notable exception to this may have been the school, if they did get a protective order granted.

3.2.7 It may be that Monckton Smith's notion of the hierarchy of violence explains why Louise may not have received the help she needed. She posits that all types of abuse and violence exist in a hierarchy of violence with physical violence that causes injury at the top. Victims also sit in a hierarchy of status with women killed by a stranger at the top. The more intimate the victim is with the perpetrator, the less status she has. Put together, a woman who suffers low level assaults from her live-in husband has a very low status or importance in the eyes of society and its agencies. If the victim does not respond to interventions in a way that fits agencies' agenda, then even that low status is diminished. [51] Louise's continued contact with Damien may have reduced her importance to the professionals working with her.

3.2.8 This would explain the MAPPA meeting in 2008 that was a response to Damien's assault on F2 (whom he'd just met) where the eight incidents involving Louise were not discussed. It would explain the lack of stepped-up response to the strangulation of Louise in 2012.

3.2.9 In reviewing this case and the information provided by agencies, it was not always possible to follow criminal charges through to their disposal at court, then through Damien's time in prison and then oversight by probation and release. Sometimes information differed about the same event. This was further complicated by Damien being a prolific offender and therefore there were overlapping cases. In the Review Panel discussion, frustrations were voiced about not having information on their system that would have allowed their agency to make different or better decisions. For instance, the prison noted that they do not receive information from the court that includes flags for domestic violence or the names of victims. This limits their ability to manage risk on release.

51 Monckton Smith, et al., op cit.

3.2.10 The agencies were also narrow in the view of the situation between Damien and Louise. The response tended to be incident-focused, missing the pattern of abuse and harassment and the continuing risk.

3.2.11 This incident-focus saw Louise's lack of engagement as obstructiveness. But for victims of abuse, engagement increases their risk. Victims perceive professionals who appear disinterested or uncaring as untrustworthy. Without trust, victims will not disclose; 'she may lie, she may be rude, she may be difficult, in order to get rid of that person she does not trust.' [52] Professionals need a different approach to build the victim's trust and to find other ways to intervene in the situation. Professionals should be able to explain the benefits to the victim of disclosure and the actions the professional can take.

3.3 Holding Damien accountable

3.3.1 A key and constant failure in this case is the inability of the services to hold Damien accountable for his behaviour and abuse. During the period under review, Damien's lack of insight into his behaviour, absence of remorse, refusal to accept responsibility and lack of motivation to change suggest that interventions to alter his behaviour were unlikely to be successful. However, holding him accountable through legal processes was a possibility.

3.3.2 Through individual agencies

3.3.3 *This resulted partly from poor practice by agencies:* investigations not completed (harassment and breaches), research not done thoroughly (connecting the incidents, explaining Damien's money when he was unemployed, checking wider databases), inadequate risk assessments, and slow responses (to arrest, to gather and upload information).

3.3.4 *Supervision*. The lapses of frontline workers were not caught and corrected in supervision or second tier investigations.

3.3.5 Damien's abusive behaviour was not addressed. He was clearly not suitable for IDAP, but there might have been work to improve his motivation.

3.3.6 Damien disengaged from services during his times on licence. This was not addressed with him and he was not held in breach.

[52] Lindhorst, T., Meyers, M. and Casey, E (2008) Screening for Domestic Violence in Public Welfare Offices: An Analysis of Case Manager and Client Interactions, *Violence Against Women* 14: 5 -29, quoted in Monckton, op cit, p. 63

3.3.7 Evidence for the breaches of the restraining order could have been largely supplied by police and probation officers, but the prosecution did not go forward.

3.3.8 The silo working meant that if Damien was engaging with one agency, others did not challenge his wider behaviour (probation).

3.3.9 Through systems

3.3.10 *Bureaucratic approach*. There were several examples of an overly bureaucratic approach:

(a) There was an incident between Damien and Jade that was not classed as DV because Damien and Jade were neither family members, nor had they been in an intimate relationship. But the incident was about Damien trying to find Louise and should have been labelled as DV to enable the appropriate response.

(b) The delay in taking forward the breach of the restraining order that was coupled with the harassment case suggests that the process missed the point of the order which was to protect Louise.

3.3.11 *Risk assessment*. The approach to risk is troubling in this case. The police understanding of risk appears to be based more on imminence rather than on research. The MPS noted 19 risk assessments following incidents between Damien and Louise. In 11, the risk was standard and in 8 the risk was medium. The 8 incidents in 2011 should have led to a high risk rating on escalation alone. There is an example of a risk being graded as 'standard' when the victims would not cooperate.

3.3.12 There are examples here of risk being downgraded because nothing has happened, the action plan is complete, or because Damien is temporarily detained. As different risk levels require different responses, the operational imperative for this downgrading is understood. But the downgrading often obscured the reality of the continuing risk to Louise.

3.3.13 Advice was sought from SafeLives, the domestic abuse charity that developed and rolled out the national process of MARAC. Their response is in **Appendix 3** and supports the view that risk should not be artificially lowered when a perpetrator is in custody and that risk should be reviewed with the victim on the perpetrator's release from custody or prison. This would also serve the purpose of alerting both the victim and the local police service to the perpetrator's release from prison. The MPS concurs with the review of risk on release though it did not happen on Damien's releases.

3.3.14 There is also poor use of professional judgement by police officers when assessing risk. Professional judgement cannot override the evidence obtained in an assessment to reduce the risk assessment. Officers can use their professional judgement and experience to identify particularly concerning aspects of coercive control or extreme behaviour or violence to raise a risk rating. Professional judgement should only ever be used to increase a risk rating.

3.3.15 Information-sharing between agencies was not strong.

3.3.16 *Lack of opportunity for work with perpetrators*. This case highlights an unintended consequence of using remand in domestic abuse cases. If a perpetrator is felt to be an on-going risk to the victim or likely to abscond, s/he is held on remand. But no interventions are possible on remand. Any resulting conviction does not then provide enough time for the standard interventions that might reduce the risk. So remand and a conviction might actually lead eventually to higher risk for the victim in that there is not time for the perpetrator to complete a programme that might change his behaviour.

3.3.17 *Little impact of multi-agency processes.* MARAC, MAPPA and IOM were not successful in managing Damien. The situation should have gone to MARAC and MAPPA more often than it did. When these groups did address Damien's behaviour, plans were made and actions completed. The plans are not well-enough recorded to understand how these systems overlapped or complemented each other.

3.3.18 *Breaches of licence conditions not pursued*. The supervision and DDR should have complemented each other, but there did not appear to be any repercussions for Damien of his eventual non-compliance with either.

3.3.19 Unable to follow cases all the way through the criminal justice system. It is not possible to examine decision-making regarding Damien through to the disposal of a case as the CPS does not keep sufficient documents for this. There were successful prosecutions and these would have provided some relief for Louise, but there were some outcomes that are unexplained without more information.

3.3.20 The lack of consequences for Damien of many of his activities was likely to have emboldened him and disheartened and undermined Louise.

3.3.21 *Systems failure*. When Damien killed Louise there were several processes in place that should have protected Louise. There was a restraining order, Damien was on licence and being managed by probation, and the IOM group was overseeing him. But the breach of the restraining order was not prosecuted, nor was the breach of his licence conditions that would have taken him back to prison.

3.3.22 These lost opportunities to hold Damien accountable, especially through returning him to prison, were significant.

3.4 Lessons learned

3.4.1 Safety must be central. Though all agencies have their own goals, statutory and legal responsibilities, keeping victims and their children safe must be at the centre of all interventions and systems to address domestic abuse. That would include:

(a) Understanding the dynamics of domestic abuse and the behaviours of victims and perpetrators.

(b) Understanding and identifying risks and creating safety plans

(c) Safety measures being implemented quickly

(d) Explaining the benefits to the victim of disclosures and interventions, as well as the likely outcomes of these so that the victim can make decisions based on her safety rather than the goals of the organisation.

(e) Keeping the victim informed about processes in place to support her so that she develops confidence in agencies' ability to intervene.

(f) Ensuring that the victim is aware of the perpetrator's release from custody or prison and a safety plan is offered/made with him or her.

3.4.2 Non-engagement increases the risk for victims. A victim who is not engaging with agencies or support will find it harder to find their way out of the abusive situation. To address this, agencies should understanding the following:

(a) Non-engagement of the perpetrator with agencies needs to be addressed directly with him or her. It is suggested that agencies involved in this DHR look for the evaluation of the pilot in the summer of 2017 programme[53] that seeks to address perpetrators directly and within a CCR.

(b) Non-engagement of a high risk victim should trigger an enhanced response that includes

(i) All agencies encouraging a victim to engage with specialist domestic abuse workers,

(ii) IDVAs working through other agencies,

[53] Presentation from the SafeLives Annual Conference 2016: http://www.safelives.org.uk/sites/default/files/resources/SafeLives%20Drive%20conference%20presentation.pdf

(iii) All agencies finding opportunities to get information and help to the victim to keep them safe.

3.4.3 Domestic abuse is everyone's business. Every agency has a unique role to play in keeping victims safe and holding perpetrators accountable. The criminal justice agencies have a large part to play but this case shows that convictions are not the only goal for a CCR as convictions alone do not keep victims safe. For each agency to play its part, systems must be in place for:

(a) Accurate and timely recording of information

(b) Sharing information with partner agencies

(c) Agencies to hold each other to account for their part – either individually or in multi-agency groups

(d) Working together to get information and advice to the victim.

(e) Referrals to a specialist domestic abuse agency that can work with victims. This should be an IDVA where the risk is high but IDVAs can also advise other agencies that have already established a relationship with a victim.

(f) All agencies and organisations to have a policy and procedures that outline their approach and response to victims and perpetrators. It should commit the agency to addressing domestic abuse through a coordinated community response.

(g) Monitoring of the CCR from time to time to ensure it continues to adapt and is effective.

3.4.4 Risk can remain even after all action plans are complete. Operational necessity should not obscure the risk that victims face. Risk is dynamic and can change rapidly. A victim that is assessed as not high risk (yet) still needs belief, support and safety advice.

3.5 Equalities

3.5.1 Louise was a white heterosexual woman of 43 years old. The protected characteristics of age, religion, disability, sexual orientation, race, gender reassignment, and pregnancy do not appear to have affected the help that Louise received. Louise's marital status does not appear to have affected the treatment that she received from the agencies who dealt with her.

3.5.2 Louise's gender affected the abuse she suffered in that Damien assumed authority over her and controlled her, as he tried to do with a number of women, their mothers, sisters

and daughters. Being female made her a particular target for Damien. The control he exercised kept her trapped.[54]

3.5.3 Louise's gender appears to have had an impact on the response she received from agencies. The response she received replicates Monckton Smith's finding[55] that a female victim of low-level domestic abuse who co-habits with her abuser has very low status with those agencies. That status would have been further reduced when she did not cooperate with interventions in a way that fits the agenda of that agency.

3.5.4 The information received from Louise's colleagues and the notes of MPS officers suggest that both Louise's father and mother were vulnerable through age. Further support might have been provided for them as they tried to protect and help Louise.

3.5.5 Damien was a black heterosexual man of 43 years when he killed Louise. The protected characteristics of age, religion, disability, sexual orientation, and gender reassignment do not pertain in this case. The weaknesses in the response to Damien do not appear to have its roots in racial discrimination. His understanding of gender roles appears to have played a large part in his abuse, requiring that Louise prioritise his needs (for money, attention, companionship) over her own needs and enforcing these through control, threats and violence.

3.5.6 The protected characteristics do not appear to have had an impact on the response of agencies to Damien. His personal behaviour, particularly his threatening and manipulative approach to authorities, appears to have had more influence.

[54] Stark, Evan, *Coercive Control: How Men Entrap Women in Personal Life (Oxford University Press, 2009)*

[55] Monckton Smith, op cit., p. 21.

4. Conclusions and Recommendations

4.1 Conclusions

4.1.1 There was a great deal of engagement with Damien and Louise in the 8+ years covered in this DHR and leading to the murder of Louise. It is clear that Damien was dangerous and through his activities we can see that he posed a particular threat to women: those he came into contact with (neighbours and council staff), partners, would-be partners, and their female relatives. We can also see a significant substance misuse problem that likely fed his other criminal activities.

4.1.2 In the reports provided for this review, there was evidence of frustration on the part of services that Louise was not engaging with services; was not supporting prosecutions, not ringing services back who intended to help, being seen with Damien when there was a restraining order in place, withdrawing statements, and providing conflicting information.

4.1.3 Louise rang services when she could not manage Damien. More active participation by her in agency responses might have made it easier for them to complete their activities, but would not necessarily have made Louise safer, as we've seen. Staying safe had to be Louise's primary concern and her daughter explained some of the extreme measures that Louise took to do this and how she tried to manage Damien and his behaviour.

4.1.4 The point of the coordinated community response (CCR) to domestic abuse is that it recognises the unique part each agency has to play in stopping domestic abuse and requires agencies to do their part and help other partners do their part so that victims are not alone in managing the risk to themselves and their friends and families.

4.1.5 The onus is now on the agencies involved to make the changes and embed the practices that make a coordinated community response to domestic abuse a reality and convince victims like Louise to trust that agencies can help them.

4.2 Recommendations

4.2.1 There are many recommendations in this report. This is the result of there being many agencies (21) across several areas that are involved and each took this opportunity to explore their provision and provide their own suggestions for recommendations for their agency. It is also due to the commitment of the Review Panel in trying to understand the systems involved in the lives of Damien and Louise and to explore how the coordinated community response might be improved.

4.3 Haringey Council

4.3.1 **Recommendation 1**: Haringey Council to develop and implement a domestic abuse policy as a matter of urgency. This would provide information and guidance for staff working with the public. It would also include information and guidance for employees of Haringey Council as managers, colleagues and victims of domestic abuse and include information for how to escalate concerns about one's own situation or that of others so that Haringey can be pro-active in tackling domestic abuse and supporting victims.

4.3.2 **Recommendation 2**: Haringey Council to encourage or require (as is appropriate to the relationship) organisations that work in partnership with the Council, such as independent schools, and Arms-length Management Organisations (ALMOs) to have domestic abuse policies and practices for its employees and those who use their services.

4.3.3 **Recommendation 3:** Haringey Council require all local authority schools to Include responses to domestic abuse in their HR policies for staff and provide advice to staff about domestic abuse.

4.3.4 **Recommendation 4**: Haringey Council use this case in DA training to emphasise common weaknesses in a response to domestic abuse and how to address them, emphasising the role of every agency in delivering a coordinated community response for every victim of abuse.

4.3.5 **Recommendation 5**: Haringey Council's CSP ensures that action plans associated with responses to domestic abuse, including this DHR, are completed as quickly as possible to minimise the harm resulting from domestic abuse to its staff and citizens. The action plan from the original internal review should be updated and outstanding actions rolled into the action plan from this review.

4.3.6 **Recommendation 6:** Drawing on this report and the experience of Review Panel members, create a strategy and guidance for addressing the situation of domestic abuse victims that find it difficult to engage with services. Consider high risk victims, victims of serial violent offenders and victims with complex needs.

4.3.7 **Recommendation 7**: When commissioning substance misuse agencies, Haringey Council require that such services:

(a) Gather information about clients' relationships and families as part of their assessments,

(b) And that they identify risk and include this information in referrals and feed this to partner agencies through the multi-agency groups, including MARAC, and that they contribute to MARAC.

4.4 Hertfordshire County Council

4.4.1 **Recommendation 1**: That the Hertfordshire DA Partnership Board reviews the provision for DV victims presenting to GPs, with local CCGs to ensure GPs understand their unique role in identifying domestic abuse and are trained to respond effectively.

4.4.2 **Recommendation 2**: As part of oversight of the local VAWG services, monitor Hertfordshire Constabulary's referrals to local support services, in particular the new IDVA service for high risk victims.

4.5 Her Majesty's Prison Service (HMPS)

4.5.1 This case has shown that the time domestic abusers are in prison either on remand or for short-term sentences is not used effectively to address behaviour or to engage with victims of their abuse. The prison system is not well linked to services in the community for victims of domestic abuse. There are tools and programmes that can deliver the following. This recommendation is aimed at the prison service demonstrating an overall commitment to its role in ending violence against women, thereby providing prison staff with grounds for intervention.

4.5.2 **National recommendation:** HMPS develop a national policy and practice for working with perpetrators of domestic abuse when they are in custody and for addressing its role in keeping victims and their children safe. This policy would:

(a) Ensure that perpetrators of domestic abuse are identified when in custody (even when offence leading to custody is not obviously domestic abuse), and that;

(b) The new OM model explicitly addresses the abusive relationships of offenders. Work is undertaken with DV perpetrators in custody (whether for short or longer-terms) to address their abusive behaviours and views. Where prisoners are assessed as not suitable for this work yet, work is undertaken to prepare them for such work.

(c) The prison acknowledges its role in protecting victims by:

(d) Creating opportunities for victims to access support.

(e) Signposting victims to support, and highlighting the freedom to make choices that the perpetrator's incarceration may be offering them.

(f) Improving communication and information-sharing with agencies in the community that work with victims and their children.

(g) Incorporating as part of the new initiative of monthly Offender Pre-Release Meetings, a requirement to explicitly address offenders' relationships, identifying abusive relationships and linking to external support for offenders and victims, and their families, so that safety measures can be put in place to protect victims and their children when the perpetrator is released.

(h) Offering support services for women prisoners who are victims of domestic abuse.

4.6 National Health Service

4.6.1 **National recommendation 1**: Implement the IRIS scheme nationwide to educate GPs and engage them in helping victims, perpetrators and their families.

4.6.2 **National recommendation 2**: That the NHS provide improved guidance to GPs on how to engage with DHRs including:

(a) The legal basis for sharing information in these circumstances

(b) The nature of the information needed by this process

(c) The selection of an appropriate IMR writer

(d) Support for staff in the surgery following a homicide of a patient of the surgery.

4.7 Home Office and the Ministry of Justice

4.7.1 **National recommendation 1**: That the Home Office (HO) conducts an audit of criminal justice processes to ensure that the system and its various agencies work together to create a coordinated response for the safety of victims of domestic abuse and to hold perpetrators accountable.

4.7.2 **National recommendation 2**: That the Ministry of Justice works with the HO to create a system enabling the police to be alerted when civil orders are granted that provide

protection in domestic abuse cases. (This ties into MPS Recommendation 9 and Hertfordshire Constabulary Recommendation 3).

4.8 Metropolitan Police Service

4.8.1 Recommendation 1 -Local Level for Barnet

It is recommended that Barnet Senior Leadership Team (SLT) develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

(a) MAPPA (see **Appendix 2**);

(b) Information-sharing.

4.8.2 Recommendation 2- Local Level for Haringey

It is recommended that Haringey SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

(a) Sharing the lessons learned in this review;

(b) Domestic Abuse Policies and Toolkits;

(c) DASH First responders/ Specialist Staff/ Supervisors;

(d) RARA, (risk management model: remove risk, avoid the risk, reduce the risk or accept the risk);

(e) MAPPA;

(f) MARAC;

(g) IDVA – referral to and working with to engage the victim;

(h) IOM;

(i) Research – local/ cross border;

(j) Counter allegations;

(k) Information sharing;

(l) Safety planning.

4.8.3 Recommendation 3- Local Level for Enfield

It is recommended that Enfield SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete regular 'dip' sampling should be conducted to ensure compliance. This training should include:

(a) Sharing the lessons learned in this review;

(b) Domestic Abuse Policies and Toolkits;

(c) DASH First responders/ Specialist Staff/ Supervisors;

(d) RARA;

(e) MAPPA;

(f) MARAC;

(g) IDVA – referral to and working with to engage the victim;

(h) IOM;

(i) Research – local/cross border.

4.8.4 Recommendation 4- Local Level for Waltham Forest

It is recommended that Waltham Forest SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

(a) Sharing lessons learned in this review;

(b) Domestic Abuse Policies and Toolkits;

(c) DASH First responders/ Specialist Staff/ Supervisors;

(d) MARAC;

(e) Information sharing;

(f) Safety planning.

4.8.5 Recommendation 5- Local Level – Islington

It is recommended that Islington SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and

compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

(a) Sharing lessons learned in this review;

(b) Domestic Abuse Policies and Toolkits;

(c) DASH First responders/ Specialist Staff/ Supervisors;

(d) Research – local/cross border.

4.8.6 **Recommendation 6- Service Level – TP Capability and Support – Public Protection**

It is recommended that the MPS review how 'high risk' domestic abusers are profiled and flagged to ensure that investigators have the fullest available picture when assessing and managing risk.

4.8.7 **Recommendation 7 -Service Level – the Judicial Order Working Group**

It is recommended that this review be forwarded to Simon Tee, Head of the Criminal Justice Offender Managers Services (CJOMS), for the lessons learned to be considered by the Judicial Order Working Group.

4.8.8 **Recommendation 8 -Service Level – Offender Management Working Group**

It is recommended that this review be forwarded to Detective Superintendent Sean Oxley, for the lessons learned to be considered by the 'Offender Management Working Group'.

4.8.9 **Recommendation 9- Service Level – TP Capability and Support – Public Protection**

It is recommended that upon receipt of a court order and/or restraining order that 'specified' crime report be opened, the victim contacted and the following actions completed:

(a) Contact the victim to gather and share information;

(b) DASH;

(c) RARA;

(d) IDVA – referral to and working with to engage the victim;

(e) Emergency planning;

(f) Special schemes;

(g) Panic Alarms;

(h) Special personal alarms;

(i) Research;

(j) Crimint;

(k) MARAC;

(l) MAPPA;

(m) IOM;

(n) ASBO;

(o) Supervision;

(p) Enhanced supervision;

(q) DVPO/injunction/restraining order.

4.8.10 **Recommendation 10- Service Level-MPS**

It is recommended that MPS circulate to their CSUs and PVPs information about their policy that allows the waiver of recovery costs for vehicles that have been reported as lost or stolen in situations of domestic abuse.

4.9 Hertfordshire Constabulary

4.9.1 **Recommendation 1**: That Hertfordshire Constabulary develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

(a) Basic domestic abuse awareness, including coercive control;

(b) Sharing the lessons learned in this review;

(c) Domestic Abuse Policies and Toolkits;

(d) DASH First responders/ Specialist Staff/ Supervisors;

(e) RARA;

(f) MAPPA;

(g) MARAC;

(h) IDVA;

(i) IOM;

(j) Research – local/ cross border;

(k) Counter allegations;

(l) Information sharing;

(m) Safety planning and liaising with the victims.

4.9.2 **Recommendation 2**: Risk assessments of frontline officers are monitored and a feedback is provided to ensure consistent and accurate risk assessments are provided by the staff.

4.9.3 **Recommendation 3**: It is recommended that upon receipt of a court order and/or restraining order that 'specified' crime report be opened, the victim contacted and the following actions completed:

(a) Contact the victim to gather and share information;

(b) DASH;

(c) RARA;

(d) IDVA – referral to and working with to engage the victim;

(e) Emergency planning;

(f) Special schemes;

(g) Panic Alarms;

(h) Special personal alarms;

(i) Research;

(j) Crime Information System (CIS);

(k) MARAC;

(l) MAPPA;

(m) IOM;

(n) ASBO;

(o) Supervision;

(p) Enhanced supervision;

(q) DVPO/injunction/restraining order.

4.10 Crown Prosecution Service (CPS)

4.10.1 It is important to understand how the whole of the criminal justice process works together to hold perpetrators of domestic abuse accountable for the harm they cause and to protect victims. The DHR process provides a way to do this. But to be able to review and analyse the workings of this system, there must be information on each step in the process. Currently, the CPS record-keeping policies do not allow the CPS to contribute to this process. It is suggested that the CPS record-keeping policy should mirror other criminal justice agencies in the length of time it holds records of cases.

4.10.2 **National recommendation**: That the CPS review and revise its record-keeping policy so that it can contribute meaningfully to Domestic Homicide Reviews by providing details of its decision-making in cases of domestic abuse and where protective orders are in place.

4.11 Homes for Haringey

4.11.1 Since the death of Louise and in the course of this review, Homes for Haringey has improved its response to domestic abuse in its premises and provided clear guidance for staff.

4.11.2 **Recommendation 1**: That Homes for Haringey create a policy and procedure that comprehensively deals with their role in situations where tenants are perpetrators or victims, or where domestic abuse has occurred in their premises. It should include:

(a) A response that prioritises the safety of victims and clear roles for staff;

(b) Training for frontline workers, especially concierges and repair staff, to identify abuse and engage victims in help-seeking;

(c) The sharing of information with other agencies so that the risks are known;

(d) An understanding of risk assessment in domestic abuse;

(e) Links to DV support structures in Haringey and neighbouring boroughs;

(f) A process for sharing information on threats to staff safety internally;

(g) Considerations of the alleged perpetrator's known relationships, where staff feel threatened;

(h) Ensure all staff know the process for this and the expectations of Homes for Haringey about their role;

(i) Ensure all staff know about the counselling helpline.

4.11.3 **Recommendation 2**: Improve information sharing with other agencies through referrals to Hearthstone, MARAC and engagement with MAPPA and other multi-agency meetings. Monitor these to track the impact of improved training and procedures.

4.12 Haringey Anti-social Behaviour Team

4.12.1 **Recommendation 1**: Refresh and formalise the procedure for requesting information from the MPS to ensure that requests are targeting all the information relevant to the concerns that the ASB is investigating.

4.12.2 **Recommendation 2**: ASB develop a VAWG policy that identifies their role in addressing VAWG, the training that staff need, the policies and procedures that link to this (safeguarding policies, for instance) and the link to the safeguarding procedures and relevant procedures and referral procedures. The ASB team's role in multi-agency work around VAWG, e.g. MARAC, MASE, MASH.

4.12.3 **Recommendation 3**: ASB team source VAWG and DA training for staff, including general awareness training, an understanding of risk assessment in domestic abuse and the MARAC process, safeguarding procedures and application of the relevant procedures and referral procedures.

4.13 Victim Support – London

4.13.1 **Recommendation 1**: Strengthen systems with referring agencies, including:

(a) Request that referring agency supplies several safe contact numbers, if possible, and asks the victim for safe times to call;

(b) Staff training includes notifying referrer when contact cannot be established with referred victim;

(c) Staff to be reminded in case review sessions to notify referrer in such situations and ensure this action is recorded on the VS case management systems;

(d) As part of case management, random sampling of closed cases to be undertaken to ensure that case notes show whether referrer was notified of non-contact.

4.13.2 **Recommendation 2**: Staff to review CMS for victims' details where contact with victim has not been established to identify repeat DV incidents and possible referrals to MARAC.

4.13.3 **Recommendation 3**: At four-weekly case reviews with managers, cases where the RIC was borderline high risk, that is 12 or 13, are reviewed against previous and new incidents to inform professional judgement in the case.

4.14 Solace Women's Aid and Nia

4.14.1 **Recommendation:** That any victims of domestic abuse that are referred to the IDVA and MARAC that do not engage should be discussed in case reviews as a standing agenda item and other ways of getting support to the victim discussed.

4.15 Refuge – Hertfordshire IDVA service

4.15.1 **Recommendation:** That Hertfordshire IDVA service liaises with the local NPS Victim Contact Scheme to provide support and safety planning for victims and their families when perpetrators are released.

4.16 MAPPA

4.16.1 **Recommendation 1:** London MAPPA Strategic Management Board should maintain its focus on the assessment and effective management of the risks posed by domestic abuse offenders. Key areas include the following:

(a) Training for MAPPA chairs to include domestic abuse awareness, particularly an understanding of coercive control;

(b) Use of the MAPPA Category 3 (other dangerous offenders) where appropriate so that domestic abuse perpetrators who do not qualify for MAPPA Category 156 or for Category 257 may be managed under MAPPA;

(c) The relationship between MAPPA and MARAC so that this is understood and implemented locally, in accordance with the Ministry of Justice MAPPA Guidance58, as local guidance produced by the London MAPPA Executive Office and incorporated in NPS London MARAC Guidance.

4.17 Integrated Offender Management Unit

[56] Registered sex offenders

[57] Violent offenders sentenced to more than 12 months in custody/detention in hospital under S. 37 or S 42 Mental Health Act

[58] Ministry of Justice MAPPA Guidance 2012, pp. 108FF, para 22.19 – 22.25

4.17.1 **Recommendation 1**: That the IOM Unit refresh and formalise the procedures and guidance for:

(a) Actions to proactively manage non-compliance with IOM requirements and/or licence conditions. This would include clear guidance and standards for investigation, recording and enforcement;

(b) Standards of non-compliance that should trigger a partnership assessment;

(c) Appropriate actions where offenders commit acts of violence against women and girls, including coercive control.

4.17.2 **Recommendation 2**: That the IOM Team receive training on violence against women and girls, including general awareness, safeguarding procedures and referral and other procedures to address the safety of victims.

4.17.3 **Recommendation 3**: That the IOM Unit works with domestic abuse services to review their processes around prison release to identify opportunities to protect victims of VAWG.

4.18 London Community Rehabilitation Company (LCRC)

4.18.1 As the probation services have been re-structured, the LCRC narrative related above relates to the actions of the London Probation Trust at the time of the incidents described. Consequently, the recommendations that flow from this review for London LCRC only relate to the services that they now provide.

4.18.2 **Recommendation 1**: Create clear guidance on the robust management of absences by those on licence so that the opportunity to address offending and reduce risk to others is not missed and so that offenders are held accountable.

4.18.3 **Recommendation 2**: In light of the restructure, that LCRC ensure it is part of the local coordinated community response to domestic abuse by

(a) Training LCRC staff on:

(i) Their part in addressing domestic abuse

(ii) The local referral pathways to services for perpetrators and victims

(b) Preparing and attending the multi-agency groups that address domestic abuse, that is, MARACs, MAPPAs, and IOM.

(c) Creating protocols and policies to embed this involvement.

(d) Monitoring participation in MA groups and referrals to specialist agencies. This information is compiled and sent to the local VAWG strategic group.

4.18.4 **Recommendation 3**: That LCRC develop a domestic abuse policy that addresses offenders as victims and perpetrators of domestic abuse, including:

(a) Specific work with women on Community Payback scheme who are victims of domestic abuse;

(b) Ways to identify and support victims of domestic abuse, for instance, by adding relevant questions to assessment processes and by creating opportunities for women to disclose, discuss and address the abuse they have and are suffering;

(c) Clearly outlines the response to violent offenders' reports of their relationships that addresses the risk to offenders' partners, especially when there is a history of violence against women.

4.18.5 **Recommendation** 4: That LCRC explore the option of female-only projects as a way to create opportunities for victims of domestic abuse to discuss and address domestic abuse.

4.19 National Probation Service (NPS)

4.19.1 **Recommendation 1**: Develop training for women-only cohorts so that issues of domestic abuse can be explored and strategies put in place during the probationary period.

4.19.2 **Recommendation 2**: That oversight of cases includes improvements in:

(a) Timing and quality of risk assessments;

(b) The recording of risk management plans and progress against them;

(c) The recording of MA discussions (MARAC, MAPPA, IOM) and resulting action plans in client files;

(d) Regular investigation of information and research to corroborate information from offenders and hold them accountable.

4.19.3 **Recommendation 3:** Ensure that domestic abuse victims and their families are informed about the Victim Contact Scheme and the information it can provide when the

perpetrator is sentenced to 12 months or more in prison or when the offender is detained as a mental health patient;

4.19.4 **Recommendation 4:** That the Victim Contact Scheme provides details of the local domestic abuse service(s) to victims and their families, and particularly when the service informs victims and their families of perpetrators' imminent release.

4.20 Substance misuse agencies

4.20.1 The information gathered from other agencies was incomplete and there was a reliance on the IOM to manage the risk posed to Damien's ex-partner, though her name was not known. The recommendation for substance misuse agencies focuses on using their engagement with clients to gather information, to understand the risk clients pose to their intimate partners and families and to understand their unique position to engage with perpetrators and victims of domestic abuse, while working within a coordinated response.

4.20.2 For a violent and unreliable offender with a drug problem, a partner may appear as a stabilising influence, but he or she could be at risk as well, as identified in the SafeLives-DASH risk assessment. If staff are at risk, then family members and partners are probably as well.

4.20.3 **Recommendation***:* Substance misuse services should:

(a) Include in their domestic abuse policy a response to non-engagement with services by those on licence. This case shows the link between non-engagement and increasing risk;

(b) Engage with multi-agency approaches to addressing victim safety and perpetrator behaviour.

4.21 North Middlesex University Hospital (NMUH) NHS Trust

4.21.1 **Recommendation 1**: Domestic violence training to become mandatory for all clinical staff, with priority given to staff in Emergency Departments (ED), maternity and sexual health clinics. Training to include:

(a) Routine enquiry (as stated in the Managing DV Policy, s. 62);

(b) Identifying behaviour, symptoms and injuries that are likely to be indicators of domestic abuse and enquiring further about them;

(c) Creating a safe space to ask questions of the possible victim;

(d) Responses to disclosures, including risk assessments, MARAC and referral pathways. Access to further information and advice;

(e) Encouraging engagement of victims;

(f) The unique role of health services in supporting and protecting victims of domestic abuse.

4.21.2 **Recommendation 2**: That the Trust provide an IDVA service in ED.

4.21.3 **Recommendation 3**: The Trust's DV guidelines to be expanded to be used by staff across the Trust.

4.21.4 **Recommendation 4**: The Trust develops DV Champions throughout the hospital, again prioritising ED, maternity and sexual health clinics.

4.21.5 **Recommendation 5**: The Trust's DV policy is updated to reflect these changes.

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Appendix 1: Domestic Homicide Review Terms of Reference for Louise

This Domestic Homicide Review is being completed to consider agency involvement with **Louise**, **Damien**, and **Jade**, Louise's daughter, following Louise's **homicide in December 2013**. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) places a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the Review Panel agrees what information should be shared in the final report when published (following satisfactory completion of the HO quality assurance process).

2. To review the involvement of each individual agency, statutory and non-statutory, with **Louise**, Damien and Jade during the relevant period of time: **10 February 2005 –19 December 2013 (date of the homicide).**

3. To summarise agency involvement prior to **10 February 2005**.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

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

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Haringey Community Safety Partnership.

Membership

9. The following agencies are to be involved:
   a) Haringey Council – Human Resources
   b) Haringey Council – Adult Services
   c) Haringey Council – Community Safety and Regulatory Services (including Anti Social Behaviour Team and Violence Against Women and Girls Strategic Lead and Violence Against Women and Girls Coordinator)
   d) Haringey Council – Public Health
   e) Crown Prosecution Service
   f) Metropolitan Police Service (borough and Critical Incident Advisory Team)
   g) Nia
   h) Solace Women's Aid
   i) Haringey Clinical Commissioning Group
   j) North Middlesex University Hospital NHS Trust
   k) Homes for Haringey
   l) HM Prison Service
   m) National Probation Service
   n) London Community Rehabilitation Company
   o) Victim Support – London and Hertfordshire
   p) Haringey Advisory Group on Alcohol (and RISE)
   q) Barnet Enfield Haringey Mental Health NHS Trust (The Grove)
   r) NHS England
   s) Hertfordshire Clinical Commissioning Group
   t) Hertfordshire Community Safety Partnership
   u) Hertfordshire Constabulary

v) Enfield Community Safety Partnership
w) London Ambulance Service
x) Refuge

The following agencies and services will fulfill a watching brief on the review process and will be linked to the review via the Violence Against Women and Girls Strategic Lead. This watching brief will enable these agencies to contribute to the discussion where the information relates to their field of expertise and learn the lessons for their own organisations while learning about the DHR process.

a) Haringey Council Children and Young People Service
b) Haringey Council Housing Related Support
c) Haringey Council Customer Services
d) London Fire Brigade
e) The Whittington Hospital NHS Trust

2. Where the need for an independent expert arises, for example, a representative from a specialist Black and Minority Ethnic (BME) women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel. This additional input into the Review Panel will be agreed by the Independent Chair of the Review and will be commissioned by Haringey Council on behalf of the CSP.

3. If there are other investigations or inquests into the murder, the Review Panel will agree to either:
   a) Run the review in parallel to the other investigations, or
   b) Conduct a coordinated or jointly commissioned review - where a separate investigations will result in duplication of activities.

Collating evidence

4. Haringey CSP will facilitate engagement in the process with agencies, services and partnerships outside of Haringey that are connected to the review.

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

6. Each agency must provide a chronology of their involvement with Louise, Damien, and Jade during the relevant time period.

7. Each agency is to prepare an IMR, which:
   a) Sets out the facts of their involvement with Louise, Damien, and Jade;
   b) Critically analyses the service they provided in line with the specific terms of reference;
   c) Identifies any recommendations for practice or policy in relation to their agency, and
   d) Considers issues of agency activity in other boroughs and reviews the impact in this specific case.

8. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Louise, Damien and Jade in contact with their agency.

Analysis of findings

9. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
   a) Analyse the communication, procedures and discussions, which took place between agencies.
   b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, the victim's daughter and wider family.
   c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
   d) Analyse agency responses to any identification of domestic abuse issues.
   e) Analyse organisations access to specialist domestic abuse agencies.
   f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

10. To sensitively involve the family of Louise in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

11. To coordinate with any other review process concerned with the child/ren of the victim and/or alleged perpetrator.

Development of an action plan

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

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

14. Haringey CSP will confirm and lead arrangements for delivery and completion of the action plan.

Media handling

15. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP via the Strategic Lead for Violence Against Women and Girls. The CSP is responsible for the final publication of the report on the CSP website and media contact. A media statement will be prepared for the duration of the review. On completion and publication of the review the Independent Chair of the Review and the CSP will agree a statement.

Feedback of the report

16. The Independent Chair of the Review will lead feedback of the report to family members, friends, colleagues.

17. The CSP will be responsible for ensuring, where requested, that regular updates on delivery of the action plan are provided to family, friends, colleagues as requested/appropriate/necessary.

Confidentiality

18. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

19. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

Appendix 2: Information about MAPPA (Multi-Agency Public Protection Arrangements)

MAPPA is the multi-agency approach designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders (Criminal Justice Act 2003).

Category of offender			Level of management required		
Category 1	Registered sex offenders		Level 3	Meets the criteria for Level 2, however requires senior representation to commit significant resources	Increasing Seriousness 
Category 2	Offenders, aged 18 and over, who are released on licence from a sentence of 12 months custody or more, managed by probation		Level 2	Assessed as 'high' / 'very high' risk of serious harm requiring: active multi agency involvement/ coordination of intervention to manage the risk.	
Category 3	Dangerous offenders		Level 1	Ordinary agency management (single agency)	

Appendix 3: SafeLives' response to risk question

Response of SafeLives to question about the MET practice of downgrading risk when a perpetrator is in custody:

Received on 3 March from Sally Steadman-South, Head of the Knowledge Hub

SafeLives does not believe that the arrest of a perpetrator necessarily reduces the risk faced by a victim, particularly when complex issues involving multiple perpetrators, such as HBV and gang affiliation, are involved. In all domestic abuse cases, we would expect the victim to be made aware when the perpetrator was being released from police custody and, additionally, for the police to carry out a further risk assessment in light of the change in circumstances. When being released from court, for example when bailed, the police and/or Idva (sic) should be made aware, a new DASH should be completed and the risk managed accordingly.

When perpetrators are being released from prison, it is usual that neither the police nor the victim are (sic) made aware. However, again due to the change in circumstances, communication with the victim regarding the release of the perpetrator is paramount. At this point a further risk assessment should be carried out to continue to manage the risk to the victim.

We have checked our training messages across Idva (sic) and other bespoke risk courses that we have delivered and can confirm that, as we expected, there is nothing in our material that suggests an arrest equals an automatic reduction in risk. This may be a misunderstanding based on perpetrators receiving custodial sentences; although the immediate risk to the victim might reduce it should not be assumed, regular reviews of risk should take place and there would still need to be an safety plan in place to manage the individual circumstances of each case.

We would support the assertion that risk is not automatically downgraded following an arrest and agree with your comment that, once the risk level has been reduced, there is a danger that it remains artificially low if the police or other agencies have failed to get back in touch with the victim for any reason and re-assessed risk.

Appendix 4: Prison programmes for domestic abuse offender

Glossary of Programmes

Domestic Violence Programmes

Building Better Relationships (BBR)

A programme for male perpetrators of violence and abuse within (heterosexual) intimate relationships. BBR is run within prison and community delivery sites and aims to increase understanding of motivating factors in domestic violence , reduce individual risk factors linked to violence and develop pro-social relationship skills

Community Domestic Violence Programme (CDVP)

A community delivered programme aimed at reducing the risk of domestic violence and abusive behaviour towards women in relationships by helping male perpetrators change their attitudes and behaviour and to reduce the risk of all violent and abusive behaviour in the family.

Healthy Relationship Programme (HRP)

A prison based programme for men who have committed violent behaviour in an intimate relationship. The aim is to end violence and abuse against participants' intimate partners. Participants will learn about their abusive behaviours and be taught alternative skills and behaviours to help them develop healthy, non-abusive relationships. There are two versions of HRP – the moderate intensity programme for men assessed as having a moderate risk/moderate need profile and the high intensity programme designed for high risk/high need offenders.

Integrated Domestic Abuse Programme (IDAP)

A community based domestic abuse programme designed for men who have committed violent behaviour in an intimate relationship. The aim is to end violence and abuse against participants' intimate partners. Participants will learn about their abusive behaviours and be taught alternative skills and behaviours to help them develop healthy, non-abusive relationships.

Appendix 5: Glossary

Abbreviations	
124D	A booklet used by MPS to collect information on domestic abuse incidents
ABH	Actual Bodily Harm
ABT	Abstinence-Based Treatment
ALMO	Arms-Length Management Organisation
ASB	Haringey Anti-Social Behaviour Service
ASBAT	Anti-social Behaviour Team
BCST	Basic Custody Screening Tool
BEHMHT	Barnet, Enfield and Haringey Mental Health Trust
BME	Black and Minority Ethnic
BOCUs	Borough Operational Command Units
CCA	Community Care Assessments
CJOMS	Criminal Justice Offender Managers Services
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CRI	Community Recovery Initiative
CRIS	Crime Reporting Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DAAT	Drug and Alcohol Action Team
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Checklist
DASH	Drug Advisory Service Haringey
DHR	Domestic Homicide Review
DRR	Drug Rehabilitation Requirement
DV	Domestic Violence
DVIP	Domestic Violence Intervention Programme
DVLO	Domestic Violence Liaison Officer
DVO	Domestic Violence Officer
ED	Emergency Department
ETE	Employment, Training and Education
HAGA	Haringey Advisory Group on Alcohol
HDC	Home Detention Curfew
HMPS	Her Majesty's Prison Service

HO	Home Office
HRU	Harm Reduction Unit in Hertfordshire Police. The HRU is the second line for assessment of domestic abuse
IDAP	Integrated Domestic Abuse Programme
IDAPA	Integrated Domestic Abuse Programme Accelerated
IDVA	Independent Domestic Violence Advisor
ILLY	Data base used by The Grove – Specialist Drug Service Haringey
IMR	Individual Management Review
IO	Investigating Officer
IOM	Integrated Offender Management -- is a nationally recognised approach as a key to reducing crime and reoffending. This approach brings together a number of stakeholders to supervise, manage and positively impact on the criminal activity of offenders within the community.
IRIS	Identification and Referral to Improve Safety domestic abuse training and support programme based in GP practices
LAS	London Ambulance Service
LCRC	London Community Rehabilitation Company
LCRC	London Community Rehabilitation Company – the probation company that manages all offenders in the community who are not deemed to be at high risk of harming others. Those at high risk of harming others are managed by the National Probation Service.
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASE	Multi-Agency Sexual Exploitation Meeting
MPS	Metropolitan Police Service
NMUH	North Middlesex University Hospital Trust
NOMS	National Offender Management Service
NPS	National Probation Service
OASys	Offender Assessment System risk assessment
OGR	Offender Group Reconviction
OIC	Officer in Charge, refers to a specific case
OM	Offender Manager
PAVA spray	Incapacitant Spray
PNC	Police National Computer
PRU	Pupil Referral Unit – a collection of schools for children who cannot access mainstream schooling for health, safety or social reasons. Louise worked across 4 sites.

RARA	Acronym for police response to risk: Remove the risk, Avoid the risk, Reduce the risk, Accept the risk
RIO	Electronic recording system for drugs and alcohol services
SARA	Spousal Assault Risk Assessment
SERCO	Service Corporation
SLT	Senior Leadership Team
SPECSS	Separation, Pregnancy, Escalation, Community Isolation, Stalking and Sexual Violence
TWOC	Taking-Without-Consent
VAWG	Violence against Women and Girls
VL	Victim Liaison
VS	Victim Support
VS Herts	Victim Support Hertfordshire
WDP	Westminster Drugs Project

Appendix 6: Internal Review Action Plan

Internal Review Damien and Louise: Action Plan - Update September 2017

Key actions / interventions	Milestones (SMART actions)	Lead	Progress
Community Safety 1. Ensure robust processes in place for Community Safety to be alerted at the earliest possible opportunity of serious incidents	▪ HS to speak with Andrew Meek ▪ HA to speak with Police contacts	Hazel Simmonds	● Complete. Process is now in place.
Community Safety 2. Establish a pathway for responding to any disclosures of domestic violence received from a third party	▪ Research responses of other boroughs to third party reports of DV ▪ Produce local procedure and guidance	Haringey Community Safety Team	● Complete. Process is now in place.

HR 3. Address the need for robust and effective policies, procedures, awareness raising and training for all staff on identifying and responding appropriately to colleagues and members of the public who may be victims or perpetrators of (or otherwise affected by) domestic violence (to include development of processes in relation to members of the public identified as posing a risk to staff, and identifying if they also pose a risk to others e.g. family/partner)	▪ Produce employee HR domestic violence policy using Respect and Refuge Domestic Violence Resources For Employers pack.	HR – Julie Amory with support from Victoria Hill	● Complete. The Policy was signed off by the Staffing and Remuneration Committee in July 2018. The learning from this DHR was already incorporated into the VAWG Training Standards and Framework in 2017.
HfH 4. Explore with Children's Social Care the development of a protocol for managing cases of proposed eviction where there are children / vulnerable adults in the household	Protocol in place	Sharon Morgan	5.1 ● Complete Update April 2015. HfH notify children's services and adults' services as standard when eviction proceedings are being taken. This is also included in the integrated families first form.

ASBAT 5. Introduce routine enquiry for domestic violence, mental health and drug and alcohol issues – questions to be asked where safe to do so – and to ensure appropriate pathways are in place if disclosure is made 6. Develop a checklist of all agencies involved in a particular case; to be on the front of the file 7. Engage with Police colleagues on the standard of information received following information sharing requests; also to address issues of inconsistency of information received	5.1 Set out enquiry opportunities, and limits 5.2 Arrange training on domestic violence awareness and enquiry 5.3 Ensure appropriate pathways are in place for ASBAT where disclosures are made	Mike Bagnall	5.2 ● Complete 5.3 ● Complete 5.4 ● Complete 6. ● Complete 7. ● Complete
DAAT 8. Develop and implement action plan addressing all areas of concern in drug and alcohol services; update reports to be provided		Marion Morris	● Complete.

Offender Management Unit 9. Develop and implement action plan addressing all areas of concern in IOM; update reports to be provided	9.1 GLR to develop Action Plan 9.2 GLR to monitor delivery of action plan and report on a monthly basis	Gareth Llywelyn-Roberts	9.1 ● Complete

Appendix 7: Full list of Panel members over the life of the Panel

4.21.7 London Borough of Haringey

a) Haringey Community Safety, Eubert Malcolm (In Haringey, responsibility for VAWG moved from Community Safety to Public Health in the course of this DHR.)
b) Haringey Public Health, Sarah Hart, Victoria Hill and then Fiona Dwyer
c) Metropolitan Police Service, DS Pam Chisholm
d) Haringey Police, DCI Marco Bardetti, then DI Ian Watson
e) Haringey Children and Young People Service, Jon Abbey
f) Homes for Haringey, Sharon Morgan, then Chinyere Ugwu
g) Haringey Housing Related Support, Claire Drummond, Commissioning Lead, then Nick Smith
h) Haringey Council, Anti-Social Behaviour Team, Stephen McDonnell, delegated to Gareth Llywelynn- Roberts
i) Haringey Council, Human Relations, Tina Ohagwa, then Tricia Howarth
j) Haringey Council, Adult Services, Jeni Plumber
k) Haringey Advisory Group on Alcohol/Rise (HAGA), Gail Priddy, then Elizabeth Balgobin
l) Barnet Enfield Haringey Mental Health Trust, Mary Sexton then Colin Chapman
m) Solace Women's Aid, Mary Mason
n) Nia, Karen Ingala Smith, then Rahni Binjie
o) Haringey Clinical Commissioning Group, Hazel Ashworth
p) NHS England, London, Angela Middleton
q) North Middlesex University Hospital, Julie Firth than Eve McGrath and then Nicole Booty
r) London Community Rehabilitation Company, Cassie Newman
s) Victim Support London, Caroline Birkett
t) Community Safety Unit, Shan Kilby

4.21.8 Hertfordshire County

a) Hertfordshire Constabulary, Alan Postawa, then Ruth Dodsworth, then Tracy Pemberton
b) Hertfordshire Clinical Commissioning Group, Tracey Cooper
c) NHS England, Central Midlands, Anneliese Hillyer-Thake

d) Victim Support, Hertfordshire, Christine Duala
e) Refuge, Sharon Erdman joined when Refuge gained the IDVA contract in Hertfordshire during this review and Christina Duala withdrew

4.21.9 National level organisations

a) Crown Prosecution Service, Malcolm McHaffie
b) Her Majesty's Prison Service, Louise Tuhill, then Barbara White
c) National Probation Service, Andrew Blight and then Fotini Tsioupra

Appendix 8: Action Plan

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Haringey Council							
1	Haringey Council to develop and implement a domestic abuse policy as a matter of urgency. This would provide information and guidance for staff working with the public. It would also include information and guidance for employees of Haringey Council as managers, colleagues and victims of domestic abuse and include information for how to escalate concerns about one's own situation or that of others so that Haringey can be pro-active in tackling domestic abuse and supporting victims.	Local		VAWG Strategic Lead HR	Development of a policy and guidance	March 2018	Complete
2	Haringey Council to encourage or require (as is appropriate to the relationship) organisations that work in partnership with the Council, such as independent schools, and Arms-length Management Organisations (ALMOs) to have domestic abuse policies and practices for its employees and those who use their services.	Local	All partnership organisations and ALMOs are encouraged to have domestic abuse policies and	Haringey Council	All ALMOs and partner organisations are encouraged to have guidance and free training is available through the VAWG training task and	Q2 2016/2017	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
			guidance.		finish group		
3	Haringey Council require all local authority schools to: (a) Include responses to domestic abuse in their HR policies for staff and (b) Provide advice to staff about domestic abuse.	Local			Domestic violence policy under development will be applicable to all Haringey schools. Training sessions will be held with Head Teachers' Forum and Designated Safeguarding Leads' Forum	March 2018	Agreed in principle in March 2018. Work is underway to develop a schools' version of Haringey's HR policy
4	Haringey Council use this case in DA training to emphasise common weaknesses in a response to domestic abuse and how to address them, emphasising the role of every agency in delivering a coordinated community response for every victim of abuse.	Local	DHR as CCR case study	VAWG Training Task and Finish Group	DHR case study included in all VAWG training	Q1 2017/2018	Complete Q1 2017/2018
5	Haringey CSP ensures that action plans associated with responses to domestic abuse, including this DHR, are completed as quickly as possible to minimise the harm	Local	Ensure action plans are completed asap	Haringey CSP	(a) Revise original action plan from internal review and ensure	Q1 2017/2018	Complete – action plans merged

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	resulting from domestic abuse to its staff and residents. The action plan from the original internal review should be updated and outstanding actions rolled into the action plan from this review.				actions are included in this action plan (b) Ensure action plans are completed asap		Action plan completion is a key element of Haringey's VAWG Action Plan
6	Drawing on this report and the experience of Review Panel members, create a strategy and guidance for addressing the situation of domestic abuse victims that find it difficult to engage with services. Consider high-risk victims, victims of serial violent offenders and victims with complex needs.	Local	Develop a strategy and guidance	VAWG Strategic Group	The complexity and intersectional needs of victim/survivors who find it difficult to engage has been included within our 10-year VAWG Strategy.	Q2 2016/2017	Complete Q2 2016/2017
7	When commissioning substance misuse agencies, Haringey Council require that such services: (a) Gather information about clients' relationships and families as part of their assessments (b) They identify risk and include this information in referrals and feed this to partner agencies through the multi-agency groups, including MARAC, and that they contribute to MARAC.	Local	Ensure that the requirements outlined are included within substance misuse service contracts and are included within the monitoring.	Haringey Public Health Substance misuse agencies	All commissioned services are required to carry out both (a) and (b) recommendations. The initial assessment documents were re-developed in 2016/2017 and all substance misuse agencies are required as	Q3 2016/2017	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					core members of MARAC		
Hertfordshire County Council							
1.	That the Hertfordshire DA Partnership Board review the provision for DV victims presenting to GPs with local CCGs to ensure GPs understand their unique role in identifying domestic abuse and are trained to respond effectively.		GPs to receive training provided by the CCG		A series of conferences were held in 2016/2017 to provide training; identify how to use referral pathways and systems and all GPs have access to ongoing safeguarding training All 140 GP practices in Hertfordshire have to submit e-assurance document about their safeguarding training. In North Hertfordshire the GPs clinical leads received a presentation on this DHR to embed learning	2016/2017	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
2.	As part of oversight of the local VAWG services, monitor Hertfordshire Constabulary's referrals to local support services, in particular the new IDVA service for high-risk victims.		Monitor referrals from Hertfordshire Constabulary to IDVA service		All referral levels to the IDVA service are reviewed as part of quarterly monitoring meetings	2016/2017	Complete
Her Majesty's Prison Service							
1.	HMPS develop a national policy and practice for working with perpetrators of domestic abuse when they are in custody and for addressing its role in keeping victims and their children safe. This policy would: (c) Ensure that perpetrators of domestic abuse are identified when in custody (even when offence leading to custody is not obviously domestic abuse), and that (d) The new OM model explicitly addresses the abusive relationships of offenders. Work is undertaken with DV perpetrators in custody (whether for short or longer-terms) to address their abusive behaviours and views. Where prisoners are assessed as not	National		HMPS Home Office			

Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
suitable for this work yet, work is undertaken to prepare them for such work. (e) The prison acknowledges its role in protecting victims by: (f) Creating opportunities for victims to access support (g) Signposting victims to support, and highlighting the freedom to make choices that the perpetrator's incarceration may be offering them (h) Improving communication and information-sharing with agencies in the community that work with victims and their children (i) Incorporating as part of the new initiative of monthly Offender Pre-Release Meetings, a requirement to explicitly address offenders' relationships, identifying abusive relationships and linking to external support for offenders and victims, and their families, so that safety measures can be put in place to protect victims and their children when the perpetrator is released						

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(j) Offering support services for women prisoners who are victims of domestic abuse						
National Health Service							
1.	Implement the IRIS scheme nationwide to educate GPs and engage them in helping victims, perpetrators and their families.	National		National Health Service England			
2.	That the NHS provide improved guidance to GPs on how to engage with DHRs including: (a) The legal basis for sharing information in these circumstances (b) The nature of the information needed by this process (c) The selection of an appropriate IMR writer (d) Support for staff in the surgery following a homicide of a patient of the surgery.	National		NHS England			
Home Office and the Ministry of Justice							

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1.	That the HO conduct an audit of criminal justice processes to ensure that the system and its various agencies work together to create a coordinated response for the safety of victims of domestic abuse and to hold perpetrators accountable.	National		Home Office Ministry of Justice			
2.	That the ministry of justice work with the HO to create a system enabling the police to be alerted when civil orders are granted that provide protection in domestic abuse cases (This ties into MPS Recommendation 9 and Hertfordshire Constabulary Recommendation 3.	National		Ministry of Justice Home Office			
Metropolitan Police Service							
1.	**Local level for Barnet** It is recommended that Barnet Senior Leadership Team (SLT) develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once	Local	Develop training package	Metropolitan Police Service	Specific learning was incorporated in to BOCU training days July-September 2016	December 2016	28/06/2016

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include: (a) MAPPA (see Appendix 5) (b) Information-sharing						
2.	**Local level for Haringey** It is recommended that Haringey SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include: (c) Sharing the lessons learned in this review (d) Domestic Abuse Policies and Toolkits (e) DASH First responders/ Specialist Staff/ Supervisors (f) RARA, (risk management model: remove risk, avoid the risk, reduce the risk or accept the risk)	Local	Develop and deliver training package	Metropolitan Police Service	Presentation given by BOCU DI BOCU Commander requested to initiate dip sample and complete reports.	June 2016	Completed 28/06/2016

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(g) MAPPA (h) MARAC (i) IDVA – referral to and working with to engage the victim (j) IOM (k) Research – local/ cross border (l) Counter allegations (m) Information sharing (n) Safety planning						
3.	**Local level for Enfield** It is recommended that Enfield SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete regular 'dip' sampling should be conducted to ensure compliance. This training should include:	Local	Deliver a training package	Metropolitan Police Service	Presentation delivered by DI. Emergency response Police Sergeants now provide initial advice in relation to Domestic Abuse Incidents to Initial investigating officers.		10/07/2017

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(o) Sharing the lessons learned in this review (p) Domestic Abuse Policies and Toolkits (q) DASH First responders/ Specialist Staff/ Supervisors (r) RARA (s) MAPPA (t) MARAC (u) IDVA – referral to and working with to engage the victim (v) IOM (w) Research – local/cross border				Request submitted for more IDVAs.		
4.	**Local level for Waltham Forest** It is recommended that Barnet SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling	Local	Deliver training	Metropolitan Police Service	Presentation given by BOCU DI BOCU Commander requested to initiate dip sample and complete reports. Presentation delivered by		10/07/2017

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	should be conducted to ensure compliance. This training should include: (a) Sharing lessons learned in this review (b) Domestic Abuse Policies and Toolkits (c) DASH First responders/ Specialist Staff/ Supervisors (d) MARAC (e) Information sharing (f) Safety planning				BOCU DCI. BOCU Commander requested to initiate dip sample. Results submitted to Recommendation panel 28/06/2016		
5.	**Local level – Islington** It is recommended that Islington SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:	Local	Develop and deliver training package	Metropolitan Police Service	Presentation delivered by BOCU DCI. BOCU Commander requested to initiate dip sample. Results submitted to Recommendation panel 28/06/2016		28/06/2016

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	a) Sharing lessons learned in this review b) Domestic Abuse Policies and Toolkits c) DASH First responders/ Specialist Staff/ Supervisors d) Research – local/cross border						
6.	**Service level – TP Capability and Support – Public Protection** It is recommended that the MPS review how 'high risk' domestic abusers are profiled and flagged to ensure that investigators have the fullest available picture when assessing and managing risk.	Service level		Metropolitan Police Service	Recency, Frequency Gravity methodology utilises 6 months' worth of crime and non-crime data to identify high impact individuals. Disseminated to all MPS CSUs each month		Complete 15/04/2016
7.	**Service level – the Judicial Order Working Group** It is recommended that this review be forwarded to Simon Tee, Head of the Criminal Justice Offender Managers Services (CJOMS), for the lessons learned to be considered by the Judicial Order Working Group.	Service level	Forward review to head of CJOMS	Metropolitan Police Service	Review sent to Simon Tee, head of CJOMS		Complete 28/06/2016

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
8.	**Service level – Offender Management Working Group** It is recommended that this review be forwarded to Detective Superintendent Sean Oxley, for the lessons learned to be considered by the 'Offender Management Working Group'.	Regional	Forward lessons learned	Metropolitan Police Service	Completed		Complete 15/04/2016
9.	**Service level – TP Capability and Support – Public Protection** It is recommended that upon receipt of a court order and/or restraining order that 'specified' crime report be opened, the victim contacted and the following actions completed: (g) Contact the victim to gather and share information. (h) DASH (i) RARA (j) IDVA – referral to and working with to engage the victim (k) Emergency planning	Regional		Metropolitan Police Service	On Monday 3rd August 2015 a new process for recording and circulating details of Judicial Orders on PNC was introduced. All orders must be scanned into CRIMINT as an attachment and circulated on PNC. CJOMS role is to collate the various existing business policies and processes and to work with our Criminal Justice partners to implement a		03/08/2015

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(l) Special schemes (m) Panic Alarms (n) Special personal alarms (o) Research (p) Crimint (q) MARAC (r) MAPPA (s) IOM (t) ASBO (u) Supervision (v) Enhanced supervision (w) DVPO/injunction/restraining order				future automated or streamlined process.		
10.	**Service level** It is recommended that MPS circulate to their CSUs and PVPs information about their policy that allows the waiver of recovery costs for vehicles that have been	Service		Metropolitan Police Service	Complete		15/04/2016

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	reported as lost or stolen in situations of domestic abuse.						
Hertfordshire Constabulary							
1.	That Hertfordshire Constabulary develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include: (a) Basic domestic abuse awareness, including coercive control (b) Sharing the lessons learned in this review (c) Domestic Abuse Policies and Toolkits (d) DASH First responders/ Specialist Staff/ Supervisors (e) RARA (f) MAPPA	Local	Develop and deliver a training package	Hertfordshire Constabulary	This action stems from a 2013 case and processes have moved on significantly. The Constabulary were the pilot force for the College of Police DA Matters course - 25 days of action. Officers have been specifically trained in coercion and control. Corporate Services audit how many officers attending DA incidents have been on the DA course. The essence of that course has now been incorporated into new		Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(g) MARAC (h) IDVA (i) IOM (j) Research – local/ cross border (k) Counter allegations (l) Information sharing (m) Safety planning and liaising with the victims				recruit training. Operation Oak is the Constabulary response to DA and covers the remaining points in this action - a link can be found on the front page of the Constabulary's intranet page.		
2.	Risk Assessments of frontline officers are monitored and a feedback is provided to ensure consistent and accurate risk assessments are provided by the staff	Local	Monitor RAs and feedback to ensure consistency		Risk Assessments are reviewed by supervisors - Sgts for Medium risk and Insp for High. These are further quality assured by DAISU DS's. This is a subjective process however, immediate feedback is given to the supervisors of the officers and training needs are		Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					identified when and if required.		
3.	It is recommended that upon receipt of a court order and/or restraining order that 'specified' crime report be opened, the victim contacted and the following actions completed: (a) Contact the victim to gather and share information. (b) DASH (c) RARA (d) IDVA – referral to and working with to engage the victim (e) Emergency planning (f) Special schemes (g) Panic Alarms (h) Special personal alarms				The range of suggested measures is part of established procedures in Hertfordshire, and which are managed via Daily Management Meetings (DMM).		Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(i) Research (j) Crime Information System (CIS) (k) MARAC (l) MAPPA (m) IOM (n) ASBO (o) Supervision (p) Enhanced supervision (q) DVPO/injunction/restraining order						
Crown Prosecution Service							
1.	That the CPS review and revise its record-keeping policy so that it can contribute meaningfully to Domestic Homicide Reviews by providing details of its decision-making in cases of domestic abuse and where protective orders are in place.	National		Crown Prosecution Service			

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Homes for Haringey							
1.	That Homes for Haringey create a policy and procedure that comprehensively deals with their role in situations where tenants are perpetrators or victims, or where domestic abuse has occurred in their premises. It should include: (a) A response that prioritises the safety of victims and clear roles for staff (b) Training for frontline workers, especially concierges and repair staff, to identify abuse and engage victims in help-seeking (c) The sharing of information with other agencies so that the risks are known (d) An understanding of risk assessment in domestic abuse (e) Links to DV support structures in Haringey and neighbouring boroughs	Local	Develop a DV policy and procedure	Homes for Haringey	DV policy developed in 2014. Hearthstone (specialist domestic abuse service) was TUPED across to Homes for Haringey in 2015. Homes for Haringey is currently (2017/2018) undergoing DAHA accreditation to ensure all victim/survivors who are tenants of Homes for Haringey are supported and perpetrators' behaviour is challenged, assessed and addressed	2015	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(f) A process for sharing information on threats to staff safety internally (g) Considerations of the alleged perpetrator's known relationships, where staff feel threatened (h) Ensure all staff know the process for this and the expectations of Homes for Haringey about their role. (i) Ensure all staff know about the counselling helpline.						
2.	Improve information sharing with other agencies through referrals to Hearthstone, MARAC and engagement with MAPPA and other multi-agency meetings. Monitor these to track the impact of improved training and procedures.	Local	Improved information sharing	Homes for Haringey	Hearthstone has become part of Homes for Haringey since the homicide. Domestic violence referrals are immediately referred to Hearthstone.		Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Haringey Anti-Social Behaviour Team (ASBAT)							
1.	Refresh and formalise the procedure for requesting information from the MPS to ensure that requests are targeting all the information relevant to the concerns that the ASB is investigating.	Local		ASBAT	Interviewing form amended to assess risk of domestic abuse	2014 (victim form amended) 2017 (perpetrator form amended)	Complete
2.	ASB develop a VAWG policy that identifies their role in addressing VAWG, the training that staff need, the policies and procedures that link to this (safeguarding policies, for instance) and the link to the safeguarding procedures and relevant procedures and referral procedures. The ASB team's role in multi-agency work around VAWG, e.g. MARAC, MASE, MASH.	Local	Development of policy, procedures and training	ASBAT	VAWG policy developed for ASBAT where initial referral is not flagged as DV/VAWG. All ASB identified on referral is referred to Hearthstone. (DV is not investigated as ASB)	Q3 2016/2017	Complete
3.	ASB team source VAWG and DA training for staff, including general awareness training, an understanding of risk assessment in domestic abuse and the MARAC	Local	ASBAT to undergo VAWG training	ASBAT Public Health Community	Training completed in 2015. Refresher training delivered after	Q2 2017/2018	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	process, safeguarding procedures and application of the relevant procedures and referral procedures.			Safety	restructure completed in 2017.		
Victim Support - London							
1.	Strengthen systems with referring agencies, including: (a) Request that referring agency supplies several safe contact numbers, if possible, and asks the victim for safe times to call. (b) Staff training includes notifying referrer when contact cannot be established with referred victim. (c) Staff to be reminded in case review sessions to notify referrer in such situations and ensure this action is recorded on the VS case management systems. (d) As part of case management, random sampling of closed cases to be undertaken to ensure that case notes show whether referrer was notified of non-contact.	Regional		Victim Support		2015	Complete

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
2.	Staff to review CMS for victims' details where contact with victim has not been established to identify repeat DV incidents and possible referrals to MARAC.			Victim Support		2015	Complete
3.	At four-weekly case reviews with managers, cases where the RIC was borderline high risk, that is 12 or 13, are reviewed against previous and new incidents to inform professional judgement in the case.			Victim Support		2015	Complete
Solace Women's Aid and NIA							
1.	That any victims of domestic abuse that are referred to the IDVA and MARAC that do not engage should be discussed in case reviews as a standing agenda item and other ways of getting support to the victim discussed.	Local	Ensure non-engagement is reviewed	Solace Women's Aid NIA MARAC Steering Group	All non-engagement by victim/survivors when they have been referred to the IDVA service or to MARAC is discussed as a confidential AOB to ensure safety planning can be put in place.	2015	Complete
Refuge – Hertfordshire IDVA Service							

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
1.	That Hertfordshire IDVA service liaise with the local NPS Victim Contact Scheme to provide support and safety planning for victims and their families when perpetrators are released.	Local	Ensure liaison between IDVA and VCS on release	Refuge NPS	In all cases where VCS is involved the IDVA service is informed of release dates. Cases outside of this remit, the IDVA is given the Offender Manager's contact details to liaise.		Complete
MAPPA							
1.	London MAPPA Strategic Management Board should maintain its focus on the assessment and effective management of the risks posed by domestic abuse offenders. Key areas include the following: (a) Training for MAPPA chairs to include domestic abuse awareness, particularly an understanding of coercive control (b) Use of the MAPPA Category 3 (other dangerous offenders) where appropriate so that domestic abuse perpetrators who do not qualify for MAPPA	Regional					

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	Category 159 or for Category 260 may be managed under MAPPA. (c) The relationship between MAPPA and MARAC so that this is understood and implemented locally, in accordance with the Ministry of Justice MAPPA Guidance61, as local guidance produced by the London MAPPA Executive Office and incorporated in NPS London MARAC Guidance.						
Integrated Offender Management Unit							
1.	That the IOM Unit refresh and formalise the procedures and guidance for: (a) Actions to proactively manage non-compliance with IOM requirements and/or licence conditions. This would include clear guidance and standards for investigation, recording and enforcement	Local	Refresh appropriate procedures and guidance		(a) Following a NOMS inspection in 2016 London CRC has recently undertaken an enforcement review:	2016	Complete

[59] Registered sex offenders

[60] Violent offenders sentenced to more than 12 months in custody/detention in hospital under S. 37 or S 42 Mental Health Act

[61] Ministry of Justice MAPPA Guidance 2012, pp. 108FF, para 22.19 – 22.25

Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
(b) Standards of non-compliance that should trigger a partnership assessment (c) Appropriate actions where offenders commit acts of violence against women and girls, including coercive control				• All staff have now been trained in the new Practice Standards. • Weekly reports are being sent to team leaders detailing absences. • Monthly spreadsheets are being sent to team leaders detailing the number of enforcement misses during the previous 3 months and 6 months. • Individual Offender Managers are required to account for all absences at weekly performance meetings		

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					• Individual Team Leaders are required to account for all missed enforcement actions on a weekly basis to the Area Managers. • Individual Area Managers are then required to account for any enforcement misses to the Senior Leadership Team. As a result of the above actions undertaken by the CRC there are clear guidelines and expectations of all staff to ensure that at the point where a Service User misses either two (2) appointments on a		

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					Community Order or three (3) appointments on Licence that immediate and timely enforcement is undertaken. Offender Managers are also expected to discuss and seek the approval of a middle manager/team leader (who then must record his/her approval via a management oversight entry in contact record) for more than four (4) Acceptable Absences (during the lifetime of the Community Order/Licence), on the contact log, (for example medical reasons, family reasons, etc). This will reduce the potential (as it		

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					was in this case) for the Service User to effectively avoid supervision by providing medical certificates. In such instances these case(s) will either be recalled to prison or returned to court for re-sentencing on the basis that the Order is unworkable. Offender Managers/Middle Managers and Senior Operational Managers are accountable for the compliance and enforcement of their team/areas Community Order/Licence cases and failure to comply with the Practice Standards could		

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					result in either capability/disciplinary action being taken against them • Non-Compliance will often cover instances for example where a Service User is only superficially engaging with either his licence and or Community Order Requirements but is attending all appointments, or in some case could involve an escalation in risk, further arrest for minor offences etc. • In such cases, the reasons for breach action and or recall will initially be discussed with the first		

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					line manager and/or the wider partnership in the case of an IOM or MAPPA nominal. • Although any resultant action is discretionary and alternatives to recall or breach should be considered in all cases for example home visit, extra licence conditions, three-way meeting, Senior Manager Warning Letter etc. However, where this does not resolve the issues of non-compliance a recall or breach can be initiated so long as the steps to avoid it have been fully recorded and have		

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					been signed off by a team leader or manager. As above any actions which lead to an escalation in risk can trigger breach or enforcement action if required. In some cases where for example this is based on Police/Partnership intelligence (and has not led to arrest), consideration can be given to the following actions: • Risk Escalation to the National Probation Service: The risk must be assessed as imminent and there must be		

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					evidence to support actions taken to reduce the risk. • Criminal Behaviour Order/Injunctions to reduce the risks to the victim. • Referral to MAPPA as a Level 3 offender (which would result in further partnership resources being allocated to the case). • Breach or recall (see above notes)		
2.	That the IOM Team receive training on violence against women and girls, including general awareness,	Local	IOM team to source and undergo VAWG	IOM	All probation staff must evidence their attendance at Safeguarding and		Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	safeguarding procedures and referral and other procedures to address the safety of victims		training		training, which must be refreshed every three years as part of ongoing CPD. All council employees (working in the gangs team are also required to attend safeguarding and domestic violence training as part of their ongoing professional development. All staff including the IOM gangs workers should also demonstrate evidence as part of their annual training profile that they have received training in domestic violence, safeguarding and victims awareness.		

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					Safeguarding, domestic violence, risk, and victims awareness training also forms part of the Probation Training Requirements for newly qualified staff. London CRC and the National Probation service are also required to provides a Statutory Section 11 Report to the Local Children's Safeguarding Board detailing their Safeguarding procedures and practice.		
3.	That the IOM Unit work with domestic abuse services to review their processes around prison release to identify opportunities to protect victims of VAWG.	Local	Review processes	IOM	The Community Safety Strategy is currently being refreshed alongside the Councils' Strategic	Q3 2017/2018	Strategic Assessment has been completed.

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					Assessment, (both of which will be signed off in the summer of 2017). Both of these Strategies will be aligned to the Mayor's Policing and Crime Plan, which broadly encompasses four main themes, Violence (including DV), Vulnerability, Exploitation and Victims. Alongside this, the IOM unit is being refreshed and as part of this review we will seek advice from the VAWG lead to ensure that both the processes and practice(s) of the IOM gangs and Prolific Offenders teams are		The Community safety Strategy is being aligned to the new Borough Plan (Q2 2018/2019)

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					aligned to the VAWG strategy.		
London Community Rehabilitation Company							
1.	Create clear guidance on the robust management of absences by those on licence so that the opportunity to address offending and reduce risk to others is not missed and so that offenders are held accountable.	Regional	Agree the principle of what is required when medical certificates are received.	LCRC	LCRC have practice standards that include clear guidance about the expectations around compliance and enforcement. These are now a working document and can be easily updated once the principle has been agreed.	September 2017	Complete
2.	In light of the restructure, that LCRC ensure it is part of the local coordinated community response to domestic abuse by (a) Training LCRC staff on: (i) Their part in addressing domestic abuse	Regional	Engage with key partners and stakeholders to agree broad principles of engagement for	LCRC	LCRC has restructured to a geographical model, away from the original cohort model. This will support local relationships with partners.	October 2017	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	(ii) The local referral pathways to services for perpetrators and victims (b) Preparing and attending the multi-agency groups that address domestic abuse, that is, MARACs, MAPPAs, and IOM. (c) Creating protocols and policies to embed this involvement. (d) Monitoring participation in MA groups and referrals to specialist agencies. This information is compiled and sent to the local VAWG strategic group.		these multi agency groups.		LCRC has just completed a recruitment phase to introduce 15 new roles across the 5 areas. These include a Quality and Performance Manager, Contracts and Partnerships Manager and an Interventions Manager. Once these roles are filled, LCRC can review its approach to engagement with these groups. A MARAC rota is now in place within every borough		
3.	That LCRC develop a domestic abuse policy that addresses offenders as victims and perpetrators of domestic abuse, including:	Regional	a) Develop a draft Domestic Violence policy in line	LCRC	A 12-month transformational plan is currently in place for CP LCRC has restructured to a geographical model, away	December 2017	Complete

Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
(a) Specific work with women on Community Payback scheme who are victims of domestic abuse (b) Ways to identify and support victims of domestic abuse, for instance, by adding relevant questions to assessment processes and by creating opportunities for women to disclose, discuss and address the abuse they have and are suffering (c) Clearly outlines the response to violent offenders' reports of their relationships that addresses the risk to offenders' partners, especially when there is a history of violence against women.		with the reviewed MOPAC policy b) Ensure that this is incorporated within the CP transformation plan		from the original cohort model. This will support local relationships with partners. LCRC has just completed a recruitment phase to introduce 15 new roles across the 5 areas. These include a Quality and Performance Manager, Contracts and Partnerships Manager and an Interventions Manager. Once these roles are filled, LCRC will look to develop its Domestic Violence policy		
4. That LCRC explore the option of female-only projects as a way to create opportunities for victims of domestic abuse to discuss and address domestic abuse.	Regional	a) LCRC continue to explore the ongoing development	LCRC	LCRC currently has 3 women's hub across London. In other boroughs, there are	April 2018	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
			of the women's hub b) Ongoing discussions with CP about creating female only opportunities within CP projects.		female only reporting hours. LCRC has also commissioned Advance to deliver a key worker service to women in 16 London boroughs and have also commissioned RISE to deliver DA and Sex Worker interventions in three London female Prisons.		
National Probation Service							
1.	Develop training for women-only cohorts so that issues of domestic abuse can be explored and strategies put in place during the probationary period.	Regional		NPS	HMPPS Women's team has issued 'Working with Women Offenders' in July 2017, which addresses training, and there is now national training available for frontline staff. The implementation of this training is in the Women	Q2 2017/18	Complete

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
					Offenders London Delivery Plan under an action to develop the skills and knowledge of the NPS London Offender Managers to enable them to provide a trauma informed service to women.		
2.	That oversight of cases includes improvements in: (a) Timing and quality of risk assessments (b) The recording of risk management plans and progress against them, (c) The recording of MA discussions (MARAC, MAPPA, IOM) and resulting action plans in client files (d) Regular investigation of information and research to corroborate information from offenders and hold them accountable.	Regional		NPS	We have 6 weekly case audits in Haringey, Redbridge and Waltham Forest that addresses these points. Learning from audits is disseminated to staff.		Complete & Ongoing

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
3.	Ensure that domestic abuse victims and their families are informed about the Victim Contact Scheme and the information it can provide when the perpetrator is sentenced to 12 months or more in prison or when the offender is detained as a mental health patient.	Regional		NPS	This is the agency expectation and it has been reiterated to staff in the Victim Liaison teams and offender management.		Complete
4.	That the Victim Contact Scheme provide details of the local domestic abuse service(s) to victims and their families, and particularly when the service informs victims and their families of perpetrators' imminent release.	Regional		NPS	This is the agency expectation and it has been reiterated to staff in the Victim Liaison teams and offender management.		Complete
Substance Misuse Agencies							
1.	Substance misuse services should (a) Include in their domestic abuse policy a response to non-engagement with services by those on	Local		Blenheim	All substance misuse services in Haringey are core members of MARAC	2016	Complete

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
	licence. This case shows the link between non-engagement and increasing risk. (b) Engage with multi-agency approaches to addressing victim safety and perpetrator behaviour.				as well as engage with MAPPA		
North Middlesex University Hospital (NMUH)							
1.	Domestic violence training to become mandatory for all clinical staff, with priority given to staff in ED, maternity and sexual health clinics. Training to include: (a) Routine enquiry (as stated in the Managing DV Policy, s. 62) (b) Identifying behaviour, symptoms and injuries that are likely to be indicators of domestic abuse and enquiring further about them (c) Creating a safe space to ask questions of the possible victim	Local	To ensure staff have access to Domestic Abuse and Violence training Routine Enquiry Routine Enquiry should be included as part of the initial assessment on	NMUH	Domestic Abuse and Violence training in now as standalone training session as part of the mandatory safeguarding study day for all clinical staff RE is included in the booking for expectant mothers and will continue to be part of the assessment process	04/09/17	Training is now implemented and can be reported via compliance with the KPI for Safeguarding Adults and Children

Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
(d) Responses to disclosures, including risk assessments, MARAC and referral pathways. Access to further information and advice (e) Encouraging engagement of victims (f) The unique role of health services in supporting and protecting victims of domestic abuse		admission to hospital Routine Enquiry is in the Domestic Abuse Policy Staff should have access to Domestic Abuse Resources to support and sign post victims		Proposal to be taken the Documentation Group for discussion for inclusion in the policy Domestic Abuse Policy due for review November 2017 Resource area on the intranet reviewed and updated October 2017 Development of a Resource Tool Kit for all staff due for launch November 2017	27/11/17 30/11/17 25/11/17	Complete and audited to evidence compliance Discussed at the Safeguarding Adult Committee 19/10/17 and approved Resource Toolkit

	Recommendation	Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
							developed and due for launch 25/11/17
2.	That the Trust provide an IDVA service in ED.	Local	The Trust to work with external partners to identify funding to support the development and implementation of a IDVA service	NMUH	A successful bid was submitted by Haringey and Enfield in conjunction with the Trust to become a National DV and Health Pathfinder site	31/10/17	An AE service is due to commence Q3/Q4 2018/2019
3.	The Trust's DV guidelines to be expanded to be used by staff across the Trust.	Local	The Trust Domestic Abuse Policy to be reviewed	NMUH	The updated Domestic Abuse Policy was taken to the Safeguarding Adult Committee for approval 19/10/17	27/10/17	Launch 25/11/17

Recommendation		Scope i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
4.	The Trust develops DV Champions throughout the hospital, again prioritising ED, maternity and sexual health clinics.	Local	The Safeguarding Adult Lead Nurse and the Named Midwife for Child Protection to develop a safeguarding champion role	NMUH	Proposal to be brought to the Safeguarding Adult Committee and the Safeguarding Children Committee for discussion and approval	January 2018	Complete January 2018
5.	The Trust's DV policy is updated to reflect these changes.	Local	The Trust Domestic Abuse Policy to be reviewed	NMUH	The updated Domestic Abuse Policy was taken to the Safeguarding Adult Committee for approval 19/10/17	27/10/17	Complete – launch event 25.11.17