DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF THEMIS[1]

Name	Age at the time of the murder	Relationship
Themis	28	Victim
Abasi[2]	35	Husband and perpetrator
Child 1	2.5	Son
Child 2	7	Son

Address 1 is the home in LB Tower Hamlets where Themis lived with her husband and children at the time of the murder.

Address 2 is the home of Themis's parents in LB Tower Hamlets where Themis lived with her husband and child before 2009.

INTRODUCTION

This Domestic Homicide Review (DHR) report examines agency responses and support given to Themis, a resident of LB Tower Hamlets prior to the point of her murder in 2012.

The Review Panel would like to express their condolences to the family members of Themis and are grateful for their involvement in this Review. The Panel also wishes to thank all the professionals who have contributed and assisted with this Review.

Legal context

Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9. This created a duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements and was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* in April 2011.

This defined a Domestic Homicide Review (DHR) as:

- a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by,

[1] Not her real name
[2] Not his real name

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself;
- held with a view to identifying the lessons to be learnt from the death.

The purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

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

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; these are the responsibility of agencies working within existing policies and procedural frameworks.

For the purpose of this report, the definition of domestic violence is in accordance with the current cross-government definition:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

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

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

Local context

The London Borough of Tower Hamlets is to the east of the City of London and north of the River Thames. It is in the eastern part of London and covers much of the traditional East

End. It also includes much of the redeveloped Docklands region of London, including West India Docks and Canary Wharf. Many of the tallest buildings in London are located on the Isle of Dogs in the south of the borough and a part of the Olympic Park is also within its borders.

The Borough has a population of around 254,000, which includes one of the highest ethnic minority populations in the capital, consisting mainly of Bangladeshis. Somalis represent the second largest minority ethnic group and there are also a number of Chinese, Vietnamese, Indian, Pakistani, and Black African/Caribbean residents. Tower Hamlets is one of the most ethnically diverse boroughs in London.

The borough is one of the most deprived in the country, although there are small pockets of wealthy areas. Levels of unemployment are high but conversely, HSBC and Barclays both have their head offices in Canary Wharf.

At the May 2010 election, the composition of the Council was 41 Labour, 8 Conservative, 1 Respect and 1 Liberal Democrat councillor. Since then Respect gained a seat from Labour at a by-election, and in three separate groups a total of 8 Labour Councillors and one Conservative defected to Mayor Lutfur Rahman's independent group.

This shifting of political allegiances is normal for Tower Hamlets. Between the 2006 and 2010 elections five Respect councillors defected to Labour; one Respect and one Labour councillor defected to the Conservatives; one Liberal Democrat defected to Labour; and one Labour councillor was gained through a by-election at the expense of the Liberal Democrats.[3]

Tower Hamlets currently has one of the highest rates of reported domestic violence incidents across the 32 London boroughs. In the period 2011-2012, the Police received 6625 reports of domestic violence.

High risk referrals to the Tower Hamlets Multi-Agency Risk Assessment Conference (MARAC) have increased year on year, such that 2011-12 will see around three times as many high risk cases being referred as in 2008-09. In the last 12 months there has been an increase of 30.6% in the number of cases referred.

Domestic abuse and incidents of violence currently accounts for a high proportion of referrals to LBTH Children's Social Care and is a key child protection issue for the borough.

The Borough's high levels of immigration have an impact on responses to violence against women. For example, 20% of women seeking help for domestic abuse need language support. In addition, a significant proportion of women facing abuse in the borough have no recourse to public funds due to their immigration status and this affects which services these victims can access. Neither of these issues were applicable in Themis's case and are included solely to give some of the context in which local services are operating.

Tower Hamlets has recently launched a comprehensive violence against women strategy and it is clear that local agencies have put much effort into developing good working partnerships. In common with most Boroughs, there is an IDVA service and a MARAC. There are also ethnic specific services to meet the needs of the local Asian population. A multi agency One Stop Shop also operates in the Borough, managed between the police and local authority.

[3] Information taken from http://en.wikipedia.org/wiki/London_Borough_of_Tower_Hamlets

SUMMARY OF THE CASE

Themis and Abasi had been married for 10 years and they had two sons aged 7 and 2. Abasi had a gambling problem – running up thousands of pounds in debts - leaving Themis and the children frequently without access to any money. Abasi was often verbally and sometimes physically abusive. There was a gap of two years between reported incidents of physical abuse but it is clear that Themis was experiencing varying degrees of coercive control.

Themis reported some of this abuse to local agencies and also confided in her family. In February 2012, her family called a meeting to discuss their marriage. Abasi asked Themis to forgive him for losing their savings, spending her wages and selling her car and jewellery. Desperately not wanting her children to come from a broken home, and against the advice of her father, Themis agreed to give Abasi another chance. Themis's mother also revealed that Themis felt if she separated, that Abasi would not leave her alone and that she would need 24 hour protection – which wasn't possible.

In May 2012, Themis was stabbed to death by Abasi in front of their youngest child. This occurred around lunchtime. Abasi then fled to relatives in Luton, leaving his son alone with his mother's dead body, and with food still cooking on the stove. Several hours later, the relatives in Luton alerted the police who broke into the house and rescued the young boy. The oldest child was at school. Nobody had come to collect the child so the school were trying to contact Themis and other relatives.

POST MORTEM

On 26/05/2012 a special Post Mortem was conducted by at Poplar Mortuary. It concluded that Themis's death had been caused by the loss of blood from a stab wound. She had been stabbed three times.

The first two injuries were described as defence wounds; one was to her hand and the other was to her forearm. The fatal blow was a single stab wound to her neck. The knife entered through the rear of her neck through the neck bone and severed her spinal cord and the left vertebral artery.

COURT DATES

Abasi pleaded guilty to murder in November 2012 and was sentenced to life imprisonment with a minimum tariff of 14 and a half years. An appeal against the sentence was lodged by the family as they believed the sentence was unduly lenient, but their appeal was subsequently dismissed by the Attorney General.

An Inquest was opened and then suspended until the criminal trial had concluded. There are no plans to reopen the case.

SCOPE OF THE REVIEW

The panel set the period to be reviewed as beginning in January 2005. This was because the first known disclosure of domestic violence at the start of the review was to the police in 2007. The Panel wished to reassure themselves that there had not been previous

disclosures to other agencies. Although this longer search revealed routine medical appointments, there were no domestic violence disclosures and the family and indeed Themis's own reports to agencies, later confirmed that the marriage only started to come under strain in 2007 when Themis and Abasi moved into their own home and their second child was born.

TERMS OF REFERENCE

The terms of reference for the review are set out below.

The DHR Panel will consider:

1. Each agency's involvement with the following family members between 1st January 2005 and the murder of Themis in May 2012:

- Themis
- Abasi
- Child 1 & child 2

2. Whether, in relation to the family members, standards were met or exceeded and whether there were any gaps in services or processes that might have led to a different outcome for Themis. The areas to be considered include:

(a) Communication between services

(b) Information sharing between services with regard to the safeguarding of children

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Themis, her husband or their children, concerning domestic violence or other significant harm from 1st January 2005. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards. This should include full consideration of any issues which may have been a contributory or aggravating factor to the murder such as gambling, substance use or mental health issues.

(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

(d) The quality of the risk assessments undertaken by each agency in respect of Themis and Abasi

5. The training provided to adult-focussed services to ensure that, when the focus is on meeting the needs of an adult, this is done so as to safeguard and promote the welfare of children or vice-versa.

6. Whether thresholds for intervention were appropriately calibrated, and applied correctly, in this case.

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any special needs on the part of either of the parents or the child were explored, shared appropriately and recorded.

8. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

9. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies ' ability to respond effectively.

TERMS OF REFERENCE FOR THE CHILD'S ELEMENT OF THE DOMESTIC HOMICIDE REVIEW

10. In relation to this Review the child is not identified as a victim as specified in paragraph 3.3. 3.4 and 3.6 of the DHR Guidance. The primary role of this element of the Review in relation to the child affected is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children.

11. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in LB Tower Hamlets and also any other agencies and local authorities. It should also highlight any good practice that can be built on.

12. Specifically the areas of this Review relevant to the **child** involved are as follows:

Whether LB Tower Hamlets Children's Services took appropriate action to protect and support the child from the time the homicide was reported and in the immediate seven days afterwards.

(b) Whether the agencies had in place policies and procedures for safeguarding and promoting the welfare of children in relation to domestic violence and whether there were any gaps or failings in the policies and procedures themselves, in the implementation of policies and procedures, in management oversight or in compliance with policy and procedures.

(c) How well the needs of, and potential risks to, the child involved were identified by all agencies and how well were the child and the parents engaged in this process. In particular the Review will explore whether the impact of domestic violence on the child was recognised and appropriate action taken to respond to her needs in the light of what was known by any agencies about domestic violence that was occurring in the household.

(d) Whether each agency has systematic processes in place to ensure compliance with statutory responsibilities to safeguard children in the context of domestic violence including appropriately targeted training.

(e) Whether practitioners in all agencies were aware of the needs of the child involved, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child's welfare.

TIMESCALES

Themis died in May 2012.

Three days later, the CSP Chair wrote to members of the Community Safety Panel to advise them of the death and asking for their views on convening a Domestic Homicide Review.

Replies were requested to be returned by 18th June 2012. Unfortunately these responses were delayed in their return so the CSP Chair was unable to write to the Home Office until 24th July 2012 advising them of the intention to hold a DHR in this case.

Various correspondence was then exchanged between interested parties and the first meeting of the Panel was set for 16th November. A delay was experienced in obtaining the contact details of those to be invited, with this not being received from interested parties until 13th November 2012. This delay led to the meeting on 16th November being cancelled due to the short notice in inviting relevant parties.

A subsequent meeting was arranged and this took place on 14th December 2012.

This Review thus began on 14th December 2012 and was concluded in December 2013. Six substantive meetings of the DHR Panel took place[4].

The delayed start also meant that the appointed Chair was unavailable for three months during the process of the Review.

The final report was circulated to Panel members for their sign off in August 2013.

The extended time period to conclude this Review did not prevent agencies from implementing emerging lessons learned as is evidenced in the information below.

PARALLEL INVESTIGATIONS

[4] Administrative confusion led to some Panel meetings being cancelled.

In addition to the criminal case detailed above, there was also a Serious Incident Review undertaken by Barts Hospital Trust. This was assessed and analysed by the IMR author with recommendations made.

CONTRIBUTORS TO THE REVIEW

DHR panel members were as follows:

- Barts Hospital Trust
- Jagonari (local domestic violence specialist service and location of the One Stop Shop)
- LBTH Children's Social Care.
- LBTH Community Safety
- Metropolitan Police
- Poplar Harka (Housing Association)
- Victim Support

All of the above were represented by senior staff and were all independent of the case. IMR authors attended those Panel meetings where their IMR was discussed.

DISSEMINATION

DHR Panel members have all received a confidential copy of this report along with members of the victim's family.

CONFIDENTIALITY

The findings of this review are confidential and all parties have been anonymised. For ease of reading, the victim and perpetrator have been allocated alternative Pakistani names. Information is available only to participating officers/professionals and their line managers until the report has been approved for publication by the Home Office Quality Assurance Group. Information discussed by the agencies representative, within the ambit of DHR Panel meetings, was strictly confidential and was not be disclosed to third parties without the agreement of Panel members.

Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.

INDEPENDENCE

This report was written on behalf of the DHR panel by the Independent Chair of the Review, Davina James-Hanman.

Davina James-Hanman is the Director of AVA (Against Violence & Abuse) which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK. From 2000-08, she had responsibility for developing and implementing the London Domestic Violence Strategy for the Mayor of London.

She has worked in the field of violence against women for almost 30 years in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and two book chapters and formerly acted as the Dept. of Health policy lead on domestic violence as well as being an Associate Tutor at the national police college. Davina has also authored a wide variety of resources for survivors.

She was also formerly a Lay Inspector for HMCPSI, acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence (2007/08) and Chairs the Accreditation Panel for Respect. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. In recent months, her focus has been on improving commissioning and increasing survivor involvement in service design and development. Davina is also a Trustee of Women in Prison.

This report was written in August 2013.

None of the IMRs report writers had any contact with the victim or perpetrator and each IMR was signed off by a senior manager within the organisation. All Panel members, including the Chair, were also similarly independent.

THE REVIEW PROCESS

The Tower Hamlets Domestic Homicide Review Panel was initially convened on 14th December 2012 with all agencies that potentially had contact with the victim, perpetrator and their children prior to the murder.

Agencies were asked to give chronological accounts of their contact with the victim and perpetrator prior to the murder (see appendix A) and to complete an IMR in line with the format set out in the statutory guidance. Where there had been no involvement, agencies were asked to consider why that might be the case and what changes might be needed to make their services more accessible.

Each agency's report covers the following:

A chronology of interaction with the victim and/or their family;
What was done or agreed
Whether internal procedures and policies were followed
Whether staff have received sufficient training to enact their roles
Analysis of the above using the terms of reference
Lessons learned
Recommendations

Six IMRs were completed by the following agencies:

- Barts Hospital Trust
- LBTH Domestic Violence & Hate Crime Team
- LBTH Children's Social Care
- Metropolitan Police
- Poplar Harka (Housing Association)
- Victim Support

Each IMR was scrutinised at a Panel meeting and in some instances, additional recommendations were made which have been included in the action plan at appendix B.

EQUALITY AND DIVERSITY ISSUES

All nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel and several were found to have relevance to this DHR. These were:

Pregnancy: The first incident of domestic violence which came to agency attention was in 2007 when child 1 was three years old. However, the next occasion is in 2009 when Themis was pregnant with her second child. Domestic violence often begins or, if a pre-existing issue, increases in severity during pregnancy and is an established risk factor. Less widely appreciated is that the risk increases post-partum, at least in the first year.[5]

Religion and belief: Both victim and perpetrator were Muslim but there was no evidence that this influenced the course of events or the services received. The only possible event where religion may have been a factor is when Themis declined an examination by a male GP but this equally could have been personal preference.

Ethnicity: Both victim and perpetrator were of Pakistani origin. There is no evidence to suggest that this affected services received.

Sex: Being female is the single greatest risk factor for domestic violence. Whilst clearly relevant to the case, there is no evidence to suggest that this affected services received.

INVOLVEMENT OF FAMILY AND FRIENDS

The Chair made contact with Themis's mother and met with her to explore what questions she and her other family members would like the DHR to address. A copy of this report has been provided to the family for comment. The DHR Panel is indebted for their willingness to contribute to this process at their time of grieving.

Efforts were also made to contact Abasi but these were unsuccessful.

The family wished the DHR Panel to know that Themis was an adored member of their family and that she was devoted to her children. They are devastated by her loss and still grieve daily. Some family members have changed their route to work as they cannot bear travelling past her house. Three days after the murder, Themis's grandmother had a heart attack and was devastated to be in the hospital for the funeral as they were very close. The youngest child remembers witnessing the murder and still talks about that day. Both children now reside with Themis's parents and are much loved but as her mother said, 'Seeing her children every day also means my heart breaks every day'.

Family members were provided with a copy of the final report and approved its content. They requested that an additional action be included within the action plan, namely that Abasi be deported once his sentence was concluded.

[5] Mezey, Gillian C., and Bewley Susan. 'Domestic Violence and Pregnancy: Risk Is Greatest after Delivery.' BMJ: British Medical Journal. 314.7090 (1997): 1295.

CHRONOLOGY

A complete chronology of relevant agency involvement is attached at appendix A. Below are edited highlights of the most significant events relating to the murder

05/06/2007: This is the first occasion that Themis and Abasi came to police notice. Police had been called to their home address by a neighbour who reported hearing screams, a baby crying and a thumping noise coming from the address. The couple were spoken to separately and both stated to police that they had been arguing over the two of them having different jobs and working different hours. They both stated that there was nothing for the police to be concerned about. No criminal allegations were made by either party. Child 2 was at the address. A risk assessment was completed and rated as 'standard' and a notification (Merlin) made to Children's Social Care. This was dealt with by a social worker who categorised the incident as a 'family dispute' and no further action was taken. Responses of the police and Children's Social Care were in line with expected standards, existing policies and procedures.

07/01/2008: Themis reports an allegation of criminal damage to her car, which she attributes to unknown youths.

18/12/08: Themis has her second pregnancy confirmed at the GP. A number of routine medical appointments followed, during which time Themis was screened for domestic violence by her midwife. When asked, Themis answered no.

11/05/2009: Police were called to address 1. Themis and Abasi were seen separately by officers and both confirmed that they had been arguing. Themis explained that she had been shouting loudly at Abasi but confirmed that it was no more than an argument. Themis said that this was the first time they had a heated argument that resulted in her shouting. It was noted that she was pregnant and the estimated due date was August 2009. No criminal allegations were disclosed by either party but a risk assessment was completed and was shown as 'standard'. Intelligence checks were conducted on their address that identified no prior reports as the couple had moved residence since the last police report. Staff should have also checked on the names although this would not have changed the outcome. This has since been rectified. Notification (Merlin) to Children's Social Care was also made but an initial assessment was not allocated to a social worker for six days. On 12th May, notification is received by the health visitor for child 1. This is not followed up and is filed in the child's records rather than the family records. Information is not shared with maternity services so they are unaware when Themis attends the hospital 20th May with abdominal pains.

21/05/2009: The Social Worker calls Themis to rearrange a planned home visit to discuss the incident of domestic violence. Themis said the issue had been resolved and she did not want a visit. This was checked with the manager who made the decision to close the case as the violence was verbal rather than physical. However, the manager stipulates that in the event of another contact there will need to be an initial assessment.

June 2009: Throughout this month, there are several medical appointments concerning abdominal pain. According to the Barts IMR, frequent incidents of abdominal pain should be a trigger for domestic violence to be raised with the patient, but the guidance at the time was not specific about the definition of 'frequent'. This has since been rectified.

July 2009: Further pregnancy related contacts with health professionals took place in July and in August, Themis gave birth to her second child.

04/08/09: Themis is seen at home by a community midwife on 4th, 7th and 12th and by the breastfeeding support worker on 4th. There is no record of any screening for domestic violence in contravention of existing guidelines at that time.

12/08/09: Themis is seen by the Health Visitor. There is no evidence that the recent Merlin was shared with midwifery services.

15/08 2009: The Health Visitor undertakes new birth visit. Themis is screened for domestic violence and answers in the negative.

Over the next few months, there is some confusion between health professionals regarding GP registration due to the change of address eight months previously. This is eventually resolved. Although this played no part in the events leading up to the homicide, it is easy to see how it could have had potentially serious consequences had this confusion coincided with a period of help-seeking.

03/09/2009: Abasi reports that he had a bag stolen from a betting office whilst he was playing the gaming machine at the location. It contained the keys to his flat and his business and £1000 cash. Abasi did not want the reporting officers to tell his wife that he was in the betting shop as she thought he was at the cash point and she would be very upset to find out where he was. The incident was investigated and when Abasi was spoken to by a Detective, he became nervous and pensive when he was being asked about the circumstances and how much money he had put into the roulette machine. He eventually admitted that he had in fact lost in the region of £5000 that day and fabricated the report to cover some of his losses. It was also established that he had arranged for someone he knew to take his bag from the venue in order to make the incident appear more credible. Abasi attended the police station and was issued with a stern warning for his false report to the police. He was remorseful and admitted having a gambling problem. No further action was taken by the police.

15/09/2009: Follow-up visit from the Health Visitor. Themis reports feeling depressed.

Over the next few months, the only record of agency contact is with health professionals regarding child 2.

16/05/2010: Themis and Abasi report a burglary at their home address. Abasi was the last person to secure the premises and Themis had returned and found that the front door to the premises had been forced. Abasi reported that he had £8100 cash stolen from a drawer, a black laptop worth £400 and £2100 of jewellery stolen. Abasi was interviewed and eventually admitted that although the premises had been burgled he had lied about the stolen cash. He was further interviewed by police with an interpreter and he confessed that a burglary had not taken place and he had intended to make a false claim on his household insurance to cover up gambling loses. Abasi was issued with a fixed penalty notice for wasting police time.

05/10/2010: Themis is seen by the GP complaining of stress at home. She reported having verbal arguments with her husband and at times feeling suicidal. GP records state that there was no history of domestic violence even though health visitor records show there was a police referral 17 months previously.

08/10/2010: Themis sees the GP again and reports that things are much better at home now she has spoken to her husband. She requests individual rather than couple counselling and the GP refers her to Tower Hamlets psychology and counselling service six days later.

02/12/2010: Themis is discharged from the psychology service as she has not responded to attempts to contact her either via letter or phone.

Over the next couple of months, Themis is seen several times at the GP surgery with stress-related symptoms and is re-referred to the psychology service. She attends an initial assessment and says she wishes to wait six weeks to see if she needs the service again.

02/04/2011: Themis reported to the police that their flat had been entered by someone removing a double glazed UPVC window and had stolen jewellery worth £800.

13/04/2011: Themis calls Children's Social Care reporting stress from the two burglaries and that child 1 is now very clingy. She is advised to contact the lettings section to resolve the housing issues and ask her GP for a referral to CAMHS if the clinginess of child 1 continues.

20/06/2011: Themis reports to the police that her car (Nissan Micra) had been stolen whilst left parked in the street. This vehicle has not been recovered. It is considered possible that Abasi sold the vehicle without her knowledge to cover his gambling debts.

07/07/2011: Themis visits her GP and discloses she is having problems with her husband gambling. She says she feels down about this sometimes and thinks she will leave him if he does it again.

13/01/2012: Themis attended an appointment at Poplar Harca to discuss rent arrears. She spoke about her husband and what had been happening; namely that her husband had a gambling addiction, leaving her with no money to pay the rent, and that he self harmed, (cut himself) when he lost a bet. This information about Abasi self-harming does not appear again in agency records despite it being a risk factor.

It was agreed to refer Themis to other supporting agencies. Another meeting was agreed for 17th January to complete the relevant forms because Themis was very distressed and crying. She was advised to attend the One Stop Shop.

17/01/2012: Themis went to Poplar Harca as arranged to complete the necessary referral forms. She constantly repeated that contact must only be made through email or text messages through fear of her husband finding out. Themis said that she feared her husband would kill her. At the end of the meeting, Themis said that she felt more at ease but found the form filling daunting and frightening. She asked for there to be a delay in submitting the referral forms, and that she would make contact when she agreed to having contact with other supporting agencies.

23/01/2012: Themis is referred to Victim Support IDVA service by Poplar Harca. As well as the referral form (DV1) the housing officer also attached a completed Inter Agency Children's Services Referral and Multi Agency Risk Assessment Conference referral form for information (the original being sent to the MARAC Co-ordinator). She also sent the risk assessment with seven ticks. The DV1 stated that the only safe method of contacting Themis was via email. No telephone number was given for Themis. An e-mail was sent the same day which included information about the IDVA support service and how IDVA's may help and support victims of domestic abuse. The IDVA also provided Victim Support's

address and telephone number and offered to see Themis face to face where and when it was convenient for her.

25/01/2012: Themis e-mails the IDVA asking for an appointment at 11am the following day. The IDVA is not available but books an alternative appointment for 27th January.

27/01/2012: The IDVA met Themis. She disclosed that she had been experiencing domestic abuse from her husband. She said seven years ago when her husband came to the UK there was a low level of violence which included verbal and emotional abuse. When her husband joined her in the UK they lived at her mother's home. However, after the birth of their second child, Themis and her family moved out of her mother's place and into their own home. She said the abuse escalated and the frequency of the incidents increased. She also said her husband's behaviour became very controlling. She said she was not allowed to invite friends round and that her husband always checked her phone and her handbag. When she was out he would harass her by calling her to check where she was. As a result Themis felt very isolated and lonely as she was kept apart from her friends and family.

She also disclosed her husband accused her of having affairs with other men. She said when he came back from work he would wake up their seven year old son and question him asking him if any men visited their house in his absence.

She said her husband had physically assaulted her twice in the past, which included slapping, kicking and pushing her around. He had made threats to kill her and had pointed a knife at her.

She said over the last two years there was no physical violence; however the psychological and emotional abuse had increased. She said when they moved in to their own place she would ask him to contribute towards the house keeping but he would refuse to do so. He used all his money to gamble and sent money to his parents in Bangladesh. She said during the incidents her husband would get close to her face in anger and intimidate her but would not touch her. She said he did this very often.

The IDVA carried out a needs assessment, discussed the dynamics of domestic violence and undertook a DASH Risk Assessment which scored 12. Themis was informed that her case would be referred to and discussed at MARAC and this process was explained. Comprehensive safety planning advice was provided.

Themis asked about her housing and legal options which was explained and an offer was made to give her a list of solicitor's contacts. However, Themis said she did not want to take it because her husband checked her handbag regularly. The IDVA encouraged her to attend the domestic violence One Stop Shop.

01/02/2012: Notification is received from Poplar Harca by Children's Social Services. Notification includes details of verbal abuse and controlling behaviour and the threat to kill. Attached is a copy of the DV1 referral form and the MARAC referral. It is clearly stated that contact can only be made via e-mail and that Themis is afraid of her husband killing her.

02/02/2012: Health Visitor and School Nurse are informed of the latest developments.

4/02/2012: Themis attended the police station and reported that she was suffering from emotional abuse. She explained that she had an argument with her husband that morning

about his gambling. She reported that she had confided in a local counsellor about previous issues who had advised her to consider reporting incidents to police. Themis stated that their problems had started five years ago when Abasi had started gambling, drinking and smoking. She explained that Abasi was short tempered but very protective of her and would often think that she was having an affair. His behaviour would often lead to arguments when he would refer to her as a prostitute, slapper and a bitch. Themis also disclosed that in 2010 she had threatened to leave the relationship but Abasi had threatened to kill her. He was alleged to have said 'If you report me to the police I would kill you, you would be murdered and I would own up that I did it'. She had been reluctant to report the incident at the time as she had been scared. At the time of this report, Themis stressed that she did not want police to take any action or speak with Abasi. She provided details of her brother as a single point of contact. A DASH risk assessment was completed and was shown as 'standard' and a Merlin (notification to Children's Social Care) is completed. The incident was further investigated by a Detective Sergeant from within the Community Safety Unit (specialist investigation unit for domestic violence). The brother of Themis was contacted as this was recorded as her preferred choice of contact. The brother confirmed that to his knowledge there had never been any physical violence and the conditional aspects of the threats were discussed with the brother. It was established that Themis was being well supported by her family. The police officer reviewed the risk and confirmed that the risk remained as 'standard'.

In relation to the threat to kill, it should be noted that it had occurred two years ago and had not been seemingly repeated in the two year interim period despite other domestic incidents. It should further be noted that there was no record of a MARAC referral within any of the MPS systems. This information was kept solely within the Tower Hamlets home drive of their own computer based system. This issue has been subsequently addressed.

06/02/2012: Themis attends the One Stop Shop at Jagonari[6]. She said she had come to get some advice and information about her options. She disclosed her husband was very controlling, always checked where she was going and always checked her phone. She said he had been verbally and emotionally abusive. Themis stated that she had had enough and would like to leave. However, she said she would like to know her options before she could make a decision. Housing and legal options were comprehensively explored along with safety planning advice.

At some point around this period, Themis called a family member during an incident where Abasi threatened her with a knife. Two family members went round to the flat and a row ensued about Abasi's gambling. Themis left with the children and moved into her mother's home . Arrangements were then made for a family meeting the following day to try and sort out the problems. At this meeting, Abasi eventually admitted that he had a gambling problem. Themis's father suggested a separation but Themis was not happy about this and she did not want her children to have a broken home. She begged for him to be given another chance. Her father was not happy but accepted her decision. Abasi cried and begged for forgiveness. Subsequent to this meeting, Themis moves back in with Abasi. It is thought that this period spans between a week or two and seems to have concluded by 20/02/2012 if not earlier.

06/02/2012: MARAC referral received from Poplar Harca.

[6] Jagonari is a local community centre from which a range of services operate including the domestic violence One Stop Shop. Responsibility for the One Stop Shop rests with the police and local authority.

The same day, an e-mail is sent by Children's Social Care to Themis asking her to make contact. A phone call is also made by Poplar Harca to Children Social Care informing them that they had received a text from Themis the previous Friday but before they could respond another text arrived saying not to text but only to e-mail.

07/02/2012: The case is heard at MARAC. There were concerns raised that there was no direct telephone number to contact Themis. Other Panel members also raised concerns that it was not safe for the children in that environment as the perpetrator was very controlling and wakes his children up when they are asleep, asking them if the mother had invited any men in the house while he was out. It was shared that there was a Health Visitor appointment with Themis on 29th February 2012, so it was agreed that there would be a joint visit with the IDVA. Children's Social Care were also told to arrange a home visit. The same day health confirms that the Health Visitor has been updated regarding actions agreed at the MARAC.

08/02/2012: The IDVA receives an e-mail stating that as Themis was not currently living at her home address, she would not have received the appointment letter for the Child development check on 20th February.

10/10/2012: Health Visitor calls Themis to arrange a home visit.

13/02/2012: Health Visitor meets with Themis and both her children. Themis reports that her husband has promised to look after her and the children. During the visit, Themis says that the domestic violence has been going on for three years and that her husband has a gambling problem. She also says that she has great support from her family and she knows where to get help if she needs it.

16/02/2012: IDVA sends e-mail to Themis asking her to make contact.

20/02/2012: Health Visitor meets with Themis again for a development review for child 2. Themis looked well and reported that her husband's behaviour was a lot better and her family were now aware that she was a victim of domestic violence which she had previously hidden from them. Themis reported that she was aware of services and who to contact if needed.

22/02/2012: Themis calls her IDVA but she is out of the office. Another IDVA offered to help but Themis says she would rather call back later.

05/03/2012: The case is discussed at Children Social Care and agree that the case should be reviewed again once the MARAC action to meet with Themis has been completed. However, there are no recorded actions regarding making arrangements for this visit.

12/04/2012: The IDVA e-mails Themis again, asking her to get in touch.

25/05/2012: Themis is murdered.

INDIVIDUAL MANAGEMENT REVIEWS

BARTS HOSPITAL TRUST

This IMR was written by an independent author who has previous experience of reviews. The IMR indicates the extensive review that was undertaken of relevant files and records

for the key individuals and details the interviews that were conducted with relevant staff. This is good practice and ensures that perspectives of practitioners are obtained who have first- hand knowledge of the individuals, systems and processes. This IMR is a particularly well-structured report with probing analysis covering the responses of midwifery team, health visitors and the GPs. The IMR also assessed and analysed a Serious Incident Review undertaken by Barts Hospital Trust after the murder.

Key issues arising from the IMR are as follows:

1. As a consequence of the records review, although much of Themis's care and service received from the maternity and health visiting service met with the expected standards at the time there were some aspects with specific respect to domestic enquiry and domestic abuse management that the author considers could have been improved, both in terms of the documentation around this issue and in respect of actions taken or not taken.

2. In July 2010 there was a note in Child 1's records that he had moved out of the locality. His records were therefore sent to the child health records department. It seems as though duplicate records were put together for Themis and her children which resulted in important information becoming separated (the duplicates were not complete). The Merlin relating to the incident when the Themis was pregnant with Child 2 was attached to Child 1's records in the original notes only. The organisation now has an electronic record system. Merlins are scanned onto the system, ensuring that the above situation will not occur again.

3. In February 2012 there was a lost opportunity for the completion of a Common Assessment Framework. This followed a home visit to Themis by the health visitor where she was informed by Themis that she was already accessing support from Victim Support and that no further domestic abuse incidents had taken place. The Serious Incident Review stated that *' so it appeared that the risks to the victim and family had been reduced'*. The non-completion of the Common Assessment Framework meant that other agencies may not have been aware of Themis's situation as they could have been.

4. Following the health visitors meeting with Themis at her home and then at her son's 13 month developmental check on 20 February 2012 a follow up plan should have been formulated via the THVis system (this is the electronic record keeping system for health visitors). Usage of this system would have ensured follow up of Themis and her children within eight weeks of the 20 February contact. There was a need to treat child 2 as a vulnerable child.

5. There was clearly recorded information in the health visitor record that the domestic abuse coordinator had made contact by telephone to provide information about the MARAC referral . There is a copy of the letter sent to the school nurse and health visitor by the domestic violence coordinator following the MARAC meeting within the health visiting records, but not in the school health records.

6. There is an expectation that the health visitor and school nurse will share with each other information concerning domestic abuse incidents where there is a pre-school and school age child in the family. This did not happen in this case. From a safeguarding children's perspective, the lack of communication between the health visitor meant that the school nurse was unaware of the MARAC referral. She therefore did not have the opportunity to make contact and offer support to the

mother or to gain consent from her to share the information with the school so that Themis's child could be monitored there.

7. In 2010 a retrospective audit was conducted by the domestic abuse coordinator for Barts Health. The period of time covered by the audit was March to August 2009. Barts IMR recommends that this audit should now be repeated including an assessment of the frequency with which health visitors are undertaking the appropriate risk assessments and also the quality of the documentation.

Recommendations arising from these findings have been included within the action plan.

LBTH DOMESTIC VIOLENCE & HATE CRIME TEAM

This IMR covered both the One Stop Shop and the MARAC process and was supported with extensive documentation covering protocols and procedures. It is clear that much work has been undertaken to ensure a quality and comprehensive service at the One Stop Shop and for a smooth running and effective MARAC. To deal with the volume of referrals, the MARAC now takes place fortnightly and participants are to be congratulated for developing systems which are, for the most part, very robust. The IMR identifies several areas within the MARAC where processes could be strengthened still further which were discussed and considered in detail at the Panel meetings. A range of recommendations have been included within the action plan which collectively aim to integrate still further the work of the One Stop Shop and the MARAC with other agencies and processes such as MAPPA.

LBTH CHILDREN'S SOCIAL CARE

This IMR demonstrates the thorough examination that was undertaken of relevant files and records which not only included contact with the family, but also reviewed the extensive changes that have taken place with regard to child protection policy and procedures over the review period. The IMR also details interviews that were conducted with relevant staff which enables information to be appropriately and contextually assessed. It is clear from the information provided that Tower Hamlets is managing an ever increasing number of referrals with a domestic violence component and that managing this volume of referrals is a challenging task. There is evidence of good communications with other agencies and a very real commitment to addressing domestic violence effectively. Nevertheless, some key issues were identified by the IMR author:

1. This review has shown that over the past five years, there has been a change in the thresholds applied to domestic violence in Tower Hamlets, which is at variance with the London Child Protection Procedures. The threshold has been raised by senior managers in order to deal with the volume of contacts. It has also highlighted the different views of the domestic violence thresholds held by the IPST (Integrated Pathways and Support Team) and Advice and Intervention (A&I) team managers given that the A&I manager felt that the 2012 contact would have warranted a s47 investigation. This was never tested at the time as there was no discussion between the managers, illustrating how difficult it can be to determine risk in domestic violence incidents. The regular practice meetings that have now been started between the IPST and A&I will assist in ensuring knowledge of each other's thresholds. Work has already begun on developing a unified domestic violence strategy for CSC that outlines thresholds and interventions and will continue to be developed with partner agencies.

2. In interview, a senior member of staff said that she felt staff became "normalised" to domestic violence because of its ubiquity and volume in the work, showing that maintaining staff sensitivity and curiousness to domestic violence is an important task of management and training.

3. The significance of past history is vital in understanding the impact of domestic violence. The team manager has made a focus of emphasising the importance of a cumulative analysis and taking account of history in her team development. It is known that victims under-report incidents of domestic violence and may minimise its impact either through shame or fear of the consequences of disclosing to CSC. Even if the presenting problem is not domestic violence, a past history should prompt some probing to ascertain if it is still occurring. Staff need assistance in having these domestic violence prompts.

4. FWI is a system that supports statutory CSC work and has limitations in supporting tier 2 to be effectively recorded when there is no decision that an assessment is required. Some enquiries that are low level need to be made but the pressure is on to deal and finish with a contact within the timeframe of 24 hours.

5. The representation of CSC on the MARAC has now been increased and strengthened. A practice manager from IPST and a service manager (on a rotational basis) now attend to ensure effective and timely responses can be made within CSC. Not all cases that are presented at MARAC where the victim has children are allocated within CSC: this needs to be reviewed. MARAC does not always formally review the cases it has discussed so does not get a feedback loop about outcomes.

6. The Service Manager, Assessment and Early Intervention, said that senior managers are reminding staff of the importance of the timeliness of their recording on FWi. The LBTH Recording policy is currently being reviewed and will be re-launched.

7. The imminent formation of a Multi-agency Safeguarding Hub (MASH) in Tower Hamlets will further strengthen the information sharing and risk assessments that take place on receipt of a contact.

8. Information sharing after the murder was done well and the social workers assisted the maternal family to take over the legal responsibility for the children, who have effectively lost both parents.

9. This case shows that even relatively low level incidents of verbal abuse, which score low on various tools to assist risk assessment, can escalate to fatal consequences. However, it could not be known on the information available, that such an outcome could be predicted.

Recommendations arising from these findings have been included within the action plan.

METROPOLITAN POLICE

This IMR provided useful background into the family circumstances and gave a good indication of the systems and processes in place during the relevant review period. This included how the Metropolitan Police dealt with matters of domestic abuse over time, the recording and dissemination of information both internally and externally. The well-constructed report examined reported domestic abuse incidents and also provided useful insights into the extent of Abasi's gambling. An analysis of each incident and outcomes was also provided. Contextual and organisational change also receives comment.

As with all the IMRs, the police IMR provided a chronology of contacts (see above). Those relevant to domestic violence consisted of three police reports over a five-year period, which were all verbal in nature. On each occasion, a risk assessment was completed and assessed as 'standard' and notifications were made to Children's Social Care in line with force policy and practice.

Other incidents reported to the police concerned (alleged) burglaries, (alleged) thefts and criminal damage. The latter of these is not felt to be relevant to this DHR; the former however, are indications of Abasi's gambling problems and the subsequent financial abuse experienced by Themis and the children.

Four issues arose from the police IMR:

1. Although unlikely to have affected the outcome of the case, the police IMR revealed that intelligence checks were done solely on the postal address . The family had moved and although three years had elapsed between the first and second domestic incident, the two events were never linked. This practice has since been rectified.

2. In February 2012, Themis reported to the police a threat which Abasi had made two years previously to kill her. This threat to kill was a conditional threat and made on the basis of what could happen if Themis left the relationship. The actual criminal offence of a threat to kill is not made out in these circumstances. However the matter was reported, recorded and support offered to THEMIS. In addition THEMIS had made it clear that she did not want police to take any action.

3. In line with force policy, the police notified Children Social Care of the presence of children in a home where domestic violence incidents were also been reported. This notification was done electronically with a delivery receipt required. The receipt was duly received but the notification was never received by Children's Social Care. Subsequent investigations revealed that the delivery receipt is only a confirmation that the e-mail has been successfully delivered to the server and not necessarily to an inbox. If the notification had been received, it is unlikely to have altered the course of events. However, this situation does raise issues of concern and a recommendation is included within the action plan.

4. Issues regarding information sharing, particularly cases that have been heard at MARAC, meant that the police were not always operating with the full information available. This is unlikely to have affected subsequent events and new systems have since been put in place to address these issues. Nevertheless, the police IMR also raised ongoing issues with the MARAC process which have been addressed in the recommendations.

Recommendations arising from these findings have been included within the action plan.

POPLAR HARCA

This IMR provided useful information revealing one of the consequences of Abasi's gambling, namely that Themis and Abasi fell into rent arrears. When attempting to address this issue, Themis disclosed the abuse she was experiencing. The Poplar Harca

support officer created a safe agreed method of contact and ensured that Themis was referred for appropriate support and advice. It is clear from documentation provided detailing the e-mail and text exchanges between Themis and the support officer that a trusting relationship was established. Poplar Harca are to be commended for the quality of their domestic violence support.

The IMR did raise one issue, namely the way that joint tenants are managed when there are rent arrears. Current practice only requires Poplar Harca to meet with one of the joint tenants but practice will now change to ensure that both tenants are seen. Other recommendations have been included in the action plan.

VICTIM SUPPORT

This comprehensive and thoughtful IMR outlined the involvement that Victim Support had with Themis. As detailed in the chronology above, Victim Support had contact with Themis between January and February 2012, although two further unsuccessful attempts were made to contact Themis in March and April. The quality of the service provided directly to Themis by the IDVA is to be commended for its thoroughness. The IMR does, however, raise a number of issues with regard to liaison with other agencies, particularly in cases where direct contact with the victim is restricted, as it was in this case, to e-mails only. The IMR also contained detailed information about the steps that Victim Support took subsequent to the murder to identify lessons to be learned and to implement these as soon as possible. This includes the development of new Standard Domestic Violence Operating Instructions for the delivery and management of cases which supplement the general Standard Operating Delivery Standards that were in place at the time. Referral pathways have also been clarified and communicated to staff and randomised audits of case files to test out and ensure standards are being implemented

CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

EFFECTIVE PRACTICE

Several instances of effective practice were identified during this DHR. These are:

1. The service provided by the housing officer at Poplar Harca to Themis demonstrates good levels of professional curiosity and subsequent to disclosure, was on-going, supportive and trusting as evidenced from a series of emails that were shared with the Panel.

2. The Victim Support IDVA assessment was very thorough and covered not only the completion of the DASH form but also included the development of an immediate and comprehensive safety plan and information about the full range of options available.

3. The quality of service offered by the One Stop Shop was described by Themis in an email as follows:

   'Oh and I did go to get advice from the domestic violence advice center at the Jagonari Center in Whitechapel, they had different panels, solicitors, victim support, housing, refuge etc, I went to all of them...they were FANTASTIC! I now

know what options are available for me if things don't work out and I would definitely advise anyone who is in this situation to go there, they are so so good!'

Overall, this DHR evidenced a high level of awareness and understanding of domestic violence and of survivors' needs amongst a core group of critical agencies. It is clear that the One Stop Shop is a valuable resource and the risk procedures are generally well understood and followed.

LESSONS LEARNED

Transfer of critical information

At one point, the Metropolitan police made a referral to Children Social Care via e-mail and requesting a delivery receipt. Unfortunately, unbeknownst to both parties, the delivery receipt only indicated that the e-mail had been delivered to the server and not to an inbox. As such, Children Social Care remained unaware of this referral although it did not affect the outcome.

The transfer of health notes was also disjointed at times and critical information did not seem to be communicated to the GP. It is by pure luck that this did not affect the course of events and steps have been taken to rectify this gap.

Gambling

This was identified as an issue and it was clear from information provided by Themis' mother that it was the source of much of the tension between Themis and Abasi. As well as being the cause of rent arrears which threatened the roof over her and the children's heads, Themis was also forced on occasion to ask family members for money to eat. Gambling does not, in and of itself, cause domestic violence, it did lead to Abasi financially abusing Themis and the children.

Response of solicitors at OSS

Information was requested from the firm of solicitors who advised Themis when she visited the One Stop Shop. This request was declined on the grounds of client confidentiality. As a consequence, the legal support for the One Stop Shop will be reviewed to ensure that all lawyers providing a service will be willing to keep notes which they will share with partner agencies.

Long delay in IDVA making contact after Themis called

This has been identified as a missed opportunity and action has now been taken to address this.

MARAC

Further missed opportunities were identified as a consequence of guidance not being followed. Some MARAC actions were not completed and others were completed but failed to be reported back. This has been addressed in the action pan.

Risk identification

Risk was identified appropriately calibrated and interventions escalated when Themis reached high risk. The case was appropriately referred to MARAC and an action plan devised. The implementation of this was not as robust as it could have been and steps to remedy this have been included in the action plan.

One critical issue which this case also demonstrates is the importance of understanding coercive control and framing domestic violence as a pattern of behaviour rather than isolated incidents. At several points in the review period, Themis disclosed behaviours she was subjected to that indicate a high degree of coercive control but the very low level of physical violence meant that the abuse was not always treated as seriously as it could have been. All professionals need to be aware that coercive control is a far reliable indicator for future homicide than history of physical abuse. [7]

Appropriate services

Overall, Themis was offered appropriate services and was able to access support, advice and information in a timely fashion when she chose to engage. Like many women who experience domestic violence, Themis sought reassurance on several occasions and seemed to need time to consider the future course of action.

The only gap identified in services offered to Themis, was a referral to Families Anonymous who could have provided her with support over Abasi's gambling.

Communication and clarity of roles and responsibilities between agencies

LB Tower Hamlets services are to be commended with regard to this as there was much evidence of clarity between agencies concerning their roles and responsibilities. Overall, information sharing between professionals was very good with the exception of information being shared with GPs.

DHR process

The Chair would like to commend participating agencies in this Review for the high standard of IMRs produced and the commitment shown to the DHR process. Attendance at the Panel meetings was good and there was a real lack of defensiveness, a willingness to learn and improve local provision. Unfortunately the administrative support was, at times, disjointed and inconsistent leading to unnecessary delays in the process.

WAS THIS HOMICIDE PREVENTABLE?

Overall, communication between agencies and appropriate interventions were offered, policies and procedures were correctly applied and risk was, for the most part, appropriately calibrated.

However, there are some instances where responses could have been more robust and these have been addressed in the accompanying action plan. The conclusion of the DHR Panel is that whilst this will improve local provision, that these did not have a material impact on the course of events.

[7] See, for example, '*Coercive Control'* (Evan Stark) or '*If Only We'd Known'* (Reagan et al)

There is evidence of much good practice with regards to domestic violence service provision within London Borough of Tower Hamlets and domestic violence is a high priority across the key agencies. It is clear from agency records that Themis knew about and was able to access local services.

Lessons arising from this Review have already begun to be implemented. However, there are no instances where it can be confidently claimed that this homicide could have been predicted and prevented. This DHR acts as a timely reminder that despite all the hard won achievements, there remains more to do to ensure that all victims are safe.

The Panel wishes to express its condolences to the children, family members and friends of Themis.

Appendix C: Glossary of Acronyms

BOCU: Borough Operational Command Unit
CAD: Computer Aided Despatch
CAF: Common Assessment Framework
CSC: Children's Social Care
CRIS: Crime Recording Information System
DASH: Domestic Abuse, Stalking and Harassment (risk assessment tool)
DHR: Domestic Homicide Review
DV: domestic violence
DV1: Domestic Violence referral form
FPN: Fixed Penalty Notice
HMCPSI: Her Majesty's Inspectorate of the Crown Prosecution Service
HV: Health Visitor
IDVA: Independent Domestic Violence Adviser
IMR: Individual Management Review
IPST: Integrated Pathways and Support Team
LB: London Borough
LBTH: London Borough of Tower Hamlets
LSCB: Local Safeguarding Children Board
MARAC: Multi-Agency Risk Assessment Conference
OSS: One Stop Shop