LONDON BOROUGH OF EALING

SAFER EALING PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

'M F JONES' AGED 25

FATALLY STABBED IN SEPTEMBER 2016

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM
11 SEPTEMBER 2018

Safer Ealing Partnership - Domestic Homicide Review Panel
MFJ killed in September 2016

LIST OF CONTENTS

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INTRODUCTION

1. This report of a domestic homicide review (DHR) examines agency responses and support given to Mr 'M F Jones'[1], a resident of Acton in the London Borough of Ealing prior to his homicide on 17 September 2016.

2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3. At approximately 2300 on Saturday 17 September 2016 police were called to Flat in the London Borough of Ealing where M F Jones aged 25 was found lying on the pavement outside with multiple fatal stab wounds.

4. Arrested and subsequently charged with his murder was his partner Rachel aged 27 of the same address. Rachel's two children were asleep in the flat at the time of the incident: Child A aged 7 years from father JK and Child B aged 2.5 years from M F Jones.

5. Following a trial at the Central Criminal Court and a defence that the fatal injury was inflicted when Rachel was in fear for her life she was acquitted of all charges in April 2017.

6. The review will consider agencies contact/involvement with M F Jones and Rachel from January 2012, the year in which they commenced a relationship, to the day of the homicide in September 2016. Any relevant fact from their earlier lives will be included in background information.

7. The key purpose for unertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

8. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with M F Jones' voice at the heart of the process. Following a Panel discussion, it is accepted that, notwithstanding the acquittal on criminal charges of murder and manslaughter, Rachel had never denied inflicting the fatal stabbing on her partner, so it is a domestic homicide[2] for the purpose of this review. Their relationship was volatile and included domestic abuse that was reported on both sides by agencies participating in the review, therefore, the same operating principles have been applied to understanding Rachel's situation.

[1] A pseudonym chosen by his family
[2] Killing of one person by another *Oxford Dictionary*

TIMESCALES

9. The review began with a Panel meeting on 10 May 2017 when Terms of Reference were agreed, and Chronology reports commissioned from all identifiable public and voluntary organisations that may have had contact with M F Jones and Rachel. At the second meeting on 26 June, an Integrated Chronology was reviewed and Individual Management Reviews (IMR) commissioned from agencies that had relevant contact with either party (see table 1 below). A third meeting on 5 September reviewed and debated the five IMRs received and acted to ensure the outstanding reviews were returned. Five more were available for the meeting in December. Addendums, suggestions and follow up enquiries had been completed for the meeting in March and the fifth version of the overview report was debated in April, the sixth in May and the seventh in June. Further revisions were drafted through secure email and telephone correspondence until presentation to the Safer Ealing Partnership on 11 September 2018.

CONFIDENTIALITY

10. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

11. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased will be referred to herein as M F Jones or MFJ as appropriate to the narrative. Similarly, his partner will be referred to as Rachel. Initials or letters will be used to refer to others that feature in the chronology and these are included in the glossary for reference.

12. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of chronologies and IMRs was provided to all Panel members for review and discussion.

TERMS OF REFERENCE

13. Following discussion of a draft in the first Panel meeting, Terms of Reference (ToR) were issued on the same day (appendix 1) with a chronology template for completion by agencies reporting contact with MFJ, Rachel, Child A and Child B.

METHODOLOGY

14. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Violence Homicide Review (DVHR) was commissioned by the Safer Ealing Partnership and, in April 2017, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DVHR Panel. Tony Hester has supported him throughout in the role of Manager and Secretary to the Panel.

15. This review was commissioned under Home Office Guidance issued in December 2016. Attention was paid to the cross-government definition of domestic violence and abuse and is included in appendix 1.

16. The following policies and initiatives have also been scrutinised and considered:
    - HM Government strategy for Ending Violence against Women and Girls 2016-2020
    - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    - MPS Domestic Violence Investigation and Supervisors Toolkit issued in July 2013
    - London multi-agency safeguarding adults policies and procedures 2015
    - HMIC (Her Majesty's Inspectorate of Constabulary) Reports: 'Everyone's business: Improving the police response to domestic abuse' 2014 and 'The Metropolitan Police Service's approach to tackling domestic abuse' 2014
    - Ealing Council website: 'Domestic Violence and Abuse?' and related services

17. In addition, the Chair has taken account of two prior DHR reports by Ealing Council, 'Barbara' published in August 2014 and 'Rose' from November 2015, for any parallel learning or repeat lessons to be learned.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

18. With the assistance of the police family liaison officer, MFJ's father, stepmother and aunt were interviewed by the Chair. The Home Office explanatory leaflet was also provided. Given their concerns about the outcome of the trial, the potential benefit from a referral to AAFDA (Advocacy After Fatal Domestic Abuse) was highlighted. Contact details were provided for a long-standing friend who also gave evidence at the trial, however, repeated requests for an interview were not responded to.

19. Rachel was contacted and provided the leaflet through her clinician who confirmed she is well enough to be interviewed. Contact was organised eventually with the assistance of mental health services. Following a brief telephone conversation with the Chair in January 2018 in which he explained the DHR purpose, Rachel reflected overnight and provided the following text message:

    There were lots of shortfalls with how myself and [MFJ] were handled. We asked for help ie anger management and couples counselling from the social services and GP and were told didn't fit criteria. Now, after what's happened I'm still struggling to get help counselling and support. I've lost my children due to unfair reports and I'm struggling with that. I'm in debt due to going to prison and I lost my job and am finding it hard to get a new one. I'm still waiting to be re-homed and sleeping on sofas of friends and mother. We can't go back and change things. But if you can offer help for me now then I would happily talk with you. If not I think it unwise to go back to things that cannot be undone

20. The Panel debated receipt of this message and whether it should be included in full, because only the first sentence is within the scope of the review. The issues raised in the first sentence regarding her experience of services has been incorporated into Panel

discussions. The subsequent concerns raised by Rachel have been referred to appropriate agencies for consideration.

21. Rachel made a second contact by text message in April 2018 when she had heard that the Chair had met with MFJ's family in April and expressed concern that the draft report was blaming in character. A text reassuring that was not the case was sent along with another invitation to participate. Nothing was heard until June when, on the advice of her Social Worker, Rachel contacted the Chair and a meeting was held in Central London. This overview report is more accurate and insightful as a result. She has nominated the name 'Rachel' for herself in the redacted report.

22. MFJ's family were dismayed by the Jury verdict at the trial, citing concerns about the conduct of the prosecution which had been observed throughout by aunt, EF. They were granted and attended a 'bereaved family meeting' with the Crown Prosecution Service (CPS) when 15 questions were put forward for consideration. These were provided to the Chair and a response requested from the CPS which was done. Family liaison in respect of these issues and developing versions of the report have continued in February, March and April. At the latest of the family meetings in April, the Chair was asked to consider whether Rachel had exhibited the behaviour known as DARVO (Deny, Attack, Reversing Victim and Offender)[3] when dealing with professionals in the course of this review. The Panel debated this question and concluded there was insufficient information available on which to draw such a finding. His family have chosen 'M F Jones' and MFJ for the deceased in the redacted report as it was a school nickname he was fond of.

CONTRIBUTORS TO THE REVIEW

23. This review report is an anthology of information and facts from the organisations represented on the Panel, most of which were potential support agencies for MFJ and Rachel, as well as Child A and Child B. They are listed in Table 1 below. Each agency provided an Individual Management Review (IMR) containing their record of contact, their analysis of what happened, identification of good practice as well as any lessons to be learned with recommendations for improvements to the system for safeguarding. IMRs are conducted by a senior manager not connected with the events. The Chair was assured of the independence of Panel members.

24. The school attended by Child A and, within Imperial College Healthcare NHS Trust, Charing Cross and Queen Charlottes and Chelsea Hospitals had records of contact with nothing relevant to this review so IMRs were not requested.

[3] Source: Jennifer Freyd 1997

25. *Table 1 – Agencies and records of relevant contact in the order that it occurred*

Contact period	Agency	Summary of contact
07/12 to 09/16	Local Family Practice	GP services for Rachel, Child A and Child B
08/08 to 09/16	Metropolitan Police Service (MPS)	MFJ involved in various domestic abuse incidents with family members, the last in 05/11 Rachel involved in domestic abuse incident with her mother when pregnant with Child A in 02/09 and harassment from former partner and father of Child A in 02/11 Six domestic abuse incidents (DAI) were recorded involving them as a couple: 1. 02/12 MFJ assaulted Rachel when both intoxicated at night out 2. 06/12 Rachel called police to eject MFJ from her mother's after verbal argument 3. 02/14 MFJ called police because Rachel had refused entry to collect his clothes 4. 01/15 Rachel called police when MFJ assaulted her by body punching and biting her nose after she asked him to leave 5. 10/15 mother of Rachel called police as MFJ had damaged property and made threats to kill and next day committed burglary, leading to MARAC referral 6. 09/16 domestic homicide of MFJ by Rachel
02/09 to 03/16	Ealing Children's Services (ECS)	02/09 assistance provided to Rachel following domestic incident from JK (father of Child A) to identify alternative accommodation when pregnant with Child A 06/09 birth of Child A 02/11 supported Rachel when harassed by former partner JK 06/12 gave advice to Rachel after report of DAI 2 10/13 supported Rachel when pregnant with Child B following visit to local Hospital A&E 11/13 birth of Child B 02/14 supported Rachel following DAI 3 and held Child and Family Enquiry (CFE), concluding 03/14 01/15 provided support to Rachel and conducted further CFE following DAI 4, concluding in 06/15 10/15 provided support to Rachel and conducted further CFE following DAI 5, concluding in 03/16

03/12 to 06/14	National Probation Service (NPS)	05/12 MFJ sentenced to Community Order (CO) of 18 months with 60 days Integrated Domestic Abuse Programme Accelerated (IDAPA) 08/12 MFJ cited for breaching the order and new CO with One-to-One Domestic Abuse Programme imposed 01/13 MFJ breached order again and Court imposed additional 40 hours Unpaid Work (UPW)
04/14 to 04/15	London Community Rehabilitation Company (LCRC)	04/14 Case allocated to London CRC when subject to above order and summons issued for breach 05/14 warrant issued for MFJ's breach 01/15 safeguarding entry by Ealing MASH (nose-biting incident)
04/15 to 09/16	Dorset Community Rehabilitation Company (DCRC)	04/15 to 05/15 MFJ did not attend some of UPW project and breach proceedings letter sent 07/15 MFJ did not attend appointment with PO and summons issued for breach 08/15 breach proceeding withdrawn on technical point. Further enquiries did not resolve and remained incomplete when MFJ died
07/12 to 03/16	London North West Healthcare NHS Trust (LNWHT)	11/13 birth of Child B in local maternity Hospital 09/14 Child B attended Urgent Care Centre - banged head on table while crawling. Not admitted 11/14 MFJ attended local Hospital following overdose with suicide ideation. Not admitted 09/15 Child B taken local Hospital with high fever symptoms. Not admitted 10/15 MFJ attended local Hospital after fall from ladder. Not admitted 03/16 Rachel admitted to local Hospital following inadvertent overdose. Not admitted
12/12 to 09/16	London Ambulance Service NHS Trust (LAS)	12/12 Rachel fell unconscious at mother's home and conveyed to large Hospital 01/13 MFJ felt ill at RACHEL mother's home – call passed to NHS Direct 05/13 Rachel pregnant with Child B fainted at mother's home and conveyed to local Hospital 10/13 police called LAS to address in LB Newham where Rachel, pregnant with Child B, had called MFJ & he believed she may have cut her wrists. Found to be uninjured but became unwell with maternity stomach pain and conveyed by police to hospital 12/13 MFJ suffering with chest pain having been assaulted across back with a candlestick. Bruising observed. Upon assessment when no longer in pain, MFJ declined to be conveyed to hospital

		03/14 Rachel reported pain from contraception device. Telephone assessment that LAS not needed and RACHEL would attend local Hospital 07/14 Rachel reported painful ankle from fall previous day. Referred to NHS 111 03/16 attended call to Rachel who said she had had inadvertently overdosed herself on anti-psychotic medication. Conveyed to local Hospital 09/16 called to MFJ where police applying CPR following two stab wounds to neck and shoulder. Conveyed to emergency department but MFJ could not be saved
05/13 to 05/16	Ealing Housing Demand Department, latterly, A2 Dominion (A2D)	Rachel provided with temporary accommodation in LB Newham until accepted social housing in LB Ealing from 10/13 A2D carried out various repairs to flat occupied by Rachel and MFJ that was scene of homicide No reports of anything relevant noted
10/13 to 03/16	West London Mental Health NHS Trust (WLMHT)	MFJ self-presented twice to local A&E: 11/14 was following a mixed overdose after an argument with Rachel – discharged to father and GP in Bournemouth 12/15 had been kicked out by partner, had been drinking and experienced suicide ideation – assessed and discharged as above Rachel had first contact with perinatal MHS in 10/13 and attended 3/6 sessions offered until 02/14 when urgent referral from GP 03/14 diagnosed with Bipolar II Disorder Referred to Ealing Recovery Team East (ERTE) 11/15 referred to psychotherapy but not taken up 03/16 seen in A&E following self-referral for inadvertent overdose
10/14 to 02/15 02/15 to 03/16	Local Surgery Practice Local Surgery, Bournemouth	GP services for MFJ - seen on one occasion and nothing relevant Last registered GP services for MFJ 02/15 Prescribed citalopram for depression. No suicide or self-harm ideation. Interim review 03/15 last time seen

THE REVIEW PANEL MEMBERS

26. *Table 2 - Names of the Panel members, their agency, roles and job titles*

Name	Agency/Role
Joyce Parker	London Borough of Ealing (LBE) Community Safety Team Leader
Carolyn Fair	LBE Children's Services, Director Child and Families
John Churchill	LBE Children's Services Head of Safeguarding
Kogie Perumall	LBE Children's Services
Robert Bradshaw	LBE Children's Services IMR author
Jack Dempsey	LBE Housing Head of Housing Allocation
Sophie Shah	LBE Adult Safeguarding Lead
Richard Christou	Ealing CCG Designated Adult Safeguarding and Clinical Quality Manager
Alena Buttivant	NHS England
Jeremy Mulcaire	WLMHT Social Care Lead
Parminder Sahota	WLMHT Safeguarding Adult Lead
Sandra Rose-Campbell	LNWHT Named Nurse Safeguarding Children
Catherine Wilson	London Ambulance Service NHS Trust (LAS)
Antony Rose	National Probation Service (NPS)
Moriam Baruwa	A2 Dominion (Ealing Housing Provider)
Natalie Norris	Metropolitan Police Service (MPS) Ealing Borough Community Safety Unit (CSU)
Janice Cawley	MPS Specialist Crime Review Group and IMR author
Meena Patel	Southall Black Sisters*
Kay Wale-Ajasa	Hestia*

Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

*Provided specialist domestic abuse advice and were not able to attend all meetings, but were given the opportunity to comment on each iteration of the overview report

AUTHOR OF THE OVERVIEW REPORT

27. Set out in appendix 2 are the respective background and 'independence statements' for Bill Griffiths as Chair and author and Tony Hester who managed the review process and liaison with the CSP and Panel.

PARALLEL REVIEWS

28. When the DHR Panel was convened in May 2017, the criminal trial had already concluded. There are no misconduct allegations. Following the conclusion of the criminal trial, the Coroner closed the Inquest in July 2017. Ealing Children's Safeguarding Board has considered and decided against the need for a joint Serious Case Review with respect to Child A and Child B.

EQUALITY AND DIVERSITY

29. Consideration has been given to the nine protected characteristics under the Act in evaluating the various services provided. Both parties and the children are White British. Rachel was diagnosed with Bipolar Disorder type II in October 2015 and this can be considered a disability within the Equality Act if assessed by a Medical Clinician, which was not the case. Under the Care Act, the diagnosis would come under the umbrella of her having a "care and support need". There are reports that both MFJ and Rachel had attempted suicide and could be considered "adults with care and support needs".

DISSEMINATION

30. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

BACKGROUND INFORMATION (THE FACTS)

M F Jones

31. M F Jones was born in March 1991 to AB and CD who divorced in 1992. MFJ stayed with his mother but then moved to live with AB and his new partner, EF, shortly after they married in 1995 and they successfully applied for custody. In 2002, AB and EF separated, and MFJ moved with his father to New Milton, Hampshire. He remained there until he was 16 when he moved back to London to live with his paternal grandmother. He appears to have moved with her when she entered sheltered accommodation and police records indicate he was not permitted to stay there on a permanent basis.

32. MFJ was known to the police between 2008 and 2010 for a series of ten domestic incidents involving him, his father and, occasionally, the paternal grandmother who had become disabled, hence the sheltered accommodation. These were minor disputes, such as over who should have control over the TV channel, that escalated into noisy arguments. In November 2008 when aged 17, MFJ assaulted his father as he ejected him from the flat, for which he received a referral order. In January 2010 (when 18), MFJ was convicted of affray and criminal damage of his grandmother's possessions at the flat and sentenced to a conditional discharge.

33. The eleventh and last time the police were called in this context (May 2011), MFJ was found in the communal area of the accommodation with a mouthful of tablets that he attempted to swallow. He was taken to hospital for treatment.

34. Throughout his life, MFJ maintained a positive relationship with his maternal aunt, JK and his stepmother, EF, and she ran a business that provided him with occasional work in market research. He was also involved in telephone sales and bar work[4]. This suited his gregarious nature and he was good at cultivating productive client relationships. He was described by work colleagues as open-hearted, easy going and funny, yet sensitive with a charming manner. He was popular with the team.[5]

Rachel

35. Rachel was born in July 1989 and lived with mother, LM, her two sisters and their brother. LM parted from Rachel's father before she was born and she has met him only twice. LM became mentally unwell with bi-polar disorder and Rachel was placed in foster care from the age of 8 to 13, then lived with her paternal grandparents in Somerset followed by an aunt and uncle in the same county.

36. Rachel returned to London to live with her mother in 2006 when aged 16. A relationship she had formed with PQ continued and she fell pregnant with Child A (born in 2009). In early February 2009, Rachel reported to police that her mother had started shouting at her for no apparent reason. She was concerned because of her pregnancy and the fact that

[4] In November 2012, he reported to a Probation Officer that holding three jobs at once
[5] Source: EF and JK

her mother had not been taking the medication she was prescribed for her mental health condition. She was advised to contact her GP for assistance.

37. A week later, an anonymous caller alerted police to loud screaming at the house and, on arrival, this was LM who was taken into custody for mental health treatment[6]. Rachel was present at the home. About three weeks after that, Rachel had cause to feel alarmed when a man entered the house using a key he had been given by her mother. He left, but shouted abuse outside and Rachel called police who assisted to relocate her with her maternal grandmother.

38. In June 2009 she had a daughter, Child A, from PQ who was considerably older. The relationship broke down soon after the birth. Subsequently in February 2011, Rachel reported harassment and threats from Child A's father which the police dealt with by the arrest of PQ and, with Racel's approval, a warning was given and the harassment ceased.

39. Rachel left school aged 16 with 9 GCSE passes and initially worked in a hotel. She then found regular employment in the retail jewellery trade and, at the time of the fatal incident, was an Assistant Manager. In March 2014, Rachel was diagnosed with Bi-Polar Disorder Type II, meaning she suffered from predominant depression with relatively mild hypomanic episodes.

Their relationship together

40. M F Jones met Rachel in 2010 when he was 19 and she 21. They moved in with LM who had been discharged from hospital with prescribed medication for her condition. When Rachel was pregnant with Child B, they lived in provided accommodation in Newham until housed at the Ealing flat from October 2013, where, in November, they had Child B together. It appeared to be an 'on/off' relationship throughout with MFJ moving out to live with his father in Bournemouth from February 2015. Rachel would say that they were together, just not living with each other all the time. MFJ had returned for about three weeks before the homicide.

41. Witness statements gathered from friends and family during the homicide investigation and interviews with AB, CD and EF provided conflicting views of MFJ and Rachel's relationship. MFJ's family members say that Rachel was jealous and controlling of MFJ and allege that she had assaulted him. There are examples given of MFJ challenging Rachel regarding women he was supposedly 'eyeing up' and one occasion when she threw a drink over his head at a party and slapped him (acknowledged as correct by Rachel at her trial). Another incident from stepmother CD's experience occurred when MFJ had left the relationship to stay with her. Rachel's behaviour was "like a Banshee" when she followed him and the door was answered.

42. EF recalls there were a number of occasions when Rachel would throw MFJ out of the flat as his name was not registered there and she had full control. MFJ would be told to leave,

[6] This was a frequent experience for Rachel when growing up

often late at night, essentially with nowhere to go. MFJ did not want his family to know the full extent of what was happening and did not always reach out to them for support.

43. On one occasion he did when Rachel threw him out with literally nothing apart from what he was wearing. He asked to stay with EF and she advised him that he should not carry on in such a dysfunctional and toxic relationship. EF called Rachel the next day and asked if she would allow MFJ to collect some belongings to at least enable him to change his clothes for work, but she was not willing to allow him to do this. EF gave MFJ money to buy some clothes and then noted that Rachel bombarded MFJ with calls and they were back together by the next day. When this harassment by social media occurred, EF noticed that MFJ's demeanour would change. She observed he felt "suffocated" by always needing to prove where he was and what he was doing.

44. There are no police reports of assault by Rachel on MFJ. However, in June or July 2015, MFJ called on CD and she noticed he had a cut on his upper left arm that he admitted when questioned had been inflicted by Rachel with a knife. A photograph of MFJ carrying Child B with a scar clearly visible on his left arm was provided to the Chair to corroborate this allegation. MFJ's family are concerned that the evidence provided in a witness statement by CD was not adduced at the trial. The Case Officer did bring it to the attention of Prosecuting Counsel when he was informed about the photograph, but the decision was taken that it had been brought to notice too late in the trial process to be introduced as evidence.

45. What was adduced, and acknowledged by Rachel in evidence at her trial, was an incident known to the LAS in December 2013 when called to the flat because MFJ had chest pains and difficulty in breathing. It was explained that his partner (not named) had twice struck him across the back with a candlestick. Examination showed red marks and bruising across the back. He recovered and was left with pain relief medication. The LAS did not share this information with the police or, apparently from the record of contact, consider possible safeguarding concerns, both which were omissions.

46. On the other hand, Rachel's friends and family were aware of unreported violence by MFJ against her. Rachel referred to this when interviewed about the homicide and said she had not reported the incidents as she did not want Social Services to become involved and then consider taking her children into care. In addition to the domestic abuse incident known to the LAS and prior to the fatal incident in September 2016, there are five domestic abuse incidents reported to the police by Rachel or her mother between February 2012 and October 2015. These are set out in the timeline below.

47. One feature of their relationship that emerged at the trial was the extensive text traffic between them that, in transcripts provided to the Jury, was counted in thousands. An impression gained from this evidence is that Rachel suffered from low self-esteem and needed a great deal of reassurance. She was in the habit of calling MFJ if he was socialising with friends, then demanding to speak to that person to verify he was not with another female. If he did not respond to a call or a text, she would send an 'essay' of a rebuke. At the beginning of September 2016, her messages can be interpreted as

pleading with him to return from Bournemouth to live with her again. This evidence reveals a pattern of controlling behavior.

48. MFJ could be critical also in his text messages to Rachel, for example: "You are the most difficult person I know", and "No one else would have you". It seems that neither could leave 'unfinished business'; much of the bickering ("like children" according to EF) was so as to have the last word in the argument.

49. As parents, each was observed to be loving to the children. MFJ treated Child A as his own and she regarded him as her father. However, there were some concerns recorded regarding the impact on the children of observing parental arguments.

Timeline of reported domestic incidents and other significant events 2012 to 2016

50. There are six domestic abuse incidents reported to the police and one to the LAS in the seven years of their relationship, the seventh incident being the fatal one. These are set out within a chronology of what was known to public bodies and their involvement with MFJ and Rachel. There is no known contact with voluntary agencies.

2012

51. In February 2012, MFJ and Rachel had been on a night out in Uxbridge for her sister's birthday. As MFJ became intoxicated, he began to argue with her. She alleged that when they left the nightclub, MFJ grabbed her round the throat and throttled her until two witnesses intervened. Police attended and arrested MFJ who admitted assaulting Rachel and the two witnesses.

52. MFJ told his family that the incident started when Rachel threw a drink over him. He left the club and she chased after him, striking him with a stiletto shoe. The throat grabbing was to stop her assaulting him. He admitted being responsible for the whole thing because he was concerned at the impact on Child A if Rachel was arrested. The police record of interview has been checked and MFJ did not advance any of this version when afforded the opportunity to do so. He was legally represented in interview and, presumably on advice, admitted responsibility for the three assaults.

53. The CRIS (Crime Report Information System was correctly 'flagged as a domestic abuse incident and the risk assessment was 'standard', the choices being standard, medium and high. However, the DASH (Domestic Abuse, Stalking and Harassment) risk identification checklist was not completed. There is no record of referral to support services being offered to Rachel, albeit the Victims Code of Practice (VCOP) was complied with.

54. The MPS Domestic Violence Standard Operating Procedures (DV SOP) in place in 2012 required five-year intelligence checks be completed but, if they were carried out in this investigation, the results are not recorded on the CRIS. Research should have identified that Rachel had a daughter and therefore a MERLIN[7] Pre-Assessment Check (PAC) was

[7] The report of a child coming to notice that the police share with relevant agencies

required. This was a missed opportunity to inform Children's Social Care that Child A may be exposed to domestic abuse at home.

55. The evidence file was referred to the Crown Prosecution Service (CPS) and authority given to charge MFJ with three counts of common assault and he was bailed to attend court. In May 2012, MFJ pleaded 'guilty' to the three charges and was given a Community Order of 18 months' duration with 60 days' activity under the Integrated Domestic Abuse Programme Accelerated (IDAPA).

56. This involved the National Probation Service (NPS). MFJ initially denied to his Probation Officer (PO) that he was still in the relationship with Rachel, then confirmed it was current but they were not living together. Following several non-attendances to see his PO, he was brought back to Court for breach proceedings in August 2012. The original order was revoked and replaced with a new Community Order with a One-to-One Domestic Abuse Programme imposed.

57. One evening in late June 2012, Rachel called police to request assistance to get MFJ to leave her mother's address in West London. When police attended, Rachel said they were no longer required as MFJ had left whilst she was calling police. She was reluctant to allow the officers to enter, but did so, and completed a statement confirming that a verbal disagreement had taken place.

58. A DASH risk assessment was completed. Negative responses were given to all questions in the pro forma and the risk assessed as 'standard'. In line with extant policy, a MERLIN was completed in respect of Child A who was asleep and did not witness the incident.

59. The police MERLIN report received by Ealing Children's Services (ECS) stated that this appears to be the first domestic incident between Rachel and her boyfriend [MFJ]. This inaccuracy was possibly because of a different spelling in the document or, more likely, due to lack of a 5-year intelligence check that should have been discovered and reported that MFJ was on a Community Order for domestic assault and abuse of Rachel. This omission was not picked up in the secondary supervision phase in the Community Support Unit (CSU), but Rachel was sent an information letter containing support services information.

60. The MERLIN report disclosed that Child A was asleep and did not witness anything and was observed by police to be safe, well and happily playing with her toys, which would have provided reassurance to ECS social workers. A week later, SAFE team (Ealing's early help service) involvement was offered by ECS and declined by Rachel because Child A "had not been exposed to regular violence or arguing".

61. Meanwhile, MFJ's attendance record with probation improved and he also reported planning to go on holiday in August 2012 to Turkey with Rachel and Child A, that he told the Court had been booked prior to the breach proceedings. The domestic abuse sessions between MFJ and his PO commenced in October 2012, covering subjects such as relationships, negotiation and analysing and understanding the nature of violent and abusive behaviour. Case scenarios were used, and MFJ acknowledged that there had

been verbal arguments that had not escalated into violence. He also displayed a tendency at times to deny the original incident, saying that Rachel had initiated it.

62. In December 2012, the London Ambulance Service were called to LM's address where Rachel was unconscious, having fallen backwards into a mirror. She was unresponsive with her eyes open for several minutes and her legs were shaking. She could hear LM and MFJ trying to rouse her, but she could not respond. She was conveyed to Charing Cross Hospital accompanied by MFJ. She did not allege any alternative account to the ambulance crew or at the hospital.

2013

63. Second breach proceedings in January 2013, due to non-attendance, commonly blamed by MFJ on work or health commitments, resulted in a more onerous requirement of 40 hours Unpaid Work (UPW) to run alongside his Community Order. In April, MFJ told his PO that things had come to head with Rachel, he had walked out and she had asked him back. He would only return if LM was present to ensure no breach of the peace. Within a week, he reported that things were stable.

64. In early May 2013, the LAS were called to LM's home where Rachel, who was 11/40 weeks pregnant with Child B was found on the floor by her mother and it was not known how she had got there, although it was established that she had suffered from headaches for two days prior. She was conveyed to Hospital with her [recorded as] 'boyfriend'.

65. Also in May, LM's mental health condition relapsed and she evicted Rachel, who by now knew she was pregnant with Child B from MFJ. Emergency accommodation was provided to Rachel in the London Borough of Newham and MFJ went to live with his stepmother in West London for a few weeks. Whilst living in Newham, Rachel continued to take Child A to school in Chiswick. In June, MFJ reported to the PO that there had been verbal arguments which he reassured had not led to physical confrontation.

66. At this point he asked for assistance with housing but declined to provide details or sign forms to re-start the One to One Domestic Abuse Programme because he was unhappy at the prospect of Social Services involvement. In July, MFJ disclosed that he and Rachel were frequently arguing. He admitted being verbally abusive but said that she provoked him. By September, he reported the relationship as 'harmonious and stable'.

67. In mid-October, MFJ called police from Bournemouth where he was staying with his father. He reported that Rachel had called him from the Newham address, was in distress and "had done something stupid". He believed that she may have cut her wrists. She was eight months pregnant and her daughter, aged 4, was there with her.

68. On further enquiry, MFJ said that Rachel was hysterical and told him she would "end it all". They had argued the preceding Friday and she had kicked him out. She demanded that he return to look after Child A, but he was not in a position to do so. He did not know if she had self-harmed before. The call operator researched available records, found a link to the second reported incident and alerted the LAS.

69. Police officers attended within nine minutes and found the door wide open. They spoke to a neighbour and ascertained that Rachel had left two minutes earlier. The flat was searched without trace of Rachel or Child A but they returned shortly after. Child A was spoken to separately and assessed as safe and well. There was no sign of injury to Rachel, by self-harm or otherwise. The LAS were cancelled but, at this point, Rachel experienced stomach pains. There was no ambulance available for urgent deployment, so the officers conveyed Rachel and Child A to a Newham Hospital, where she quickly recovered, and no treatment was required.

70. A MERLIN PAC was completed for the unborn Child B and shared with Newham social services the next day. The 'Families First' team made three visits and left letters but were not able to contact or assess Rachel and Child A. It was considered that the criteria for the Families First approach were not met, by which time Rachel had moved back to Ealing.

71. Rachel says that MFJ had, in fact, fled to Bournemouth having assaulted her by angrily clutching her arms causing bruising and became worried about what he had done. She says the bruising was noted on her arrival at Newham General Hospital. It has not been possible to verify any medical evidence as written consent was not provided.

72. A few days later, Rachel was seen by the psychiatry liaison team at her treatment Hospital in relation to thoughts of self-harm (she talked about cutting herself with a bread knife). The assessment was that there was non-significant risk to herself or her unborn child at that point in time. She was, however, booked for a further review the following week.

73. The next day, Rachel telephoned the hospital about having thoughts of harming herself. Rachel disclosed that she was living in Newham and was referred to Newham Children's Services for assessment. Later in October, MFJ told his PO that, following another verbal argument, he had walked out and gone to live with his father in Bournemouth.

74. About a week later (having been referred by her GP in August), Rachel was seen in clinic for initial assessment by the perinatal psychiatric nurse specialist from hospital. She was given a diagnosis of moderate depressive episode and commenced on sertraline 50 mg once a day. She says that she did not take the medication. It was noted that no immediate risk was elicited to self or others. There was a risk of postnatal depression if her mood did not improve which included a risk of bonding and attachment difficulties with the new born.

75. Follow-up was arranged with GP, IAPT (Improving Access to Psychological Therapies), community midwifery, health visiting and referral to Sure Start. She attended three of the six sessions offered by IAPT up to February 2014. She did not attend the last session but was given telephone advice to seek an urgent psychiatric assessment for her mood swings.

76. Housing records show that, from late October, Rachel and Child A were provided with a social housing flat in Ealing and they moved early in November.

77. In mid- November 2013, Rachel gave birth to Child B in maternity hospital. MFJ moved in with her and the two children at the new flat. It is documented that at discharge Rachel was asked about domestic abuse, but she denied any. The records also note that she denied living with her partner and father of Child B but that he stayed 2-3 nights a week to support her.

78. In early December, a Health Visitor made a new birth visit with no concerns noted. Rachel reported as 'normal and pleasant'. A supervisor directed that, due to the client's history of depression, a mood assessment check be undertaken.

79. Two days later, the LAS were called to to the flat by Rachel to a 22-year old male with chest pains [MFJ]. She informed that she had struck him on the back some 30 minutes earlier, but the symptoms had just come on. Rachel has subsequently disclosed that Child B had been crying a lot since birth and MFJ became angry and started shouting at Rachel. She struck him with the candlestick as a proactive defensive measure.

80. On arrival, the LAS crew recorded that, following an argument, Rachel had struck MFJ twice across the back with a candlestick. Red marks and bruising across his back were noted, but the pain symptoms had subsided, and MFJ declined to be conveyed to hospital. The LAS crew documented that there was a new baby at the home and, in line with procedure, should have made a safeguarding referral but this was not done. They also omitted to inform the police of the assault that had been reported to them.

81. These two omissions are acknowledged as an oversight and it has not been possible to establish why this happened. London Ambulance Service NHS Trust has issued a bulletin to staff that includes the expectation that all domestic assaults encountered will be reported to the police and, when children are in the household, safeguarding services.

82. As the result of this incident, MFJ returned to live with his father in Bournemouth and began negotiating contact with his son, Child B, through a family mediation service.

2014

83. In mid- February, there was an urgent referral by Rachel's GP to Ealing Assessment Team (EAT) with cconcern about her erratic mood and poor sleep, although no thoughts of harm to self, others, or suicidal ideation noted at that time. After failed telephone communication and non-attendance at one appointment, Rachel was seen in March (see below).

84. It seems at this stage in the relationship that MFJ regularly stayed at weekends with Rachel and, a week after the referral above, he called police for assistance to recover his property from the flat, but Rachel had denied him access. He explained that earlier that day, Rachel had asked him to leave as she believed he was being disrespectful. He had left but his clothes were inside. The officer interviewed Rachel who claimed that she had purchased all the clothes and had the receipts to prove it. She added that she was not willing for him to remove the clothing so he could: "carry on seeing other women in them behind my back". Rachel now acknowledges that she was being petty and awkward but

she was angry with him because he was drunk, not something that was noted by police at the time.

85. The officer felt that this was essentially a civil dispute but did ask Rachel to answer the DASH risk assessment questionnaire. She declined because she felt it was a minor incident. She did disclose she had a three-month old baby with MFJ and that she had been diagnosed with bi-polar disorder. MFJ became angry that he had not got what he wanted and walked away from the scene.

86. Rachel made it clear she would not engage further with police and a DA report book was not completed, but a MERLIN PAC in respect of Rachel's disclosure about Child B (but not Child A) was. Had 5-year intelligence checks been correctly completed, the two previous DAI's should have been picked up and the fact that Rachel had another child. Proper supervision within the CSU was also lacking and the report was closed without further action.

87. In early March (the reason for a 13-day delay is not clear), an ECS Social Worker (SW) contacted Rachel and MFJ by telephone to seek consent for agency checks. Rachel refused consent for agency checks but the Social Worker explained that she needed to "make checks for safeguarding reasons". MFJ consented to checks being undertaken

88. A check with the mental health trust revealed Rachel's provisional diagnosis, including that she has Bi-Polar Disorder Type II, meaning predominant depression with relatively mild hypomanic episodes. Agency checks were undertaken with Probation and Mental Health. The Mental Health service worker in Ealing Assessment Team is quoted as saying she:

> *"was recommending mother is seen by a psychiatrist in order to get a diagnosis. She reports that mother has mood swings and there may be Bi-Polar disorder traits…she said that mother reports she has been seeing things [example given]… she explained it is possible mother has post-natal depression with psychotic features. The Mental Health service worker said it was her view that mother poses no risk to the children because the children are her protective factor. She further commented that mother loves her children and she has good insight into her mental health."*

89. A subsequent call to the ERTE reported that there was no written record of the shared EAT concerns. Rachel was seen on two weeks later and denied that she had experienced [*the example given*]. She then disclosed her fear of being honest about her mental health because she understood that information is shared between agencies and is acted upon. This appears to indicate a more general strategy to prevent agencies knowing about the difficulties she was having, an approach that is also observed in MFJ's attitude to contact with agencies.

90. Checks were undertaken with Child A's school and with the health visiting service which did not raise safeguarding concerns. There are no records of contact with the Police, Sure Start (or Home Start who Rachel said were involved), with MFJ or with Newham Council. There is a comment recorded that Rachel said Newham took no further action in respect of the Ealing referral (confirmed in writing and via phone) in October 2013.

91. Rachel refused to attend a meeting if it involved the school and the health visiting service but agreed to meet with the Social Worker (SW) and the mental health team. The recording indicates an appropriately more assertive approach with Rachel around the need for information sharing notes. The conversations (which are well recorded) conclude with a discussion with the Recovery Team East which communicated the Social Worker's recommendation that:

    "ECIRS close the case in light of mother engaging with CMHT, being compliant with her medication and presenting with stable mood. I explained … that the case would be transferred to her team shortly in order for mother to receive 2-3 monthly reviews at their outpatient clinic. I discussed with… Recovery Team East [that they] should make a referral to ECIRS if there are any safeguarding concerns due to mother's mental health."

92. The decision around case closure was informed by Rachel's suspicion of social services involvement and a judgement that she was more likely to take advice and confide in CMHT and health visiting services. Case Closure involved appropriate sharing of information with the school, health-visiting and mental-health services. There is no evidence of SAFE support being offered at this point.

93. The IMR author notes that there is evidence on file of appropriately challenging social work. However, it would have been reasonable at this point to have checked with all services (in particular with Newham Council and Home Start), to have met with MFJ and to have used the Assessment Framework and Barnardo's DV risk assessment matrix to assess the risk of continuing domestic violence. This would have provided more robust analysis to inform the decision about whether to close the case.

94. At the March EAT clinic with Rachel, the nurse made a provisional diagnosis of possible Mood Disorder or Postnatal Depression with psychotic features. A crisis card with out-of-hours number plus advice to access A&E services if needed, was provided and an out-patient appointment given four days later. The EAT Doctor's probable diagnosis was of Bipolar II Disorder. Rachel was commenced on quetiapine 25mg for one week and then to increase to 50mg. The sertraline was stopped and planned to review in 6 weeks. She was referred to IAPT for CBT assessment.

95. The nurse had also liaised with Child and Families (C&F) team to make them aware of the assessment and to ascertain if the children were open to the child and family social work team which they were and a professionals' meeting with Rachel held in late March. The role of C&F services was explained and that they had to share information with her daughter's school and the health visitor. Rachel said that she was managing to care for her children and that if she was having difficulties she would ask for help. She was reassured that C&F may not need to have any further involvement and she would be contacted once discussed with C&F manager.

96. Rachel discussed her current mental health diagnosis and type of medication she was prescribed. She had insight into her illness and the need to engage with mental health services. She agreed to follow-up and monitoring with the Recovery Team. She reported

that since she increased the quetiapine to 50mgs; she had been feeling more sedated and irritable. Following discussion with the doctor, this was reduced to half the dose.

97. Rachel was transferred to the Ealing Recovery Team East (ERTE) and appointments made between May and September were either cancelled by them or Rachel did not attend. A reminder letter was sent and copied to her GP but there was no further contact and she was not formally discharged. Rachel has challenged the perception that this was deliberate evasion, putting it down to a combination of work commitments and travel difficulties. She did not gain the impression that these appointments were important.

98. At Hammersmith Magistrates Court, in late May, the court issued a warrant not backed for bail in relation to MFJ failing to comply with his Unpaid Work. By this time, his supervision had been transferred from the NPS to London Community Rehabilitation Company (LCRC) due to restructuring of the service.

99. In June or July, EF noticed that MFJ has a cut on his upper arm that he alleged was caused by Rachel. A scar is visible on the photograph supplied by his family. Rachel has subsequently disclosed in her account of this incident that MFJ had arrived at the flat drunk and was shouting through the letter box to be allowed in. They argued and he threatened her with a kitchen knife. They grappled together, falling to the floor and the cut was caused in the struggle. In her opinion, it was more of a scratch than a cut and did not require medical treatment, other than being covered, and that the scar in the photograph was not noted by the pathologist who examined MFJ's body.

100. In late November, MFJ self-presented to the local Emergency Department (ED) following a mixed overdose. He reported to be experiencing unspecified problems with his partner [Rachel]. He felt down and angry, regretted the overdose and had no further thoughts of suicide. He was discharged home and was reported to be living with his father in Bournemouth.

101. MFJ attended the Hammersmith GP practice with Rachel on at the end of December, the only occasion he was ever seen there. He reported that he had been feeling down for about a year, worsening in the last few months and reference was made to the overdose incident above. He found that he "snaps easily", can become angry over minor things and admitted being verbally abusive to Rachel. There was no drugs or alcohol involved. She told the GP that she was not afraid for herself but was scared at the harm he might do himself. She confirmed that they have two young children and MFJ had never shown anger or aggression to them. They asked for help with counselling. Citalopram was prescribed for depression (2 weeks) and a counselling referral letter would follow. He was warned that social services may be involved because of the children, but it is not clear if this notification was in fact made. In any event, MFJ did not attend the follow-up appointment. Rachel says this was because he had moved to Bournemouth with his father.

2015

102. In mid-January 2015, Rachel called police alleging MFJ had attacked her when she asked him to leave. Police attended and MFJ had left. Rachel explained that MFJ had been staying with her over the Christmas period and they had argued regarding Child B's nursery placement. She said she asked him to leave and he asked her for the money for the train back to his father in Bournemouth. He started a phone call and then suddenly grabbed her, forcing her into the child's bedroom where he but his hands around her neck and tried to bite her nose. Rachel says she struggled with him and scratched his face to defend herself. She then overheard MFJ say to his father he was going to kill her. Rachel used the landline to make the emergency call to police. At this, MFJ grabbed his bags and left before the police arrived.

103. The officer noted Rachel had a small cut to her nose and reddening around the neck. She declined to answer the DASH risk questions, as well as to accept the offer of medical assistance or referral to support agencies. She did disclose that MFJ was controlling and jealous. She had tried to end the relationship in the past. Based on the available information, the DASH risk assessment was standard. A MERLIN PAC was completed for attention of Children's Services.

104. Intelligence checks revealed that MFJ was wanted on an arrest warrant for breach of the Community Order but the 'any other intelligence gathered' section was not recorded on CRIS. The investigation was assigned to the CSU. Enquiries were initiated to locate MFJ and Rachel was eventually visited 7 days after the incident. She showed them a letter from a mediation company in Bournemouth seeking access for MFJ to Child B. She did not know where he was staying in Bournemouth. The officers must have developed a safety concern because a 'Special Scheme'[8] was authorised for the address. However, there was no review of the risk level which remained at standard. There is no record that the mediation centre was asked for MFJ's location.

105. Both LNWHT and ECS report that this incident was discussed at the MASH (Multi Agency Safeguarding Hub) but the only follow up noted there was to share the information with MFJ's current Community Rehabilitation Company (CRC) officer. The case was at this point transferred to the SAFE team in ECS.

106. Five days later, authority was given by a Detective Inspector to record MFJ on the Police National Computer (PNC) as 'wanted' for the attack on Rachel. It was then established that MFJ had been detained on a few days earlier in Bournemouth for the breach of his probation order and had been bailed to his father's home. A supervisor directed that a review be conducted and a comprehensive DA history was added to the CRIS record.

107. MFJ was arrested for this allegation by Dorset Police two days later and transferred to Acton custody suite. When advised of this development, Rachel withdrew her support for a prosecution because MFJ did not live with her anymore. In interview, MFJ declined legal advice and denied grabbing, biting, pushing or punching Rachel. Since moving back to his

[8] A 'flag' on the location with current information in the event of emergency calls

father in Bournemouth he had been in daily contact with Rachel in cordial terms. The investigator referred an evidence file to the Crown Prosecution Service (CPS) for advice and it was that no further action be taken. MFJ was released from custody with cautionary advice about future contact with Rachel.

108. The IMR author has highlighted that prompt registration on the PNC of MFJ as wanted for this offence would have led to an earlier arrest. An analysis of the intelligence research coupled with the heightened risk factor (strangulation) apparent in this incident should have prompted a re-evaluation of the risk level and consideration of a referral to a Multi-Agency Risk Assessment Conference (MARAC) based on professional judgement. Consideration could have been given to the use of a Domestic Violence Prevention Notice (DVPN) as an additional safeguard for Rachel.

109. In mid-February, Rachel complained to her GP of feeling low and had recently broken up with her partner. She was referred to the ERTE. She said that she had stopped taking the prescribed medication since her last appointment in July 2014. Numerous attempts at contact were mostly unsuccessful. The few that led to appointments were not then attended.

110. Almost a week after that, MFJ attended the Local Surgery in Bournemouth. He had split with his partner and moved to live with his father who was supportive, hence the change of GP. He confirmed that he had seen his GP in London for depression in December. He was not thinking of suicide or self-harm and did not abuse drugs or alcohol. A higher dose of Citalopram was prescribed and a self-referral to counselling recommended. An interim review of his depression in March did not result in change to medication and he was not seen again at that practice.

111. In March, the Offender Manager (OM) at the Dorset CRC assigned to take over supervision of the case contacted MFJ to arrange an induction meeting. He did not attend because his request to have Child B present was declined. The London OM contacted MFJ and explained that the report of the fifth reported incident had caused safeguarding protocol to be followed. MFJ reacted negatively to then being contacted by social services and criticised the OM for causing inappropriate concerns to be raised. He was angry at the perception that he was a danger to his son and wanted to make a recording of the meeting that was held to explain safeguarding policy.

112. It was noted that the investigation would not be taken further and that the observation of MFJ with Child B was positive: “He was actively involved with [Child B] throughout the session and appeared to be a calming influence towards [Child B]. I observed [Child B] to be a very happy well looked after child, he was clean and smiling throughout the session”. MFJ agreed to attend the induction in Dorset.

113. A SAFE Assessment completed in late March was positive about Rachel’s parenting skills. It described controlling and violent behaviour from MFJ (who was not seen during her assessment). The ‘professional opinion’ recorded the children being at risk of witnessing further aggressive behaviour towards their mother which could have a negative impact on their development and well-being if MFJ returns to the family. The SW thinks

that is likely given Rachel's continuing 'strong feelings' for him. It was noted also that Rachel: "Has limited understanding of the impact of Domestic Violence on child development".

114. It appears that Rachel found the assessment challenging to the extent that it led her to complain and to refuse to work with the SAFE service and she did not share the SAFE service's view that continual exposure of the children to domestic violence was likely and that such exposure was harmful to the children's development. The Social Worker also reported that the flat smelt of cannabis and Rachel has since disclosed that she strongly reacted to this assumption because young people on the estate where she lived openly smoked cannabis in the street nearby and the odour had drifted in. She felt unfairly accused of drug use when she had never done so and her reaction informed her attitude thereafter to the SAFE service.

115. The transfer to Ealing Locality was delayed until the end of March and the C&F assessment occurred 2.5 months after the fifth reported incident in October. In the C&F assessment, MFJ is said by Rachel to be receiving treatment for anxiety and he talked himself about receiving treatment for depression at this point. He also refers to an intention to do work on anger management. Rachel and MFJ both contend that they are not in a relationship. The assessment echoes the SAFE assessment concluding that further violence is likely if the parents resume their relationship. The assessment concludes that there is not enough evidence to suggest the family meet the threshold for Social Care Intervention. The case would be closed with the proviso that if the family come to the attention of Social Care again and they have not undertaken actions [around not resuming their relationship without undertaking work] outlined in the plan then serious consideration should be taken for Child Protection procedures to be undertaken to support the family. The case was closed in early July.

116. During April and May, MFJ attended for UPW on some occasions but not others. Breach proceedings were commenced and later discontinued for 'legal reasons'. He did not attend the supervision visit with the local PO in July and, due to the expiry of the original order, the case was closed. Nonetheless, the OM contacted ECS with concern that MFJ may have resumed contact with Rachel with an undertaking to send a referral that was not followed up:

> *"There is a history of DV involving [MFJ] and the mother of his child. The reason for the call was the suspicion that [MFJ] may have returned to London and tried to start up a relationship with the mother again. There is no firm evidence for this at present. After discussion about the risks and the on/off nature of the relationship we agreed that I would e-mail a copy of our referral form to [the Probation Officer] and he would in the meantime write to the father requesting reassurance that he had not struck up a relationship with the mother again. If there is no reply from [MFJ] within two weeks Bournemouth Probation intends to send in a referral."*

117. In mid- June, MFJ attended RISE (alcohol misuse service) on a voluntary basis. At the time he claimed he had two weeks of alcohol abstinence[9]. He did not attend again.

[9] Source: MARAC Minutes 08/12/15

Rachel has since disclosed that MFJ told her that a friend of his who did have a drink problem used his name to register at RISE. It has not been possible to verify either way if it was MFJ who attended.

118. In early October, Rachel required confirmation of her condition for a benefit claim and she was seen by a doctor. Her current mental state, which was mild to moderate depression, and history was reviewed and it appeared consistent with a diagnosis of bipolar disorder. She was provided with literature on her condition and medication and a follow-up appointment two days later. The doctor confirmed the diagnosis of bipolar disorder type II.

119. One evening in late October 2015, LM called police from the Ealing flat because MFJ was outside punching the windows. She added that there were two children inside the flat. The call handler recorded on the log that banging could be heard in the background. Police attended and spoke with Rachel who said MFJ had been staying with her for a few days so that he could see his son, Child B. She said she had a discussion with him about him getting a job as she needed some financial assistance with the children and she worked full time.

120. At this, he became moody and stormed out of the house only to return a few hours later smelling of alcohol. She believed he had been back to his father's home in Bournemouth. When Rachel asked why, MFJ flew into a rage and began hitting doors around the house, causing dents and then breaking the toilet cistern lid and bath panel. He was also verbally abusive with the children present so she ejected him from the house.

121. LM had been contacted and arrived at the flat and Rachel managed to keep MFJ outside while LM gained entry. They called police because it was possible that MFJ could force entry. In addition to the damage caused, MFJ had taken her bank card and withdrawn £30. Both reported they heard MFJ make threats to kill Rachel from outside. He ran off once he was aware police had been called. Rachel agreed to stay with her mother whilst police attempted to locate MFJ. This interview was recorded on a body worn video (BWV).

122. The officer completed a DASH risk assessment with Rachel which revealed several heightened risk factors were present and the risk was graded medium. The intelligence checks that were undertaken did not identify all prior DA incidents. The CRIS was supervised by the Duty Inspector who acknowledged there was a history of domestic abuse, but re-assessed the risk as standard, commenting that an early arrest would reduce the risk significantly.

123. The IMR author's opinion, taking account of the known domestic abuse, the level of aggression during the incident and the fact that MFJ's whereabouts were unknown is that a risk grading of high was justified.

124. The next day, Rachel returned to the flat to find that a video game console and some cash missing, she called police and this discovery was recorded as a burglary allegation with MFJ as the suspect. Rachel was fearful of what MFJ might do if he returned. She

said she had obtained a non-molestation order (NMO)[10] but this had not been served on him as she did not know where he was.

125. Another DASH assessment was made with the risk level of medium. A MERLIN PAC was completed for the two children. This officer also recorded Rachel's vulnerability due to her mental health condition that she told the officer about and completed a MERLIN ACN (Adult Coming to Notice) with respect to her.

126. On receipt of the MERLIN, a Senior Social Worker recorded the view that this met the threshold for statutory intervention with consideration given to child protection procedures and, in early November, recorded clear management direction for a CAADA-DASH assessment with Rachel, a visit to the children and a case discussion scheduled for two weeks later. The IMR author has commented that the threshold was met for a Strategy Discussion and for the case to be taken to a child protection conference.

127. Both police investigations had been passed to the CSU where the risk level was assessed and confirmed at high. A comprehensive investigation plan was set and arrest enquiries for MFJ put in place with Dorset police. The investigating officer completed referrals to the Ealing Multi Agency Risk Assessment Conference (MARAC) and to an Independent Domestic Violence Advocate (IDVA) at HESTIA.

128. Around mid-November, Rachel attended an ERTE Doctor's appointment. She reported that she had an adverse reaction to one of the prescribed drugs (lamotrigine) and had stopped it. She was advised to commence on aripiprazole. She informed the doctor about the break-up of her relationship with MFJ but not about the police contacts in October or the alleged burglary. She was referred to psychotherapy.

129. Four days later the SW recorded unsuccessful attempts to contact Rachel by phone and an appointment letter was sent.

130. Dorset Police were not successful in locating MFJ and, on 7 December, the investigating officer contacted LM regarding provision of a witness statement. This was declined and a message given that Rachel wished to retract her complaint. LM was advised that Rachel would have to do this in person and that enquiries would continue to locate MFJ.

131. About a week into December, Rachel's history was presented by the police for review by all agencies attending the Ealing MARAC. Rachel had declined to engage, or had avoided contact, with any agency that could provide her with support and actions were raised. Two days after that meeting, Rachel contacted the investigator by email requesting that she withdraws her statement, adding that the stolen property had been returned.

132. The MARAC actions include considering 'therapeutic intervention for the children', encouraging contact with IDVA, informing STADV when consent is provided to enable a GP letter to be sent and feeding back MARAC actions to Rachel. There is no evidence of explicit consideration of these actions in case-work or supervision records.

[10] Rachel has since confirmed that, on the grounds of affordability, she did not apply for a NMO

133. On the day of the MARAC, the SW recorded contact with the school, noting that Rachel is working and drops the children for breakfast club and collects from after school club and that school attendance is not a problem. Rachel is noted to have been in the school on occasions with MFJ, either dropping off or picking up Child A. No other agency checks are recorded as having been made.

134. The first successful SW contact with Rachel was in mid-December and, two days later, she was seen with the children and no concerns noted. She asked that the home visit be postponed until after Christmas. Rachel has since pointed out that this was because her extended pre-Christmas working hours meant she was not available.

135. The MARAC action for police was to involve the fugitive team to locate and arrest MFJ. The MARAC records show this complete on when in fact an arrest was not made until a few days before Christmas when Rachel informed the investigator that MFJ would attend for interview and that she planned to spend some time with him and the children over the Christmas period.

136. On that day, police visited Rachel's flat to complete a welfare check and there found MFJ looking after the children. He said he had arrived the day before and was just staying for Christmas because he had to go back to work in Bournemouth in early January. He and Rachel were no longer in a relationship. Advice was sought from the CSU as to whether he should be arrested and it was agreed he would attend Acton police station once Rachel had finished work and she could resume care of the children.

137. This happened, and MFJ attended the police station voluntarily. He was interviewed under caution regarding the allegations from October and denied making any threats to kill or causing any criminal damage. He admitted swearing and shouting in the street but denied kicking the door. He also disclosed he had returned to the flat on the night of the initial incident and slept there. The property he removed the next day belonged to him. An evidence file was referred to the CPS who directed no further action be taken

138. It is not clear from case records whether the BWV from the initial report from Rachel was included for consideration of a 'victimless prosecution' or if a DVPN was considered as a deterrent measure.

139. Just adter Christmas, MFJ self-presented to the local ED for the second time. He reported to feel low in mood and suicidal. His partner had kicked him out and he drank a lot of alcohol and felt suicidal with thoughts of jumping in a river. The relationship with the partner has been on and off. He came to A&E to seek help. He was again discharged home to his father in Bournemouth, however, there was no plan for ongoing support, nor follow-up scheduled.

2016

140. In mid-January, the SW interviewed Rachel at the office and the C&F assessment discussed. She agreed to a home visit and a CIN Plan (to be completed by February) formulated, including:

Rachel and MFJ to engage with domestic violence services
A working agreement to be formulated
The SW to engage Child A in direct work
MFJ to engage with RISE (alcohol misuse service)
The SW to explore support available from the extended family

141. Rachel did not allow Child A to be seen alone until the subsequent home visit in early February. The first two attempts to speak to her in Rachel's presence were unsuccessful (she is described as clinging to her mother). It is hypothesised that this may reflect Rachel's experience of being taken into care by social workers. Owing to the limited time the SW spent with Rachel she was: "not able to fully explore [Rachel's] current emotional wellbeing… It is not known whether [Rachel] continues to experience any mental health difficulties, and whether she receives any current support or treatment"

142. The SW saw all family members in this visit and references her own concerns about the impact of domestic violence on the children and notes that these are minimised by Rachel. The assessment indicates concern about Rachel's and MFJ's truthfulness about their relationship and their commitment to addressing the identified issues. This note in the report about mental health may be prescient:

"Rachel's mental health condition is bipolar and without medication, it is not predicted how she is able to manage her mood changes which can impact on her reactions in any confrontational situation. She said that this is not something she can change even on medication as that is how bipolar condition presents itself. Rachel has said that because of her condition, she is not able to easily walk away from confrontational situations or conflicts until she gets an answer. [MFJ] also said that he likes to walk away in heated arguments or confrontations to defuse situations however when Rachel doesn't take her medication, her bipolar makes her gets worried when there is a conflict between them"

143. Supervision from the Deputy Team Manager (some of which was written up at a later date and in which the team manager later notes there are gaps) indicates that the children are suffering significant harm, but there is no consideration of the possibility of holding a Strategy Discussion and stepping the case up to child protection. The case file indicates the parents will not engage with a CIN Plan and the DTM reluctantly agreed to close the case. The case file indicates:

"Closure is due to unresolved parental issues, not absence of need for locality support for the children in this family. Mother is protecting herself from a system that she, understandably from her younger experience, struggles with. This prevents her from more openly considering how we would be able to assist her with better protection of her children from the consequences of hers and their father's poor and damaging relationship and the violence that has featured"

144. By mid-March, Rachel had not followed up on any of the psychotherapy appointments offered so a letter was sent discharging her from that service with a copy to her GP. Rachel has since disclosed that she was experiencing very disturbing dreams at this time but did not seek help as she did not feel ready for analysis or counselling.

145. Four days later, the LAS were called to the Baker House address where Rachel had taken an overdose of anti-psychotic tablets. It was further reported that she suffered from bi-polar affective disorder. Before the end of the call, she tried to cancel the ambulance but was advised that a face to face assessment was necessary. Following assessment, she was conveyed to the local Hospital. There were no safeguarding concerns noted regarding the children.

146. When assessed by triage, Rachel said that she did not take the overdose to end her life but for bad period pains as she had not slept for three nights. She denied suicidal ideation. Seen by Liaison Psychiatry Service (LPS), she again strongly denied taking the tablets with the intention of harming herself. She stated that she realised that she had taken too many and was concerned that she may have caused some damage to her heart. She said she did not want to die because of her children. Her partner [MFJ] corroborated her version of events. Rachel also apologised for not maintaining contact with ERTE. She was discharged, and this was the last contact with WLMHT.

147. In early April, Rachel and MFJ attended a family dinner to celebrate JK's birthday. MFJ had been to watch a football match and was late, for which Rachel berated him and eventually "stormed out". [Rachel would say now that she was simply relaying to MFJ the pressure she had been under from JK for his absence and he over-reacted at which point she decided to leave]. As it was late, JK was concerned for her safety and sent MFJ after her. The couple returned "all smiles and hugs". JK has cited this example as typical of the nature of their relationship.

148. In June, Rachel's GP noted that she had become concerned with increasing anxiety and anger in the run-up to her period each month. She felt she had been becoming verbally aggressive and expressed her concern over her potential to become physically violent, although she denied ever having been violent before. She was reviewed in July and no concerns were expressed, with the intention to review after the next cycle. There were no further consultations prior to the fatal incident in September.

The fatal incident

149. On a Friday in mid-September, Rachel left MFJ with the children saying she was going out. As the evening drew on, MFJ started to text Rachel regarding her whereabouts and was she safe. Multiple and increasingly frantic messages were ignored so MFJ used phone tracking software and located her phone to the home of Rachel's friend. A text message that he had done that was also ignored. Rachel returned home the next day and relations were 'courteous'. The pre-agreed plan for the day was that she would take Child A to a family celebration of her grandmother's birthday and MFJ would take Child B to a Premier League football match.

150. At 23:00 hours on the following Saturday, a distressed sounding Rachel called the LAS to a 25-year old male who was unconscious outside her address suffering from stab wounds. Police were alerted and first to arrive so commenced Cardiopulmonary Resuscitation (CPR) on MFJ. On their arrival, the ambulance crew noted a deep stab wound to the left side of the neck, severing his jugular vein and a stab wound to his left shoulder. Additional life-saving methods were administered, and he was urgently conveyed to Hospital but was beyond saving.

151. Rachel had called her mother and her brother and they attended to assist police with the temporary removal of Child A and Child B, who was said to have slept undisturbed[11] by the incident, to the home of LM. Rachel was arrested at the scene for attempted murder.

152. In interview, Rachel explained she had frequently argued with MFJ in the days before the incident. Consequently, she spent the night at her friend's house on the Friday. On the Saturday morning, she and MFJ were courteous to one another so she decided to attend a pre-planned family party with Child A where she drank a few glasses of wine. She was not concerned about returning home as she thought MFJ and Child B would be in bed (they slept in the living room).

153. This was correct, but she noticed that MFJ had bought a present for Child A (football goalkeeping gloves) and she decided to wake him to say thank you. They began to chat and she asked him if he had thought about the previous arguments they had. He responded that he had but wanted to return to sleep.

154. Rachel said she was upset so decided to go for a cigarette at the front door. She claimed MFJ attacked her in the hall before she got there. He tried to strangle her and she grappled with him to move them away from Child A's bedroom. As they went past the living room table she grabbed a large kitchen knife that had been left there. In the struggle that followed, she said she hit out at MFJ, not realising she was still holding the knife. She saw MFJ bleeding and he said: "You're mad, you are", before he staggered from the house into the street where he collapsed. She stated she had not intended to harm him and the stabbing was an accident.

[11] This is uncorroborated

155. A Special Post Mortem examination of MFJ's body discovered three stab wounds that are described as 'severe', concluding that the cause of death was shock and hemorrhaging and a stab wound to the neck. The knife was recovered from the scene and had a bent tip, indicative of striking bone with some force. There was no trace of alcohol or drugs in MFJ's body.

156. Rachel had no visible injuries on arrest, however, she complained of a sore eye and a bruise was observed later when in prison custody. Her toxicology report indicated she had a blood/alcohol content at twice the legal limit for driving.

157. In April 2017, at the end of an eight-week trial at the Central Criminal Court, Rachel was acquitted of murder and manslaughter charges.

158. MFJ's family asked for, and were granted, a 'bereaved family meeting' with the Crown Prosecution Service where they tabled the list of 15 questions (also provided to the Chair), broadly critical of prosecuting counsel. The Head of Homicide for London CPS responded to a request from the Chair for any lessons learned from their review and it was reported that the CPS Homicide Team in London had changed their system of briefing counsel so that they are instructed after the trial date and Pre-Trial Preparation Hearing date have been set. This should increase the likelihood that the counsel originally instructed will be available for the trial. This change was implemented in August 2017 and was not just a result of this case but a number of instances where counsel originally instructed was not available for the trial.

159. In the CPS response, reference was also made to lessons to be learned regarding recording of significant statements and them being shown to suspects. This relates to significant comments that were made by Rachel to the responding officer who did not make a contemporaneous record of her original account. The reason for this was the rapidly evolving situation and the officer's priority to provide CPR to MFJ pending the LAS arrival. The Homicide Investigation Team were made aware of the significant comments but did not put them to Rachel in interview because she had not been cautioned beforehand. This was discussed with the officer at the time as a matter of personal learning. There was no corroboration available, such as with a BWV record.

ANALYSIS

Overview

160. This review has identified that M F Jones and Rachel were in a volatile relationship that was characterised by bickering, both face to face and remotely via private text messaging. Some of this led to physical assault and associated allegations, such as burglary, to retrieve possessions and, for MFJ, appearances at Court and the imposition of probation orders. They frequently separated and were probably apart as much as they were together, with MFJ staying with his father in Bournemouth for most of the time apart and sometimes with EF or JK. MFJ's family perspective is that these separations were generally caused by Rachel and then she would pressurise MFJ to return, using the welfare of the children as a form of 'emotional blackmail'.

161. They were generally held to be loving and supportive parents to Child A, whom MFJ treated as his own, and to their Child B. Possibly due to Rachel's own experience as a child subject to a Child Protection Plan on three occasions and an Interim Care Order when aged 14, they were openly and jointly concerned that contact with any kind of statutory service might lead to their children being taken into care. This probably resulted in innumerable unanswered telephone calls, cancellations of appointments and omissions to take up offers of support.

162. Most of 2016 was spent apart until MFJ came to stay with Rachel and the children in late August. In that year, the relationship seemed to have calmed considerably, certainly so far as contact with agencies was concerned.

163. Only an overdose of anti-psychotic medication in March appeared on anyone's 'radar' and that, Rachel explained, was taken to ease severe period pain and it was strongly denied as a deliberate overdose. The taking of 15 tablets in one dose by an adult suggests otherwise and it is more than possible that this was a suicide attempt that was regretted. Rachel subsequently consulted her GP in June and July for the management of this recurring pain problem because it caused her to feel anxiety and anger.

164. Rachel's anti-psychotic medicine had been prescribed for bipolar disorder type II, meaning she suffered from predominant depression with relatively mild hypomanic episodes. She also had experience of her mother being diagnosed bipolar disorder, for which she had been sectioned on occasions and this was sometimes the cause of Rachel being placed in care as a child.

165. Rachel's experience, together with her fear about the implications of her own diagnosed condition, may have been connected to the couple's shared concern that contact with agencies could lead to the children being taken into care, thus suppressing or denying the access to support available to them through safeguarding agencies.

166. A stereotypical view of domestic abuse is that excessive consumption of alcohol and illicit drugs feature in domestic abuse incidents. Apart from one report of the odour of cannabis, objected to by Rachel at the time, there is no evidence of illicit drugs in this

review. Alcohol appeared to have played a part in the first reported incident in February 2012 on the part of both MFJ and Rachel. In the sixth incident in October 2015, MFJ had been drinking and, in the fatal incident in September 2016, Rachel was assessed to have consumed twice the legal driving limit for alcohol. In June 2015, MFJ apparently referred himself to RISE but did not attend again.

167. IMR authors were invited to write their respective analysis of events and these follow, grouped by agency, together with any Panel observations in parenthesis. Some comments on multi-agency collaboration and family/service user perspectives conclude this section.

National Health Service (Ealing and Dorset Primary Care, LNWHT, WLMHT and LAS) perspectives[12]

Primary Care – Chiswick Family Doctors for Rachel, Child A and Child B

168. Rachel and her children are well known to the practice over several years. Records regarding domestic violence were not available to the practice to view as the patient did not give consent for this and did not disclose. It has not been possible to establish why ECS did not send a Child Protection notice to the Practice to effect disclosure but it is suspected this was due to a lack of consent. Sharing without consent is only permissible if children are at risk of significant harm and there was no strategy discussion (paragraph 119+check para. In any event, it is regarded as a missed opportunity [See panel recommendation 1].

169. There is clear, on-going documentation on the treatment of Rachel's mental health problems. Multiple avenues for treatment were considered and discussed with the patient, with clear patient involvement in establishing the best course of treatment. There were seemingly no clear signs of instability across the reference period: a psychiatric review in October 2013 found no risk of harm to self or others, and consultations were continued in a regular fashion over the time frame to continue to monitor Rachel's mental health.

170. In terms of care of Rachel's children, it does seem that safeguarding measures were consistently adhered to by the Practice and there were no concerns received from Ealing Child Services due to Rachel's mental health. This conclusion reinforces the need for effective communication between professionals as others such as mental health clinicians did record some concerns in relation to Rachel's mental health.

171. In March 2015, following a report of a violent episode from MFJ (fifth incident), a child and family assessment in June revealed no concerns regarding the children.

172. Consultations in the surgery stayed fairly regular and no concerns were raised. Despite an overdose in March 2016 it seems Rachel's mental health management remained stable, up until June 2016 in which Rachel expressed concern at increasing anxiety and anger in the run-up to her period each month. She felt she had been becoming verbally

[12] All agency perspectives drawn from IMR's

aggressive and expressed concern over her potential to become physically violent, although she denied ever having been violent before. She was then reviewed once more in July 2016 where no concerns were expressed, with the intention to review after her next cycle. There were no further consultations prior to the incident.

173. The Panel noted that Rachel's last GP consultations regarding severe period pain had picked up Rachel's associated experience of anger and violent ideation but this seemed not to be connected to her mental health history. There could have been some professional curiosity about whom she might be feeling violent toward.

Primary Care - Hammersmith Surgery and Providence Surgery for MFJ

174. Given the very limited contact with MFJ (one at Hammersmith, two in Bournemouth) at both GP Practices, further analysis was not feasible. However, this absence of disclosure by MFJ does highlight that he did not seek help as a victim of abuse, whereas Rachel did so on some, but not all, occasions.

London North West Healthcare Trust

175. LNWHT provides a range of services to support the health and wellbeing of children and their families, including maternity services, a health visiting service, community nursery nurses, school health and the PMLS (Paediatric and Maternity Liaison Service). The review has identified that there was an unusually high number of Health Visitors (HV) allocated to the family at different times. Eight HV and one nursery nurse contributed to the care and wellbeing. In addition, six duty HV had some contact with partner agencies, about the family. It is difficult to establish if this practice had an impact on the quality of care given to the family. There were clear delays in escalating the family to an enhanced level of need. If plans are not specific, measurable, achievable and realistic (SMART) there are risks that follow up may not be undertaken in a timely manner.

176. Rachel first came to notice of the service in March 2009 when aged 19 and pregnant with Child A until the birth in June. It was noted that Rachel had been a 'looked after child' with her maternal grandparents since 2003. When dealing with the police notifications of malicious communications from PQ the estranged father of Child A, there was a significant delay of 7 weeks before telephone contact with Rachel who minimised the incident and no home visit was undertaken. As a result, her case remained as a universal service despite the notification of domestic violence.

177. It was some 15 months later, in December 2013, when contact was made with the family following a second birth notification from Queen Charlottes Hospital regarding Child B. The birth notification outlines the details of the birth and other relevant health and social information for the receiving midwifery department. It would also highlight when the HV would conduct the new birth visit, based on the baby's date of birth, which is between 10 - 14 days. The discharge letter should also detail any known information regarding concerns and vulnerability factors within the family. There were no documented concerns from QCCH maternity services.

178. A document (uploaded) onto the health database outlined a detailed maternal assessment of Rachel's mental ill health was shared with the QCCH Midwives in October, however no concerns were written in the summary of the discharge letter in November. However, a midwife informed HV2 that Rachel had been diagnosed with Bi-Polar and was not, at the time, taking any medication. The case at this point still remained as universal.

179. New Birth Policy for the Health Visiting Service (2011) is clear that women should routinely be asked about their mental health. It appears that HV3, who undertook the visit, did not read the earlier note from HV2 because there is no evidence that the Edinburgh Post Natal Depression Scale (PNDS[13]) questionnaire was applied. It is not clear why HV2 who did know about the earlier reference did not undertake the visit.

180. In February 2014, the HV team received notification from ECS of the fourth incident and then further disclosure of Rachel's postnatal depression and her reluctance to engage with HV services. At this point social care informed HV5 the case was closed as the family had moved to Newham. There is no information in the records to indicate any challenge from HV5 in response to Rachel's disengagement with the service.

181. This was a missed opportunity to fully discuss with social care the clear emerging concerns or challenge the decision to close the case at a crucial time when consideration could have been given to escalation. Any health worker with concerns relating to mental health/suspected postnatal depression or Bi-Polar disorders, coupled with a history of domestic violence and a disengaging family is expected to escalate the case and discuss further. It is therefore assumed that HV5 did not have a holistic overview of the case and may not have read all the case records on the health database.

182. LNWHT safeguarding children policy refers to a number of safeguarding leads within the Trust who are available to offer support and advice in a case like this. The policy also highlights the importance of challenging decision making. Safeguarding is everyone's responsibility, all LNWHT employees are reminded of their roles and responsibilities through training. [Note: It could be advanced that this would also apply to WLMHT involvement]. Safeguarding supervision and further discussion around this case may have resulted in improved practice for this case.

183. An area of good practice in response to the escalating concerns was an opportunistic home visit by HV4 in April 2014. It is evident in the records the visit was very comprehensive in terms of gathering information regarding Rachel's mental health and wellbeing. She reported she was coping well and had good support networks. The HV had discussed the impact of children witnessing DV and left feeling reassured that Rachel had received the messages.

184. Following the report of the fifth incident and the discussion at Ealing MASH in January 2015, the case was allocated to HV4, however, there is no evidence that the HV then contacted the family. The LNWHT MASH pathway was implemented in 2015 and

[13] A widely used 10-item questionnaire post-partum depression screening tool

reviewed and revised in 2016. This document gives specific time frames when clients should be contacted and liaison with the SW should be undertaken.

185. This is a significant point and a missed opportunity to discuss this case in supervision. During the next six weeks four HVs were involved with the family. Despite the known mental health disclosures, the case remained universal until HV6 discussed the case at safeguarding supervision on 29 May and enhanced the case to 'universal plus'. At no point was a mood assessment undertake by any of the HVs involved in this case.

186. The IMR author has also highlighted the 2015 NICE guidance on information sharing. There had been a number of liaisons between the HV Service and ECS in line with good practice. There is also evidence to the contrary:
- The HV team initial failing to enquire what were the ECS concerns
- Instances of one of the family members being seen at A&E/UCC at Northwick Park and Ealing Hospitals and a delay in communication of this information to the HV team
- Both MFJ and Rachel attendances at A&E regarding escalating mental health concerns should have triggered a question for staff about children living at home
- The psychiatric liaison service could have made a referral to the HV service

<u>West London Mental Health Trust</u>

187. Rachel received treatment from both the Ealing Assessment Team and the Ealing Recovery Team East. The care and treatment provided was consistent with the NICE Guidance. It was noted that Rachel was involved in decision-making around the options for treatment. In addition, MFJ was permitted by her to join meetings and contribute. MFJ was the main family member involved in her care before the fatal incident. He attended an outpatient appointment with her and he raised the alarm following an overdose

188. Safeguarding concerns with regards to Rachel's children were considered both at initial assessment and following her attendance at Ealing Accident and Emergency. There were deemed to be no unresolved concerns following the last attendance at Accident and Emergency. Rachel was not subject to the Care Programme Approach (CPA). In terms of her follow-up with the Recovery Team, there was not a clear timescale for discharge after her non-attendance.

189. The risk assessments were comprehensive and updated at Rachel's last contact. The panel (authors of the Serious Untoward Incident Report) noted that the risk of harm to others was not identified as a problem in the risk assessment as it had not been a feature in her history.

190. The risk to her of domestic violence was commented on, however, it is unclear if the other professionals were aware of the extent of domestic violence. This was partly because she appeared to minimise it in her interviews with professionals. [Note: This also may be an accurate observation in MFJ's case]. The panel also considered that an issue may have been whether professionals had asked enough and targeted questions to elicit this history.

191. There was evidence of partnership working between the local health services and the local authority, in particular the C&F team were involved. The panel noted that there was no opportunity to respond to the police (Merlin) report as the team had not been aware that it had been received. It was the panel's view that the matters raised did not have implications beyond West London Mental Health Trust.

London Ambulance Service Healthcare Trust

192. In respect of the third domestic incident in December 2013, it is acknowledged that a safeguarding referral should have been made and that omission does not accord with the Trusts policies and procedures. This has been fed back to the attending ambulance staff to ensure learning from the incident takes place. [Note: It is felt that the learning is wider than just the staff involved so this observation could be organisation-wide]

193. On all other occasions staff following National Clinical Guidelines to aid their decision making and there are no concerns in the treatment provided. The Trust is satisfied that the 999-call management and the care and treatment provided by the ambulance staff were in accordance with expected practice.

194. Since the introduction of the Care Act in April 2015, which included domestic abuse within the types of abuse, training and guidance was issued to staff. The Trust has also set up a pathway with Woman's Aid for referrals of patients who would like assistance. [Note: Given the circumstances of this review, consideration also could be given to a pathway for men]. The Trust also now has a domestic abuse policy which includes the importance of notifying the police even without consent. The Trust's Core Skills Refresher (CSR) training includes different aspects of safeguarding awareness. All members of road staff attend the mandatory CSR's on a yearly basis.

Metropolitan Police Service perspective

195. In all police contact with Rachel and MFJ, he was reported to be the aggressor. Information gathered during the homicide investigation suggests that this may not have been the case. MFJ had opportunities during police interviews regarding the alleged offences to make counter allegations against Rachel but chose not to do so.

196. Rachel's friends told the homicide investigators that they observed her to have injuries on a number of occasions and Rachel said in interview she did not report all of the abuse as she did not want to come to the attention of Social Services.

197. Police attempted to pursue prosecutions where offences were apparent but were unable to encourage Rachel to support the matter through to prosecution. She was supportive of police action on the first occasion that MFJ was prosecuted for assaulting her, but it is unclear if she then lost confidence in the criminal justice process.

198. The review has discovered there was inconsistency in the grading of risk assessment levels. Police were aware of MFJ's history of violence, both within his family and in his relationship with Rachel, but the frequency with which he used strangulation as a mode of assault should have been given greater significance.

199. The failure to alert safeguarding agencies to the first incident via a MERLIN report was a missed opportunity for them to engage with the family at an earlier stage. Thereafter, the use of MERLIN referrals was consistent, and included good initiative of an ACN with respect to Rachel in the sixth reported incident.

Ealing Children's Services perspective

200. In 2009, there were attempts to identify accommodation for Rachel when she was pregnant with Child A. In 2011, Rachel was provided with advice regarding the malicious communication by LB.

201. In 2012, the police MERLIN referral in the second incident inaccurately described it as the first domestic incident between MFJ and Rachel and, together with the description of Child A being "well and happy", provided false reassurance to ECRIS, and SAFE involvement did not follow as it would have done.

Newham Children's Services Perspective [paragraph 201 only - when Rachel in temporary accommodation]

202. In 2013, when pregnant with Child B, Rachel disclosed self-harm ideation in a visit, and then a telephone call, to QCCH and was referred to children's services in Newham where she was living in temporary accommodation. Records at Newham note that Child A had been exposed to psychiatric symptoms of her grandmother, LM, and that she probably also witnessed her mother having mood swings, that apparently could be triggered in an instant and over which she had little control. There is reference to the emergency call to the Newham address in October when Rachel was thought to have harmed herself. MFJ's OM relayed that he and Rachel felt social workers should not be involved with the family because this was an isolated incident when they were both under the influence of alcohol and before she was pregnant with Child B.

203. Following the fourth incident in 2014, the police MERLIN referral indicated that no violence was used but raised concerns about Rachel's mental health and MFJ's history. There were no concerns for the welfare of the children. There is evidence on file of appropriately challenging social work. Wider checks, a meeting with MFJ and the use of assessment tools would have provided more robust analysis to inform the decision about whether to close the case.

204. In 2015, following the fifth reported incident and the MASH discussion, a C&F assessment concluded that the case be closed. Case closure was undertaken prior to evidence that the family had acted on the social work advice (which was principally around how MFJ and Rachel could manage to co-parent without resuming a relationship). It was ascertained that it is not uncommon for cases to be closed to social work teams before

work is completed if the work does not involve the social work team. If there are then subsequent referrals, evidence about whether or not the family have followed up on the recommended actions should then inform threshold decisions and subsequent assessments regarding the family's commitment to change.

205. As indicated, there was already sufficient information to indicate Rachel and MFJ had an established pattern of MFJ leaving following an incident, Rachel saying she would get a non-molestation order and then of MFJ and Rachel resuming their relationship. It would have been reasonable to have considered a more robust initial response or escalation in February 2015 in light of the refusal to engage in CIN work.

206. For the response to the last incident in October 2015, the IMR author has noted there were performance issues within the team including around the quality and timeliness of recording and the team manager was covering two teams. This information provides a context to the work environment and it is not clear if this had a significant impact on the management of the case. On reviewing this case, it is clear to the IMR author that the decision to close the case was an error of judgement. Consideration should have been given to the threshold and a decision made to progress the case to Child Protection as necessary.

National Probation Service, including London/Dorset CRC perspective

207. MFJ's original Integrated Domestic Abuse Programme (following his assault conviction) was replaced by the 1to1 Domestic Violence Programme in August 2012. In practice, the programmes are identical and, through 1to1 work, the PO is able to choose the most appropriate modules to deliver. Records confirm that these were directly linked to MFJ's offending behaviour, including relationships, understanding violence, analysing abusive behaviour, personal abuse and various case scenarios. There is evidence that MFJ also engaged in the modules and it elicited further insight regarding abuse in his relationship with Rachel.

208. MFJ's case was correctly assessed within extant guidance at Tier 3 with a medium risk of harm. The reporting frequency standards for Tier 3 cases was sufficient. Whilst both the initial and termination assessments have been deemed satisfactory following NPS Quality Assurance Framework guidelines, the review in April 2013, lacked current information, particularly regarding accommodation and relationships. The risk management plan also required updating and the overall assessment could have been more comprehensive. All national standards for the management of offenders were achieved, including the termination assessment in February which was current and sufficient.

209. The record of contact would have benefited from providing more detail. Engagement with the Social Services Department could have been recorded in more detail of dates when contacts were made, responses received and details of safeguarding decisions. When disclosures have been made by MFJ regarding altercations with Rachel, there was limited engagement with Social Services and lack of clarity that information was shared and any actions recorded.

210. To ensure that practice continues to develop, Skills for Effective Engagement and Development (SEEDS) is being re-launched locally as part of the Quality Improvement agenda. The CRISSA Recording Model, which provides comprehensive guidance on effective recording, will be included in the re-launch. Probation OMs will be provided with feedback following observation from a manager or specialist quality assurance practitioner. This will assist staff in ensuring that the supervision sessions are effective, and the activity therein reflected in records of contact.

London/Dorset CRC

211. Records indicate that MFJ's OM was conscientious, proactive and responsible in her safeguarding duties. It is clear that she followed up on concerns that were presented to her, chased information when it was not forthcoming and continued to keep relevant partners involved, particularly social services and the MASH. She was also proactive in engaging MFJ despite there being a warrant out for the breach of his order and transferring from London to Bournemouth.

212. Moreover, it is important to note that the liaison with partnership agencies all took place cross borough, not solely in the borough where MFJ was being supervised. It is not uncommon for this kind of liaison to be impeded by the differing localities, but it was evidently no obstacle (nor should it have been) for the joined up working between London CRC and Ealing Social Services.

213. The IMR author has suggested there was is weakness on the part of the Ealing CSU in their delays in providing important information in January 2015 to the OM. This had to be chased repeatedly and a less conscientious OM may have just resigned themselves to poor police response. This finding is challenged by the MPS as unduly harsh. It is acknowledged that there was difficulty in securing a response to telephone contact but when email was used to communicate, it was promptly responded to on both occasions.

214. The absence of the record of management oversight is noted. It is clear that the OM was consulting with manager, including one attendance at a meeting with MFJ. The OM recalls discussing the case on a regular basis, but the Senior PO has not recorded this as required.

215. It is evident that there is a stark contrast between the risk management of the case whilst held in London CRC and that in Dorset CRC. The risk management of the case whilst in London was robust in terms of information sharing, joined up working, a child protection referral to social services due to risk concerns and the attempts to re-engage MFJ. This cannot be sufficiently said of Dorset CRC.

Social housing perspective

216. A2 Dominion provided social housing in Ealing to Rachel and her children at Baker House. They were not notified of any domestic abuse incidents by agencies or

neighbours. Repairs that were carried out in the flat were not associated with criminal damage.

Multi agency collaboration

217. The purpose of a Multi-Agency Safeguarding Hub (MASH), staffed by representatives from each safeguarding agency, is to ensure effective communication between them. There is such an arrangement in Ealing. One follow up was to notify the London CRC who were responsible for his supervision under a Community Order imposed in May 2012. The other was to refer the case to the SAFE team

218. The purpose of the Multi Agency Risk Assessment Conference (MARAC) is to review the highest risk domestic abuse cases and ensure safeguarding agencies, IDVAs and other specialists from the statutory and voluntary sectors. They work together to remove or reduce the potential of threat and harm to victims of domestic abuse. Referrals may be through the CAADA-DASH assessment tool or by 'professional judgement'. Meetings are held monthly, are minuted with actions recorded.

219. The police applied professional judgement to refer the incident in October 2015. The only new information uncovered was that MFJ had referred himself to RISE in June 2015. On 6 November, Rachel had been offered and declined assistance from Victim Support. The case was reviewed at the March MARAC and the three unresolved actions were cleared. The ECS had closed their case and Standing Together could not send a GP letter because consent was not forthcoming.

Family and service user perspective

220. MFJ's family and friends are understandably concerned about the acquittal of Rachel of all criminal charges. They hold the contrary opinion to the conclusion of the Jury and feel that justice has not been served. They were initially focused on decisions made by the CPS and Crown Prosecutor and a review meeting has been held. They are also concerned about the way they feel they have been judged and treated by ECS in the matter of custody and access to Child A and Child B. Both aspects are outside the scope of this review, however, pathways to support for their concerns were discussed at each subsequent meeting with the Chair and also shared with relevant Panel members for these issues to be picked up if not already in hand. MFJ's family have not identified any improvements in agency responses that could have led to a different outcome.

221. As a service user, Rachel initially provided feedback in the form of two text messages for consideration but declined to engage further. When she did finally agree to meet the Chair in June 2018, he was able to check with her the accuracy of version 7 of the overview report. Valuable corrections and additional insights were forthcoming.

222. She maintained that there were shortfalls in service provision and help regarding anger management and couples counselling that she and MFJ had asked for, however, she was also prepared to acknowledge her part in missed calls, appointments and, to some extent, the pattern of 'tactical avoidance' of the support that was offered. Their common

experiences of 'the system' as children had developed a suspicion that open and honest engagement could lead to the removal of their children into care. When asked about different outcomes, she felt that she and MFJ were bad for each other and would, and should, have separated if it were not for their shared love and concern for the children.

CONCLUSIONS, LESSONS LEARNED, AND GOOD PRACTICE IDENTIFIED

223. The fundamental purpose of reviews carried out under this legislation is to establish what lessons are to be learned regarding the way in which local professionals work individually and together to safeguard victims, in this case, M F Jones and Rachel. Moreover, the findings from reviews of this nature can work to eradicate a conducive culture for domestic abuse and violence between partners and the impact on their children.

224. The inherent risks to be avoided in formulating conclusions and identifying lessons are 'hindsight biases' and 'outcome biases'. The Panel has sought throughout to understand the agency operating contexts in which this tragedy occurred so that the report does not become 'should've-ist' or 'second-guessing' in character. Nonetheless, the review has identified a number of lessons to be learned that could improve the system for safeguarding in the London Borough of Ealing and elsewhere for the future.

225. Hard-pressed as the partnering services undoubtedly are in the current austere climate, it is even more important they should seize the opportunity to learn and improve from this review, perhaps by stepping back from day-to-day operations, to reflect on what could have been done differently; to examine, holistically, the dynamic connections between people and critical events and the efficacy and sophistication of agency responses.

226. There is a lengthy time-gap between the sixth known domestic abuse incident in October 2015 and the fatal one in September 2016. The relationship between MFJ and Rachel seems to have settled into a more peaceful state, albeit that they appeared no longer to be in an intimate relationship. There were few concerns for the health and well-being of Child A and Child B, save for the potential impact of witnessing aggressive arguments between their parents.

227. The known trail of domestic abuse, such as it was, had apparently subsided and none of the family featured in extant safeguarding activity during that time-gap. Of course, it is entirely possible that a trail or pattern of abuse continued unknown to anyone in authority. Rachel gave evidence in the trial that there were instances of abuse by MFJ that she did not report. And so far as MFJ's family and friends are concerned, he did not report to anyone outside their circle the jealous and controlling behaviour by Rachel, as well as some physical abuse that they observed in the relationship. They have speculated that he did not wish to be seen as 'unmanly' by reporting these instances of abuse.

228. The fatal incident was unlike anything that had come before, save that, on Rachel's account, it started with an argument over something fairly inconsequential: that MFJ wanted to return to bed to continue sleeping rather than continue with an earlier disagreement, at which Rachel became upset and went outside for a cigarette. This apparently provoked MFJ to suddenly attack her. Rachel was acquitted of all criminal charges on the basis that she inflicted the fatal wounds when subsequently defending herself from this assault by MFJ.

229. Contributing factors were a relationship in which neither could let a matter rest without having the final word and that either could 'snap' and lose control when arguing. Their

respective mental health states could have been relevant and, in the case of Rachel, alcohol may have impaired her decision making and exacerbated her response to the situation that evening.

230. The trail of domestic abuse over the period of their four-year relationship can, in this case, be observed from both sides. There were five incidents when police were called to MFJ being aggressive and on two of those occasions had assaulted Rachel, causing injury, and on another had issued threats. For the first incident, MFJ was placed on probation; none of the other incidents resulted in legal process.

231. While there were no police reports of physical abuse by Rachel, the LAS were called to an incident where she had assaulted MFJ with a candlestick causing bruising. MFJ's family and friends also provided evidence that Rachel inflicted a visible scar on his arm with a knife, whereas, she said it was a minor injury, not requiring treatment, inflicted in the course of a struggle.

232. What might then be described as a symmetry of abuse, including the controlling/coercive aspects of their relationship, highlights the point that not all perpetrators of domestic abuse are male, indeed, some data suggest that that the ratio of male to female victims of abuse may be as high as one to two[14]. That said, there is counter evidence that abuse by the female in a relationship is a survival response and this is echoed by Rachel in her second text message to the Chair, where she referred to the candlestick incident as a "form of defence".

233. In any event, this apparent dichotomy provides significant learning for organisations and could inform the content of their training.

234. A further learning point arises from Rachel's frequent childhood experiences of her mother's mental health condition and then being placed with foster parents. This may account for her evident cynicism regarding the intent of health, social care and police workers; also distrust of their processes. She appeared insecure and developed avoidance strategies for children's services in particular.

235. Rachel had a diagnosed bipolar condition and some of her observed behaviours were consistent with the wider definition of abusive controlling. MFJ also suffered from depression, with reported episodes of suicide ideation.

236. Respective IMR authors were invited to write a conclusion with lessons learned and, where included in the IMR, these are reproduced below. Any good practice identified in IMRs is listed at the end of this section.

[14] For example, British Crime Survey

Chiswick Family Doctors

237. This was a complicated issue and communication between multiple agencies is very important within the restrictions of patient consent. It was concerning that after the fatal incident occurred that the practice had not been notified, especially as Child A and Child B were placed in interim care with family. This was discussed with the Hounslow safeguarding lead and with Ealing Social services. [See Panel recommendation 1]. This was a tragic case with many agencies involved but is difficult to say whether the outcome could have been prevented in any way.

London North West Healthcare Trust

238. This IMR has highlighted a number of missed opportunities around escalation, challenge, information sharing, documentation, record keeping, and accountability. As part of the scrutiny around a deep dive into this case the Trust needs to consider how the lessons and recommendations from this DHR will be shared to ensure staff fully understand the catalogue of events resulting in sub optimal standards of care. The lack of documentation around weight monitoring, and engagement with the family will require further exploration as part of this review. It is difficult to establish from the records if the children have attended all developmental checks or if Rachel has disengaged with the service and failed to bring her children to appointments. Furthermore, as part of this deep dive it would be good to understand the process of follow up appointment for universal families. There were clearly a number of missed opportunities to enhance this case for more targeted support particularly as Rachel was requesting support with Child A's challenging behaviour.

West London Mental Health Trust

239. Rachel and her children were known to social services as there was a long history of domestic violence. She had been diagnosed as suffering from bipolar disorder (Type II) and had erratic contact with ERTE since March 2014 and was under standard (non-CPA) care. She had not been seen by the Recovery Team since November 2015, some 10 months before the fatal incident. There were plans to discharge her due to not engaging and non-attendance at her appointments.

240. She attended A&E in March 2016 following an overdose which she said was to help her sleep and not an attempt to self-harm. She was assessed there by the Liaison Psychiatric Service and referred for further follow up by the Recovery Team. This follow up did not occur.

241. Her risk assessment had been updated at the time of this last contact with services and she was assessed as having a low overall risk rating. There was a past history of self-harm and domestic violence. The latter risk which appears to have escalated and a Merlin report was provided to the Trust but was not brought to the attention of ERTE. There were no indications that she posed a risk to others.

London Ambulance Service

242. On the occasion in December 2013, a safeguarding referral was not made; this is not in accordance with the Trusts policies and procedures. The issue of safeguarding referrals not being completed on this occasion will be fed back to the attending ambulance staff to ensure learning from this incident takes place. The Trust has not identified any other issues arising from its management and the care and treatment provided by the ambulance staff were in accordance with expected practice.

Metropolitan Police Service

243. In all police contact with Rachel and MFJ, he was reported to be the aggressor. The information gathered during the homicide investigation suggested that this may not have been the case however, MFJ had opportunities during interview to make counter allegations against Rachel but chose not to do so. Rachel's friends stated that they observed her to have injuries on a number of occasions and Rachel stated she did not report all of the abuse as she did not want to come to the attention of Social Services. Police attempted to pursue prosecutions where offences were apparent but were unable to encourage Rachel to support the matter through to prosecution. She was supportive of police action on the first occasion that MFJ was prosecuted for assaulting her but it is unclear if she lost confidence in the criminal justice process.

244. One recommendation has been made for Ealing Borough Police regarding risk identification in initial investigation as there was some inconsistency in the grading of risk levels. Although police were aware of MFJ's history of violence both within his family and in his relationship the frequency with which he used strangulation as a mode of assault against Rachel should have been given greater significance. The Borough Senior Leadership Team (SLT) should dip sample grading of risk assessments in initial investigation to ensure that risk factors are correctly identified and considered as part of the wider risk management strategy for victims of domestic abuse.

Ealing Children's Services

245. There have already been changes to systems and learning applied from this case:
- The case has been discussed twice by the Ealing Locality management team and there is now a process in place involving regular meetings of the management team to review learning from particular cases and consider whether tighter processes could improve safety.
- There were repeated positive observations of the children's well-being (particularly in Police reports) and, setting aside their lack of awareness about the impact of domestic violence on the children's development, there are very positive reports of MFJ and Rachel's parenting. These positive snap-shot observations appear to have influenced professional perceptions of the level of risk. However, Child A (who was 6 years in June 2015) was shy and reluctant to talk to unfamiliar people. She was only seen alone once by a social worker when she was allowed by Rachel during after the sixth reported incident to show the SW her bedroom. The recommendation

that further work is undertaken with her was not followed through [Note: see Table 3 ECS recommendation 6]+ update

- Rachel repeatedly refused offers of family support and domestic violence services. On the one occasion when SAFE involvement was accepted, Rachel withdrew when concerns are raised about the repeating pattern referred to above. This unwillingness to engage in Child In Need services is treated in this case with resignation / helplessness rather than as an indicator of increased risk to the children. There is a system in place for monitoring the number of days taken to see children following a referral. The Team manager in Ealing Locality said the timescale within which children need to be seen has reduced from a maximum of 10 days to a maximum of 5 days. It is recommended that this (or a similar system) is embedded within the service as a whole, and that the level of concern is increased if children are not seen [Note: see Table 3 ECS recommendation 7]+ update
- As noted, there have been changes in staffing and the Ealing Locality Manager is now managing one rather than two teams.
- The SAFE team confirmed that they 'hold in mind' the possibility of couple violence being two-way. ECIRS attempt to see and speak with perpetrators as well as victims in relation to domestic violence referrals. ECIRS are undertaking work to improve the team's knowledge of mental health. This is referenced in more detail in another IMR that is currently in progress.
- No use of DV risk assessment tools was identified. Barnado's DV Matrix is now used by ECIRS to inform risk assessments. The use of this or a similar risk assessment tool would have provided a better evidence base across time about the nature of the relationship between Rachel and MFJ, perspectives around the triggers for arguments and violence and would have provided a better basis for management decision-making. There are focused sessions for ECIRS staff booked around using the Barnado's DV Matrix. This training needs to be available for Social Workers in locality teams [Note: see Table 3 ECS recommendation 1]+
- A Child Protection Advisor now leads on MARAC and this has strengthened the link between MARAC and the social work teams.

National Probation Service

246. There is evidence to suggest that the case could have been more effectively managed. The areas identified are

- Insufficient communication with partnership agencies; When NPS informed of domestic incidences with Ms Hart-Browne and when a risk is posed to the children
- Insufficient review of OASys assessment
- Lack of continuity in the management of the case. In part this is due to staff retention and Transforming Rehabilitation in 2014, where probation was split between NPS and CRC private companies.
- Insufficient progress on Unpaid Work hours following the requirement being imposed in January 2013

Good practice

247. Good practice was identified in three of the IMR's and this is replicated below.

Chiswick Family Doctors

248. The documentation by the various doctors was good and thorough. It appears Rachel felt supported as she did on the whole keep attending for review. The practice had also given the family stability by keeping them still registered with ourselves even when they lived quite outside our practice area.

London North West Healthcare Trust

249. There was evidence of opportunistic home visits undertaken by health visitors due to Rachel's lack of engagement with the service. Working with families who choose to avoid services can be particularly challenging for professionals. There is information in the records to suggest some areas of good practice with record keeping, persistence in contacting Rachel and bringing this complex case to supervision.

West London Mental Health Trust

250. The Assessment Team demonstrated good multi agency working with the Child and Families Team, liaising with them early and seeing Rachel jointly. The doctor arranged to see her in quick succession to complete the assessment and showed evidence of collaborative working involving her in decision making about her care.

London Ambulance Service

251. On all occasions staff following National Clinical Guidelines to aid their decision making and there are no concerns in the treatment provided. The Trust is satisfied that the 999-call management and the care and treatment provided by the ambulance staff were in accordance with expected practice.

Strategic learning points

252. With particular assistance provided through the learning identified by the Ealing Children's Services IMR author, the Panel have identified some key strategic learning points that will be developed into recommendations in the next chapter:
    1. There is a need to improve the effectiveness of the Ealing MASH (Multi-Agency Safeguarding Hub)
    2. There should be a review of the impact on the quality of care caused by lack of continuity of health professionals
    3. There is a need to review training and awareness of the wider definition of controlling and coercive domestic abuse and to develop a 'healthy scepticism, an open mind and, where necessary, an investigative mindset'[15] about the real situation in relationships

[15] Source: The Victoria Climbie Inquiry Report 2003

RECOMMENDATIONS

253. Individual Management Review authors have made discrete recommendations for consideration and implementation within their respective agency and twenty of these are consolidated into appendix 4 to show the latest position regarding completion. The Safer Ealing Partnership will be responsible for ensuring that all recommendations are completed.

Panel recommendations for wider implementation

254. Where an IMR recommendation was assessed by the Panel to have wider application in line with the three strategic learning points, it has been developed, consolidated and adopted as the eight Panel recommendations below. An Action Plan to achieve the recommendations is attached at appendix 4.

255. **Learning Point 1:** There is a need to improve the effectiveness of the Ealing MASH (Multi-Agency Safeguarding Hub)

Recommendation 1
The Ealing MASH (Multi-Agency Safeguarding Hub) should improve and reinforce the protocol for sharing of critical information, such as the ECS sending CP information to the GP and the GP not being informed of the homicide. Probation should also ensure that when information is received that a perpetrator has moved back in with a victim of abuse and their family the appropriate referral is made to Vulnerable Adult and/or Children's Social Care.

256. **Learning Point 2:** There should be a review of the impact on the quality of care caused by lack of continuity of health professionals

Recommendation 2
London North West University Healthcare NHS Trust Community 0 – 19 Service should look at issues arising from this case to establish if the lack of continuity of health professionals has impacted on the quality of care

257. **Learning Point 3:** There is a need to review training and awareness of the wider definition of controlling and coercive domestic abuse and to develop a healthy scepticism, an open mind and, where necessary, an investigative mindset about the real situation in relationships

Recommendation 3
Although safeguarding training is mandatory for all health and social care staff, there remains a gap in the provision of training in relation to Domestic Abuse (including the impact on both victim and perpetrator)

Recommendation 4
That all agencies are alert to the need to balance positive observations of parenting and children's well-being with detailed observation, direct work and research evidence to determine the impact on children of domestic violence

Recommendation 5
That all staff working with domestic violence are familiar with the cycle of violence. Workers and Managers in all agencies must challenge repeated assurances that relationships are over. Claims about relationships ending need to be backed up with solid evidence about what has changed

Recommendation 6
That an unwillingness to engage with family support services is explicitly treated by all agencies as an indicator of higher risk

Recommendation 7
That when parents are minimising or denying concerns and where their non-engagement places children at increased risk of harm, all agencies evidence more challenging dialogue with parents

Recommendation 8
That when there are counter-claims or observations of abuse between partners, including controlling and abusive behaviours, a 'culture of inquiry' is developed to challenge stereotypical perspectives and assumptions

Author

Bill Griffiths CBE BEM QPM

11 September 2018

Safer Ealing Partnership - Domestic Homicide Review Panel
MFJ killed in September 2016

Glossary

CCG	Clinical Commissioning Group
C&F	Children and Families
DAI	Domestic Abuse Incident
DCRC	Dorset Community Rehabilitation Company
DHR	Domestic Homicide Review
EAT	Ealing Assessment Team
ECIRS	Ealing Children Integrated Response Service
ERTE	Ealing Recovery Team East
ECS	Ealing Children's Services
ECSP	Ealing Community Safety Partnership
GP	General Medical Practitioner
ICHT	Imperial College Healthcare NHS Trust
IMR	Individual Management Review
LAS	London Ambulance Service Healthcare NHS Trust
LB	London Borough
LBE	London Borough of Ealing
LCRC	London Community Rehabilitation Company
LNWUHT	London North West University Healthcare NHS Trust
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MERLIN	Police report of a child coming to notice
MPS	Metropolitan Police Service
NHS	National Health Service
NPS	National Probation Service
OASys	Offender Assessment System
OM	Offender Manager
SAFE	Ealing's early help service
SW	Social Worker
ToR	Terms of Reference
UPW	Unpaid work
WLMHT	West London Mental Health Trust

Name references used

MFJ	M F Jones, deceased
AB	MFJ's father
CD	MFJ's mother
EF	MFJ's stepmother
JK	MFJ's maternal aunt
Rachel	MFJ's partner
LM	Rachel's mother
PQ	Rachel's former partner and father of Child A
Child A	Rachel's daughter with PQ
Child B	Rachel's son with MFJ

Safer Ealing Partnership - Domestic Homicide Review Panel
MFJ killed in September 2016

Distribution List

Name	Agency	Position/ Title
Paul Najsarek	London Borough of Ealing	Chief Executive
Joanna Camedoo	London Borough of Ealing	Councillor for Community Safety; lead on domestic abuse
Mark Wiltshire	London Borough of Ealing	Director, Community Safety Service
Jess Murray	London Borough of Ealing	Head of Community Safety Service
Carolyn Fair	London Borough of Ealing	Strategic Lead for Violence Against Women and Girls
Jackie Yates	London Borough of Ealing	Head of Adult Social Care
Judith Finlay	London Borough of Ealing	Executive Director Social Services
Andrew Meekings	Standing Together Against Domestic Violence	MARAC Team Leader and LBE MARAC Lead
Dame Jacqueline Docherty	London North West University Healthcare NHS Trust	Chief Executive
Carolyn Regan	West London Mental Health NHS Trust	Chief Executive
Mark Easton	NHS North West London Collaboration of CCGs	Accountable Officer
Diane Jones	NHS North West London Collaboration of CCGs	Director of Nursing
Tessa Sandall	NHS Ealing CCG	Head of Ealing, Harrow and Hillingdon
Antony Rose	National Probation Service	Head of Ealing, Harrow and Hillingdon
Ilid Davies	National Probation Service	Head of Public Protection
Karen Sobey Hudson	NHS England	Patient Safety Projects Manager (London Region)
Paul Martin	Metropolitan Police	Ealing Borough and West Area Commander
Janice Cawley	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
LaToya Ridge	Victim Support London	Senior Operations Manager
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Cressida Dick	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

Safer Ealing Partnership - Domestic Homicide Review Panel
MFJ killed in September 2016

Appendix 1

Terms of Reference for Review[16] + check

1. To identify the best method for obtaining and analysing relevant information, and over what period [Note: Agreed on 10 May from 2012 to date of homicide (17/09/16)] with any relevant prior information to be summarised] to understand the most important issues to address in this review and ensure the learning from this specific homicide is understood and systemic changes implemented

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: The criminal proceedings concluded with an acquittal at the Central Criminal Court on 27/0417. There are no known misconduct allegations. The Inquest has been opened and adjourned, therefore, the evidence remains *sub judice* until concluded.]

4. To identify any relevant equality and diversity considerations arising from this case and whether either victim or defendant was an 'an adult at risk' and, if so, what specialist advice or assistance may be required

5. To identify whether the victim or defendant was subject to a Multi-Agency Risk Assessment Conference (MARAC) or the victim or defendant subject to Multi-Agency Public Protection Arrangements (MAPPA) or Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings. [Note: It has been established that there was a referral to the MARAC on 08/12/15]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2013, if so, how it could be best managed within this review [Note: It is understood that the LCSB has reviewed the circumstances and decided not to commission a SCR]

7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review

8. To identify how should family, friends and colleagues of the victim and other support networks (and where appropriate, the defendant) contribute to the review and how matters concerning them in the media are managed during and after the review

[16] Subject to family views yet to be obtained

9. To identify how the review should take account of previous lessons learned in the London Borough of Ealing and from relevant agencies and professionals working in other Local Authority areas [Note: Two DHRs have been published and two others are current]

10. To identify how people in the LB of Ealing gain access to advice on domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague

11. To keep these terms of reference under review and subject of reconsideration in the light of any new information emerging

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2013 – see below)

b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system

c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned

d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences

e. The review will be guided by humanity, compassion and empathy with both victim and defendant voices at the heart of the process

f. It will take account of the protected characteristics listed in the Equality Act 2010

g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse

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.

Appendix 2

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the Royal Borough of Kensington and Chelsea CSP as Independent Chair of the DVHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner, he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the MFJ Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had no personal or operational involvement within the London Borough of Ealing, nor direct management of any MPS employee.

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

Appendix 3

Consolidated internal recommendations from agency IMR's

Rec No	Agency/Source	Action taken or to be taken within agency	Outcome of action, what has been achieved and date of completion
1	Chiswick Family Doctors	Within the practice this case was discussed as a significant event and awareness of domestic violence has increased. It would be worth considering asking patients questions regarding possible domestic violence on a more regular basis. [See also Panel recommendation 3 for this Practice]	The incident that had occurred was a clinically significant event and was discussed at a practice clinical meeting and also with the safeguarding team. No clinician in the practice has ever been involved in a case such as this, so naturally this has heightened our awareness of domestic violence. We have ensured all clinical staff are aware of referral processes and that contacts details are available in all clinical rooms. Any concerns are discussed regularly in clinical meetings. [The lead GP for Safeguarding] and another GP colleague in the practice have also attended an adult safeguarding update which included a session with Hounslow's Domestic Violence office. Practice staff have, when appropriate, increasingly asked patients if they have been subject to abuse. Completed July 2018

2	London North West Healthcare NHS Trust	For health professionals to understand response times to MARAC information	The MARAC pathway is at the consultation stage and will be incorporated into the Trust Domestic Violence & Abuse (DVA) Policy when finalised. Work in progress - Completion: December 2018
3		In response to the Care Act, to establish best practice for patients presenting in crisis at ED with MH concerns	Meeting to be arranged with the providers for mental Health services across the Trust, to establish a pathway for patients who attend the hospitals with mental health concerns. Current practice is that clients are referred to the psychiatric liaison team. Work in progress – Completion December 2018
4		To support professionals with easy access to information [See also Panel recommendation 2]	Completed May 2018
5		For health visitors to apply a recognised communication tool	Some of the practitioners have been updated on the use of the SBAR too. Part of the rollout is to develop a user

			friendly SBAR guidance and this is out for consultation Completed July 2018
6		To provide assurances around quality of care	The continuity of care audit Completed August 2018
7	West London Mental Health NHS Trust	The Team Manager must ensure that the duty team make contact directly with a patient within 7 days of them being discharged from A & E to ensure an appropriate follow up plan is developed	This was raised in the Clinical Governance Meeting Completed April 2018
8		The Team Manager must ensure that there is a robust system in place so that emails sent out by the duty mail box are followed up to ensure there is a response within 7 days	This was discussed in the Clinical Governance Meeting and agreed that if someone attends A&E we will call them and if we cannot get hold of them add it to the duty electronic diary Completed April 2018
9		The Team Manager and Consultant must ensure that there is effective communication with GPs following each outpatient appointment	This was discussed in the Team Clinical Governance Meeting Completed November 2017
10		Although safeguarding training is mandatory for all clinical staff, further support is needed in the area of domestic abuse. It is	WLMHT have been working with Standing Together against Domestic Violence (STaDV) since 2016. The work

		recommended that all staff have access to domestic abuse training and an awareness of the impact on both the victim and perpetrator [See also Panel recommendation 3]	has been focused on strengthening the Trust response to Domestic Abuse. STaDV have provided training to staff across the Trust and we have identified interested staff to become Domestic Abuse Leads. To support this work, we are engaging with the Local Domestic Abuse services and will be developing a policy and procedure for Domestic Abuse. The Team have received had presentations regarding both domestic abuse and child exploitation. We will also be arranging training through SA. The Senior Practitioner agreed to liaise with Standing Together to attend one of our MDTs Work in progress – completion July 2018
11	London Ambulance Service NHS Trust	The issue of safeguarding referrals not being completed on this occasion will be fed back to the attending ambulance staff to ensure learning from this incident takes place and be included in wider training across the Trust	We have been unable to feedback to the members of staff concerned as they have now left the Service Pre 2015 there was no further guidance to staff on domestic abuse. However with the introduction of the Care Act in April 2015, which included domestic abuse within the types of abuse, training and guidance was issued to staff. The Trust has also set up a pathway with Woman's Aid for referrals of patients who would

			like assistance (this is also the same pathway for men who are victims of Domestic Abuse (male victims would be signposted to another organisation). The Trust also now has a domestic abuse policy which includes the importance of notifying the police even without consent.
12	Metropolitan Police Service	Ealing Borough Senior Leadership Team dip sample initial reporting of domestic abuse incidents to ensure the risk is appropriately assessed and escalation of risks being correctly identified in repeat cases	In accordance with the recommendation, Ealing BOCU Detective Chief Inspector performed regular dip sampling of safeguarding cases to ensure compliance with MPS policies. West Area Basic Command Unit (BCU - formerly Ealing BOCU) was formed in June 2018 and are in the process of setting up a Safeguarding Audit Team to dip sample all MPS systems which record police interactions with a safeguarding element (eg domestic abuse, sexual offences, child abuse and exploitation). The aim of the unit is to ensure we are effective in our responses and appropriately identifying risks to safeguard vulnerable adults/ children /domestic abuse victims Completed June 2018

13	National Probation Service	Local briefings regarding effective communication with partnership agencies; With emphasis on establishing clear criteria and understanding between referrals and information sharing	Local safeguarding procedures have been communicated with staff to ensure they are aware of the relevant criteria between completing checks/information sharing and referrals Completed June 2018
14		Local Briefing and training on OASys assessments, particularly reviews	NPS implemented a new Quality Assurance process in 2018. Focusing on the quality of the core elements of NPS work; risk assessment, risk management and sentence planning Completed June 2018
15		The inclusion and launch of risk assessment workshops 'Risk Is Everyone's Business' within the local Quality Improvement Plan	Workshop roll-out began May 2018 Work in progress – completion December 2018
16		Local briefings regarding the effective management of court orders	Local managers to address with teams as part of briefings Work in progress – completion December 2018
17		Review of all Unpaid Work cases held within LDU	Initial Review completed, and action will be 'business as usual'

			Completed June 2018
18	Ealing Children's Services	That teams are educated about the use of the Risk Assessment Matrix and that management checks are undertaken to ensure that its use is properly embedded in all cases where domestic violence is a feature	To gather evidence of the use of DV matrices we added a question to the recent audit which asked whether DV was present in the family and if so was a matrix used. There are two that can be used, one measures the risk to the partner and the other the risk / impact on the children. We will find out when we have analysed the results of the audits as to whether further work on this is needed. The question can remain in our audit process so it provides an indication of improvement or not of their use in subsequent audit cycles Work in progress – completion July 2018
19		That when parents do not answer phone calls and are not at home during the day, consideration should always be given to phoning in the evening and conducting unannounced evening visits. A quick and flexible response to domestic violence incidents maximises the chances of successful engagement. If a flexible and speedy response fails to engage a parent in constructive activity to reduce the risk to children, this needs to be explicitly treated as a risk factor that may warrant the case being stepped-up	This action is part of what would constitute the planning around engaging with a family where Domestic Abuse is a factor. The process of safely engaging with families is covered in the training that is delivered to staff with the focus on obtaining Safe Contact details. This can result in meetings with the victim being held in neutral settings, such as the school. The Domestic Violence

			Intervention Project (DVIP) workers who are located with the teams also advise on this aspect in addition to other aspects of working with families where Domestic Abuse is a feature Completed July 2018
20		That work is undertaken around the application of thresholds for cases involving domestic violence within Ealing Children's Services. This should include involvement of the Child Protection Advisors who will have an overview of thresholds applied at CP Conferences [See also Panel recommendation 1]	The Child Protection Advisors are now linked to specific teams which is designed to improve consistency in application of threshold and planning with families. The DVIP workers advise on cases and are now to start attending group supervision to advise on the cases being discussed where Domestic Abuse is a feature Completed July 2018

Appendix 4

ACTION PLAN

Learning Point 1: There is a need to improve the effectiveness of the Ealing MASH (Multi-Agency Safeguarding Hub)						
Recommendation	**Scope of recommendation**	**Action to take**	**Lead Agency**	**Key Milestones Achieved in enacting recommendations**	**Target Date**	**Date of completion and outcome**
1 The Ealing MASH (Multi-Agency Safeguarding Hub) should improve and reinforce the protocol for sharing of critical information, such as the ECS sending CP information to the GP and the GP not being informed of the homicide. Probation should also ensure that when information is received that a perpetrator has moved back in with a victim of abuse and their	Local safeguarding agencies and voluntary sector	Social workers to be reminded to ensure that the GP is included in information sharing as part of the core group	Ealing Children's Service	Findings to be shared with social workers at the next Service meeting to ensure that this potential gap in information sharing is known	October 2018	**Ongoing**

family the appropriate referral is made to Vulnerable Adult and/or Children's Social Care						
Learning Point 2: There should be a review of the impact on the quality of care caused by lack of continuity of health professionals						
2 London North West University Healthcare NHS Trust Community 0 – 19 Service should look at issues arising from this case to establish if the lack of continuity of health professionals has impacted on the quality of care	North West London University Hospitals Trust	Undertake an audit to capture the current practice of care offered to vulnerable families within the LNWUHT Community 0 – 19 Service across the Trust to determine if there is continuity of care offered to families where children are made subject to a Child protection or a Child In Need plan, and if there is an impact on the quality of care offered, even if there is not continuity of health care practitioners	North West London University Hospitals Trust Community 0 – 19 Service	Findings of audit along with the recommendations to be shared with Team Leads, Managers and practitioners at Meetings, team forums and meetings and supervision sessions	August 2018	**Completed**

Learning Point 3: There is a need to review training and awareness of the wider definition of controlling and coercive domestic abuse and to develop a healthy scepticism, an open mind and, where necessary, an investigative mindset about the real situation in relationships						
3 Although safeguarding training is mandatory for all health and social care staff, there remains a gap in the provision of training in relation to Domestic Abuse (including the impact on both victim and perpetrator)	All Social Care and Health Providers (including private and voluntary)	The North West London (NWL) CCGs Safeguarding Health and Outcomes Framework (SHOF) was implemented in 2017. The SHOF sets out the contractual assurances which NW London CCGs Commissioned Providers must report on to ensure safe and effective Safeguarding processes are in place, including in relation to Domestic Violence Training	NWL CCGs (for NHS Commissioned Services and GP Practices)	Completed in 2017	Not applicable	**Completed**
		NHS Provider Trusts to report on the breadth of the Domestic Violence included within their mandatory training		By the end of Q3 2018, NWL CCGs will additionally ask NHS Provider Trusts to report on the breadth of the Domestic Violence included within	January 2019	**Ongoing**

				their mandatory training		
		Specifically, with regard to training for GP Practices and the learning identified in this review, NWL CCGs will raise with Health Education England (NW London) consideration of whether to fund additional standalone training for GPs in relation to Domestic Abuse		Funding application to Health Education England completed in August 2018 and awaits their decision	October 2018	**Ongoing**
		NWL CCG Designated and Named GPs, in collaboration with the Designated Nurses for Safeguarding to review current domestic abuse within safeguarding training, to collate and share with Member Practices what additional training opportunities may be available, what key documents		By the end of Q3 2018, NWL CCGs will distribute additional training opportunities, key documents and onward referral routes to Domestic Abuse Services via the CCG Primary Care/Network managers	January 2019	**Ongoing**

		pertaining to domestic abuse will be highlighted, as well as onward referral routes to Domestic Abuse Services and, when appropriate, the local Multi-Agency-Risk-Assessment-Conference (MARAC)				
Part of 3 above	Ealing Local Authority (for Social Care, private and voluntary organisations)	Form a Task and Finish Group to ensure that the key actions 1 – 4 above by NWL CCGs are replicated or partnered within Social Care provision by private and voluntary organisations in LB Ealing	Ealing Local Authority Adult Social Care	By end of Q3 2018	January 2019	**Ongoing**
4 That all agencies are alert to the need to balance positive observations of parenting and children's well-being with detailed observation, direct work and research	Local safeguarding agencies and voluntary sector	Design and implement revisions to the supervision template and disseminate to relevant staff	Ealing Children's Services	A revised supervision template is now being used in social work supervision which ensures that	The supervision template went live in August 2018	**Ongoing**

evidence to determine the impact on children of domestic violence				strengths are discussed and a balanced view of the family functioning is gained. Evidence based practice will be focused on at the Service meeting when the learning from the review will be delivered	October 2018	
5 That all staff working with domestic violence are familiar with the cycle of violence. Workers and Managers in all agencies must challenge repeated assurances that relationships are over. Claims about relationships ending need to be backed up with solid evidence about what has changed	Local safeguarding agencies and voluntary sector	Disseminate the learning from the review to social workers and managers	Ealing Children's Service	The learning from this review will be shared with social workers and managers at the next Service meeting	October 2018	**Ongoing**

6 That an unwillingness to engage with family support services is explicitly treated by all agencies as an indicator of higher risk	Local safeguarding agencies and voluntary sector	Disseminate the learning from the review to social workers and managers	Ealing Children's Service	All social workers have access to training which touches on the need for contact to be arranged so that risk is not increased In addition the learning from this review will be shared with social workers and managers at the next Service meeting	October 2018	**Ongoing**
7 That when parents are minimising or denying concerns and where their non-engagement places children at increased risk of harm, all agencies evidence more challenging dialogue with parents	Local safeguarding agencies and voluntary sector	Disseminate the learning from the review to social workers and managers	Ealing Children's Services	The context of non-engagement is included in the training and the advice that social worker and managers receive from DVIP	October 2018	**Ongoing**

				This will be highlighted at the next Service meeting as part of the sharing of the learning from this review		
8 That when there are counter-claims or observations of abuse between partners, including controlling and abusive behaviours, a 'culture of inquiry' is developed to challenge stereotypical perspectives and assumptions	Local safeguarding agencies and voluntary sector	Develop and encourage a 'culture of inquiry' within social worker teams	Ealing Children's Services	The new supervision template encourages reflective thinking around a case. This is being evidenced in audits of supervision. There is a toolkit designed to help practitioners understand this, called the Respect Toolkit which will be discussed with our Training department in relation to	Local Safeguarding Board Training Sub-Group – September 2018	**Ongoing**

				delivering training on this		