Part II

Overview Report

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Review of the circumstances surrounding the deaths of LP and PW

- Overview Report -

1. Introduction

1.1 This report of a domestic homicide review (DHR) examines the agency responses and support given to LP and PW, both residents of the London Borough of Tower Hamlets, prior to their deaths in April 2011.

1.2 The review will consider agencies' contact/involvement with LP and PW from 2005, when they met at a drug rehabilitation clinic, to the time of the discovery of their deaths. The review will focus most sharply on the period from January 2009 and thereafter since it was at this time that PW first came to the renewed attention of official agencies after his release from prison, having served a sentence of 21 months for arson.

1.3 The key purpose for undertaking the review is to enable lessons to be learned from this particular case. In order for these lessons to be learned as widely and as thoroughly as possible, professionals need to be able to understand fully what has happened in each case and, most importantly, what needs to change to reduce the chances of such tragedies recurring.

1.4 The deaths of LP and PW occurred only a matter of days after the commencement of the statutory requirement to conduct formal homicide reviews. The Tower Hamlets Community Safety Partnership Board, having identified the need for a DHR, appointed a suitably qualified independent consultant to form a Review Panel and manage the process of review. This pragmatic approach, though not in accord with Home Office guidance, enabled the review process (and, significantly, early corrective actions) to be set in motion quickly despite the novelty of the DHR process and the absence of an established mechanism in the borough.

1.5 The review was guided by following terms of reference:

- To establish what lessons can be learned from the case regarding the ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons can be acted upon.
- To identify what may be expected to change and within what timescales.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff.
- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic violence and its impact on victims through improved inter and intra-agency working.

1.6 The following agencies were asked to participate in the review process, conducting and reporting, Individual Management Reviews (IMR) where appropriate:

- The Metropolitan Police Service (MPS) – submitted a full IMR
- The Crown Prosecution Service (CPS) – submitted a full IMR
- Her Majesty's Court & Tribunals Service (HMC&TS) – submitted a full IMR
- London Borough of Tower Hamlets Adult Services (LBTH) – submitted a full IMR
- NHS East London Foundation Trust (NHSELFT) – submitted a full IMR
- Victim Support (provider of Specialist Domestic Violence Advocacy Services) – submitted a brief chronology of its involvement
- East London Probation Trust (ELPT) – submitted a brief letter
- The Primary Care Trust – submitted a brief letter

1.7 Agencies were asked to provide a chronological account of contact with the victim and/or suspect. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each contributing agency's report covers the following:

- A chronology of interactions with the victim and/or suspect
- What was done or agreed
- Whether internal procedures were followed
- Conclusions and recommendations from the agency's perspective

1.8 In addition to the above reports, the following documents were obtained and relevant material extracted:

- A report to HM Coroner from the MPS Homicide Investigation Command
- Statements made by various witness to the MPS
- A letter from LP's GP to HM Coroner
- A letter from PW's GP to HM Coroner
- A report of the findings of the post mortem examination of LP
- A report of the findings of the post mortem examination of PW
- The report of the investigation by the Independent Police Complaints Commission (IPCC) into the conduct of various police officers
- A note of discussions with LBTH Housing Department
- Statistical information provided by the Tower Hamlets Community Safety Partnership concerning the workloads of relevant agencies involved with domestic violence
- Operating protocols for the Tower Hamlets Multi Agency Domestic Violence Safety Planning Panel (Multi Agency Risk Assessment Conference - MARAC)
- CPS Policy for Prosecuting Cases of Domestic Violence
- MPS Standard Operating Procedure relating to cases of domestic violence

1.9 An effort was made to enrich the information from official sources with the perspectives of family, friends, community members and colleagues. LP was entirely estranged from her family and had been so for a number of years. PW was in intermittent contact with his mother but both she and friends of LP indicate that in the months leading up to her death, LP had tried (largely successfully) to limit PW's contact with his family. As part of the review process both LP's and PW's family were invited by letter to participate in the review. The Independent Chair offered to meet family members with or without friends/relatives/legal representatives present, to discuss what had happened as well as the actual process of review. PW's family did not respond at all to this invitation. LP's family responded via their solicitor, declining engagement and asking that any future contact be via their solicitor. At the completion of the draft report, copies were sent to both families by post. The Independent Chair again offered to meet with them to discuss and explain the report and asked for their comments on the content. He also offered to meet with the families after the inquests should they have any concerns at that stage. To date neither family has made any response to these invitations. At various Pre-Inquest Review hearings, the Independent Chair has taken the opportunity to introduce himself to members of both families in the hope of

generating some participation. None of the approaches has elicited a positive response.

1.10 Efforts to contact friends of PW have failed to identify any suitable candidates.

1.11 Efforts to elicit information from friends of LP, though initially unsuccessful, were more fruitful. Her closest friend (a neighbour) was initially interviewed as a potential witness by the MPS as part of its homicide investigation. This friend was some years older than LP and claims to have been regarded by LP as, "….a sort of substitute mother." The two women had in common the fact that both had suffered from drug addiction, though at the time of LP's death, neither was using drugs other than cannabis. Unfortunately, shortly after LP's death was discovered and she had been interviewed by the MPS, the friend reverted to her addictive drug habit. This and her relatively chaotic lifestyle rendered her exceptionally difficult to interview with any benefit. Happily, she is now in treatment for her addictions and was able to undertake a short interview with the Independent Chair to contribute to this review.

1.12 Additional information about LP, PW and their relationship has been gleaned from the interview by the MPS of a second neighbour of LP. Unfortunately, efforts to interview him purely for the purposes of the review have failed.

1.13 The accounts of involvement with the victim and/or suspect cover different periods. Some of the accounts have more significance than others. The extent to which key areas are covered and the format in which they have been presented varies between the agencies. Where the accounts from agencies failed to address key issues or raised unresolved issues, further requests for clarification and/or specific items of additional information were made.

1.14 The death of LP was discovered on 26th April 2011. The review was formally commissioned on 24th May 2011. The final draft of the review report was submitted to the Community Safety Partnership (CSP) on 30th January 2012, some eight months later. The extension of two months was granted by the CSP Board Chair to take account of the fact of late submission of some IMR material. Whilst the slight delay in completion of the review is to be regretted, the fact that this was the first such review to be commissioned in East London meant that in some agencies, new business processes and staff arrangements were necessary to cope with the demands of producing IMRs in an unfamiliar format. Delays in the formulation of the MPS submission to the review were exacerbated a concurrent investigation into some of the policing aspects of the case by the Independent Police Complaints Commission. The

extension of two months also allowed a proper opportunity for the Review Panel members and their staffs to review an early draft report over the Christmas period and suggest amendments.

1.15 Notwithstanding delays in IMR submission and completion of the review, significant improvements within and between agencies were identified and initiated even before the presentation of the final draft report to the Community Safety Partnership (see Appendix D – Joint DV performance Improvement Plan).

1.16 The subjects of this report are LP and PW. Their identifying details are set out below:

LP (nee H), born 05.08.1981
7 Brymay Close
London
E3 2SY

White/British

No known faith/religious affiliations

PW, born 29.09.1979
No fixed address

White/British

No known faith/religious affiliations

There are no known diversity issues other than PW's substance addictions and his intermittent homelessness.

1.17 On Sunday 24th April 2011 the Police were called by the London Ambulance Service to Weavers Field, Bethnal Green Road, London E2. On arrival the officers were approached by a young boy who told them that a male was hanging in the trees in a wooded area set aside from the open area of the park. The officers found the man hanging with a ligature around to his neck consisting of a belt attached to a branch of the tree and what appeared to be string wrapped around the man's neck. Life was pronounced extinct at 18.39 hours.

1.18 Documentation on the body identified it as that of PW. Also on the body was a set of keys which were later proved to have belonged to LP. As a result of enquiries, in the early hours of Tuesday 26th April police officers went to LP's address at 7 Brymay Close, London E3 but were unable to gain access. Later that day at 06.50 hours the officers returned with the keys found on PW's body and having received no reply to knocking, entered using the keys. In the flat they found LP's dogs and the body of LP, covered with a blanket. The body was lying on its back with a large knife embedded in the chest and a ligature around the neck. Life was formally pronounced extinct at 07.02 hours.

1.19 Both deaths were investigated by officers of the MPS Homicide & Serious Crime Command. The preliminary conclusion of the MPS homicide investigation, which has yet to be formally considered by HM Coroner, is that PW had spent most of Thursday 21st April with LP but that around 21.00 hours that night, they argued and PW left the flat at LP's request. He returned an hour or two later asking for his tobacco but then left again. It is not known where PW spent the night of 21st/22nd April but at some time after 07.00 hours on 22nd April he returned and killed LP. At some time after 07.00 hours on 23rd April, PW then went to Weaver's Field where he took his own life.

1.20 On 24th September 2012 the inquest into the death of PW concluded that he took his own life while suffering from a depressive illness. The cause of death was determined as "suspension".

1.21 The inquest into the death of LP was opened and adjourned on 3rd May 2011 and has yet to be concluded (projected date Spring 2013).

1.22 The findings of this review are confidential. This report is available to the families of the deceased, participating officers/professionals, their line managers and members of the Community Safety Partnership Board. Copies of this report have also been provided to HM Coroner and the Home Office.

2. Case History

2.1 LP and PW met in 2005 at a drugs rehabilitation clinic where they were both undergoing treatment for their respective substance misuse problems. By this time LP had had two children with a husband who had become so violent that the children were taken into care. The extent of the violence is well illustrated by the fact that in 2003, a total of 28 domestic violence incidents involving the couple were recorded by the MPS. After LP separated from her husband, her continued vulnerability to domestic violence is illustrated by the fact that in 2004 she featured in 13 domestic violence reports involving three different partners. She had been disowned by her family although her parents were granted full custody of her two children. Since this time there has been little contact between LP and her parents and no contact between her and her children. She had a substantial criminal record for minor violence, offences against property and theft. Despite the fact that LP had no convictions or cautions for drugs offences she was known to be a user of Class A drugs (cocaine and heroin) and it was as a result of a conviction for fraud in 2005 that she was subject to the Drugs Testing &Treatment Order which led to her attendance at the rehabilitation clinic where she met PW.

2.2 PW had a history of alcohol and drug abuse since the age of 16, including heroin addiction since he was 18. He had an extensive criminal record: up to the time of his death he had a total of 21 convictions for 38 offences as well as six cautions. The offences included theft (shoplifting) drug possession, arson, assault, escaping from custody, bail offences, criminal damage and racially aggravated harassment.

2.3 After leaving the rehabilitation clinic, PW and LP went to live with PW's mother in her flat at 5 Oswell House in Wapping. The couple's stormy relationship first came to the notice of police when, on 4th January 2006, PW's mother told police that during an argument, PW had damaged property and then assaulted LP by punching her in the face. LP's injuries were treated in hospital and photographed. PW was arrested some time later but cautioned for the offence largely because LP refused to co-operate with police; refusing to attend court or consent to the disclosure of her relevant medical records. The matter was properly dealt with and recorded by the police officers and an appropriate risk assessment made.

2.4 On 27th March 2006, police were called to the flat at 5 Oswell House. It was alleged that PW had punched, slapped and kicked LP. He had finally been restrained by the presence of his parents but then left the flat before the arrival of police. LP sustained relatively minor injuries and a statement was taken from her. The details of

the incident were properly recorded in the MPS Book 124D (Book 124D is a printed proforma booklet which prompts officers to record all relevant details of a domestic violence incident, including brief statements from victims and witnesses, and includes prompts for them to make a preliminary risk assessment). The officers completing the preliminary risk assessment graded the risk as "high". This initial assessment was later changed to "medium" by the Officer in the Case (OIC) after LP had apparently been rude to him, refused to listen to him and made it clear that she would not co-operate with a prosecution *(Comment: changing a risk assessment on this basis was contrary to MPS policy and practice).* The following day, LP alleged that she had been approached by PW in the street as she walked to work. Apparently PW had head-butted her in the face then kicked her in the stomach after she had fallen to the ground and then run away. Although this matter was reported in a Book 124D, no new risk assessment was recorded (as it should have been) on the crime report. The following day LP was contacted by the OIC. By coincidence this was the same officer that investigated the incident on 4th January (above). LP refused to substantiate the allegation, make a statement or attend court to support a prosecution. PW's mother and her husband also declined to make statements in relation to the incident. The case was closed with no arrest of PW and no further action *(Comment: this sequence of events should have been dealt with differently. MPS policy at the time and still extant required that in these circumstances, the suspect, PW, should have been arrested despite the wishes of the victim. On the basis of the reported incidents, there appears to have been an escalating level of risk in the relationship which remained unrecognised by officers dealing with LP and PW).*

2.5 On 27th April 2006 PW's mother called police to report that PW had made threats to burn her home down to reinforce his demand that she finance his and LP's drugs habits. It appears that both LP and PW stopped living at 5 Oswell House around this time although PW apparently returned to his mother's home on a regular basis. Attempts were made to arrest him but it was not until some months later that he was actually arrested for the offence and cautioned.

2.6 By May 2006 LP had moved to a new flat at 38 Charles Dickens House, London E2. It is not known whether PW was living with her at this time but on 15th May she called police to allege that she and PW had argued outside her flat during which he had grabbed her hair and punched her in the eye. He had apparently then followed her into the flat and ransacked it, threatening to kill her and set fire to the flat if she called the police. Crime reports were properly completed and an appropriate preliminary risk assessment completed although it is accepted by the MPS that the follow-up investigation was allowed to drift with only ineffectual supervision. PW was eventually

arrested on 29th December having been found sleeping rough in the stairwell of his mother's block of flats. He denied the offences against LP but nevertheless accepted a caution.

2.7 It is not clear whether or not LP and PW sustained their relationship during 2007, although the absence of any record of police being called to domestic disputes between them suggests that the couple had separated. It is not clear where PW was living but it is likely he was at least intermittently homeless and sleeping rough. In January he was charged with causing criminal damage at his mother's home after an argument, due to her refusal to give him money to buy drugs; indicating a substantial breakdown in their relationship. LP occupied two different privately rented flats in this period and came to the notice of police in May 2007 due to her involvement with a married man. It was alleged that LP had made threatening 'phone calls to the man's wife having herself become the victim of threats (from the wife) due to the affair. The investigation revealed that there had been provocation on both sides of the dispute. The suspect for the threats against LP was issued with a Harassment Warning. Later in the year LP reported suspicious activity in and around her flat involving the taking of her car and criminal damage to the flat. As on previous occasions, however, having made the initial allegations she then refused to substantiate them or assist with an investigation.

2.8 In October 2007 PW set fire to rubbish in a lift in the block of flats where his mother lived. He was subsequently charged with arson. The Police National Computer does not record whether the "intent" was merely to damage property or to endanger life. Probation Service information, however, records that the charge was arson with intent to endanger life or being reckless as to whether life was endangered. PW pleaded guilty at Snaresbrook Crown Court and was sentenced to 21 months imprisonment.

2.9 On 15th March 2010 LP called police to allege that her ex-boyfriend had assaulted her. It transpired that LP and PW had resumed their relationship after his release from prison. LP's call to police was made after she and PW had argued over the telephone. Apparently they had been together for about three months but separated a month earlier (i.e. around Feb 2010) after he had assaulted her (common assault). By this time LP was living in privately rented accommodation at 7 Brymay Close, London E3. An officer from the MPS local Community Safety Unit invited LP to discuss her situation and offered to refer her to Victim Support but she declined all assistance and no further action was taken.

2.10 In June 2010 PW approached his General Practitioner for help with his drug problems. The GP prescribed methadone from June 2010 to July 2010 but then referred

him for help to the Tower Hamlets Specialist Addiction Unit (THSAU) at Mile End Hospital. At this time PW was using methadone, heroin, crack cocaine, alcohol cigarettes and cannabis. He was assessed at the Unit as having a history of self harm with symptoms of severe depression, anxiety and a possible personality disorder. He was recorded as being on a Drug Rehabilitation Referral Order (imposed some months previously as part of a sentence for theft by shop-lifting) supervised by the Probation Service. PW appears to have attempted to engage with the THSAU, attending appointments and gradually disclosing more information about himself, including the existence of a "lady friend" (believed to be LP). On 9th August a medical review of PW was conducted with a Consultant. The review recorded that he had at that time managed to abstain from heroin for two weeks albeit continued to use Diazepam and Temazepam daily. *The risk assessment was that he presented a high risk to himself and others which increased when he became intoxicated.* The medical notes of the review record that a telephone message was left at the Cambridge Heath Probation Service office regarding the outcome of the review. It is noteworthy that PW continued to engage with staff at the THSAU until his death. Whilst at times his attendance and behaviour were erratic and occasionally volatile, THSAU staff provided continuing support and assistance in trying to help him with his drugs habit.

2.11 On 22nd August 2010 it became apparent that PW and LP had renewed their relationship but that once again they had argued. PW called police because LP was throwing his property out of her flat. The reporting officers properly completed a risk assessment (risk graded as "standard") and Book 124D but since no offences were disclosed no further action was necessary. This was the first occasion since the couple resumed their relationship that police were called to an incident between them.

2.12 On 8th September police were again called to LP's flat where she and PW were arguing. Apparently he had come to the flat to collect some of his property. He was drunk. After both LP and PW were spoken to by the attending officers, LP agreed that PW could stay with her in the flat but an hour later a second call was made to police. When the officers attended LP claimed the call had been made in error. The officers persuaded PW to agree to being taken to his mother's home. The incident was risk assessed as "standard" and a Book 124D was completed and properly supervised. This was the second occasion police had been called to a domestic violence incident between LP and PW since his release from prison.

2.13 A few days later, on 11th September, the police were called to LP's flat on three separate occasions. At 20.14 hours a call was made to the Police Operator. Despite the fact that there was no answer to the Operator's questions, a voice could be heard

saying words to the effect “You are terrifying me”. The Operator believed the ‘phone could be in the caller’s pocket. An urgent subscribers check was completed and the ‘phone was registered to LP’s address. Local officers then attended the address to check on the welfare of the occupiers and found both LP and PW. Having been satisfied that LP was safe and well the officers left. At 23.39 a further call was made to police from the address. This time, LP said she had been assaulted by PW some 20 minutes after the officers had left on the previous occasion. She claimed that PW, for no apparent reason, had punched her in the face then thrown her over a small gate in the flat and that when she had picked herself up again, he had pushed her back to the floor and stamped on her face about 12 times. An ambulance had been called and the crew recorded LP’s injuries as a bruised right upper arm and a swollen left cheek i.e. somewhat less than might reasonably have been expected as a consequence of the type and extent of the assault she claimed to have taken place. PW had left the flat before police officers arrived but LP provided a statement, naming PW as her assailant. An appropriate preliminary risk assessment was completed in the Book 124D. At 00.41 hours after seeing the Emergency Services leaving LP’s flat, a local resident called police because he had seen a man jump in through the window of LP’s flat. Officers returned and spoke to LP whereupon she whispered to them that PW was hiding in the bedroom. Despite trying to escape back through the window PW was arrested. When interviewed PW admitted having argued with LP during the day and alleged that she had kicked him in the shins. This caused PW considerable pain because he suffered from deep vein thrombosis (DVT) as a result of his drugs habit. PW further explained that in self defence he had grabbed both LP’s arms and that she had indeed fallen over the gate in the flat but that he had not punched her and he had not stamped on her head, insisting that had he done what she claimed it would have killed her. *(Comment: though the information was not available to any of the officers investigating the allegations, medical records from the THSAU corroborate the fact that PW suffered from DVT in his legs).*

2.14 CPS advice was sought on the case. The advice was that no further action should be taken against PW since there was not a realistic possibility of conviction. This advice was based on the following factors:

- Although PW admitted to pushing LP, he claimed self defence and there was no independent witness.
- There were only slight injuries but had LP been stamped on 12 times her injuries would have been expected to be more extensive and more serious.

2.15 Proper consideration appears to have been given to the issue of what, if any charge should have been preferred against PW. There is no record, however, of any secondary risk assessment being conducted by the police as regards LP. Nor is there any indication within the crime report that LP was informed that there would be no further action against PW or that he had been released from police custody.

2.16 A few hours after PW had been released from police custody, police were called back again to LP's flat. LP told the officers that PW had returned to her flat and tried to get in – she believed in order to recover some of his property. PW had left by the time the officers had arrived and LP had run to a neighbour's home for safety. She told the officers that she had thought PW was still in custody and was scared of him and what he might do to her. This incident should have been reported by the police on a new CRIS report. In fact the attending officers were wrongly advised by a member of the MPS Community Safety Unit to add the details to the CRIS report generated as a result of the incidents on 11th September. This was contrary to MPS policy. No secondary risk assessment was completed by the police and the only risk control measure was to tell LP that she should call 999 if PW returned.

2.17 The manner in which the incidents on 11th and 12th September were recorded was not strictly in accordance with MPS policy. Perhaps this aspect of the management of the incident is best understood by accepting that a possible interpretation of what occurred was a single incident which extended over two days rather than the three police attendances on the night of 12/13th being considered as one incident and the attendance on the morning of 13th being as a second and distinct incident – if this interpretation is accepted, the creation of a single CRIS record, rather than two separate records becomes explicable. Such an approach would explain the advice which was given to the reporting officers. It does not, however, account for the absence of a new secondary risk assessment. None was done for the incident on 11th September and none was done for the final incident on 12th September. *(Comment: this flaw is all the more serious since by the end of 12th September; police officers had attended LP's flat on a total of six separate occasions in less than a month).*

2.18 The following day PW attended his GP's surgery in a tearful state claiming to be receiving no support from the THSAU. He was apparently having thoughts of suicide and self harm. This fact is corroborated by the fact that PW's mother wrote a letter to the THSAU saying that she was unable to have him living with her because he was suicidal and in her view, needed professional help. The appropriate Consultant decided to prescribe an anti-depressant, Citalopram. In the weeks that followed it appears that PW's condition deteriorated and on 22nd September the co-ordinator of the Drug

Intervention Programme that PW was attending informed the THSAU that his drinking had become chaotic and that he was trying to secure a crisis admission for PW to the City Roads Clinic. PW agreed to undergo a telephone assessment for the admission but the following day his commitment had lessened and in the event, no assessment was completed and he was not admitted to the clinic. At this time, whilst PW denied having to drink on a daily basis, he claimed to be "losing his mind" and having blackouts since starting his prescribed Citalopram. Notwithstanding his denial of alcohol consumption, on 28th September PW attended an appointment with his Key Worker at the THSAU smelling of alcohol. A care plan was devised for PW and the Key Worker noted the need for liaison with PW's Probation Officer and GP. He assessed PW to be at risk of suicide and included in the care plan the need for a medical review if any suicidal ideation or intention became apparent, with a psychiatric admission if necessary.

2.19 When PW attended the THSAU on 18th October he was seen by a cover Key Worker as his regular Key Worker was absent. He reported that he had smoked 5 – 9 lines of heroin that day after having an argument with his mother. It was also noted that he had stopped taking the prescribed Citalopram which he blamed for causing him to have blackouts. It was noted that PW needed to have a mental health assessment in order to be readmitted to the Drug Dependency Reduction Programme and that this requirement should be communicated to his Probation Officer. The following day PW was discussed at the regular clinical meeting which includes an Adult Mental Health psychiatrist at which it was agreed PW should have a medication review in two weeks.

2.20 On 28th October 2010 PW and LP were involved in an argument in the street which led to PW assaulting her. Apparently PW knocked LP off the bicycle she had been riding then punched her in the face three times and stamped on her head. The incident was witnessed by three bystanders, one of whom intervened, causing PW to run off. LP suffered several bruises to her face and a small cut on the bridge of her nose as well as bruised legs. She attended the Royal London Hospital where her injuries were treated and photographed. At the time of the incident LP said she would support police action and attend court. After PW's arrest (see below) LP provided a statement to support his prosecution.

2.21 The initial police response in relation to this offence was correct. Positive action was taken to trace and arrest PW and he was in fact arrested two days later on Saturday 30th October 2010. When being interviewed by police officers about the incident, PW explained the argument had arisen when he had asked LP to buy him some cigarettes. The situation had escalated as he became angry and started to jump

up and down on the bicycle he'd been riding. He claimed LP had got off her own bicycle, grabbed hold of him and started kicking him on his legs, which was especially painful as he suffered from deep vein thrombosis (as a result of his drug addiction). His explanation for the assault was that he had grabbed her hair in self-defence and thrown her to the ground as a result of which she had collided with a tree.

2.22 The advice of the Crown Prosecution Service (CPS) was sought to determine whether or not to proceed with a prosecution and the most appropriate criminal charge. The decision was made to charge PW on what is known as the "Threshold Test". The Threshold Test is used in conjunction with the Full Code Test in the Code for Crown Prosecutors. The Threshold Test is applied to those cases in which it would not be appropriate to release a suspect on bail after charge, but the evidence to apply the Full Code Test is not yet available. The Threshold Test requires prosecutors to consider whether "in all the circumstances of the case there is at least a reasonable suspicion against the person of having committed an offence (in accordance with Article 5 of the European Convention of Human Rights) and that it is in the public interest to proceed." In addition to the charging decision, the CPS also provided a brief action plan for the further investigation of the incident, requesting, inter alia, referral to local DV support services, obtaining medical evidence, photographs and the outstanding statements of the three independent witnesses.

2.23 After charging, the decision of the police Custody Officer was that PW should not be released on bail. The grounds for this decision were recorded as:

- Previous failure to surrender to custody on three separate occasions
- Refusals to be drug tested or attend an initial appointment for drug testing (despite being subject to a Drugs Testing & Treatment Order)
- A previous attempt to escape from lawful custody
- On five occasions he had committed offences whilst on bail
- The risk of interference with witnesses including the victim

In view of PW's history of violence, chaotic drugs use and repeated offending, the Custody Officer's decision to withhold bail was well-founded and entirely appropriate. A consequence of the decision was that PW was held in police custody over the weekend and taken before Thames Magistrates' Court on Monday 1st November 2010.

2.24 The crime investigation of the allegation of assault was undertaken by the police Officer in the Case (OIC) in the Community Safety Unit (CSU). As a matter of routine, DV cases are also referred to another officer within the CSU (known as the CSU MARAC Co-ordinator) whose specific role is to consider whether or not the case should be referred to the Tower Hamlets Multi-Agency Domestic Violence Safety Planning Panel which is the borough's name for it's Multi Agency Risk Assessment Conference (MARAC). The aims, objectives, membership and operating protocols of the MARAC are fully explained in the published booklet which has been examined for the purposes of this review. Neither Her Majesty's Court & Tribunals Service (HMC&TS) nor the CPS are members of the MARAC partnership or the Community Safety Partnership. This separation is significant in that it enables both bodies to exercise their proper functions of independent review and decision making.

2.25 The published aims of the MARAC include:

- Sharing information to increase the safety, health and wellbeing of adult and child victims of domestic violence.
- Reviewing cases and ensuring that all possible strategies for increasing the safety of victims and imposing sanctions to deter repeat offending are fully explored and implemented in a co-ordinated way.
- Monitoring the implementation of local policies in relation to specific cases.

2.26 The MARAC operating protocols recognise that if it is to be effective in its stated aims, it is essential that DV cases are prioritised on the basis of risk. This enables the highest risk cases to be addressed as thoroughly as resources will allow. The assessment of risk is undertaken using the DASH risk assessment tool (see Appendix B). An initial risk assessment should be carried out by police officers attending DV incidents (whether or not the incident involves a crime) using the prompts contained in the report book known as Book 124D. All such report books should be checked by the reporting officers' supervisors and submitted promptly to the CSU. The initial assessment of risk should then be reviewed and where possible supplemented with additional information by the OIC in the CSU. This secondary risk assessment should then be referred to the CSU MARAC Co-ordinator. The role of the MARAC Co-ordinator is to examine each report to decide whether or not it should be referred to the MARAC for consideration as a high risk case. In Tower Hamlets the referral criteria are:

- The risk assessment shows 14 or more positive responses, or

- There is an escalation of six or more incidents/offences within a year, or
- The OIC feels in their professional judgement that the victim should be referred to MARAC

Based on the above criteria, LP did not qualify for referral under either the first or second criteria. The third criteria "professional judgement" is by its nature subjective rather than objective. It is at least arguable that the knowledge *reasonably available* to the police CSU *could* have justified referral. LP was not, however, referred to the MARAC as a high risk case.

2.27 This case raises two particular features which merit consideration as possible factors indicating heightened risk: the apparent serial vulnerability of LP in relation to domestic violence from other partners and the fact that despite the efforts of the OIC and Independent Domestic Violence Advocacy (IDVA) service, she refused to engage with the agencies which could have supported her (see paras. 2.36 to 2.38, below). Cleary however, such factors should not be formally included in a risk assessment framework without proper research to verify their applicability.

2.28 On Monday 1st November 2010 PW appeared at Thames Magistrates' Court as an "overnight prisoner" i.e. one that has been kept in custody and brought before the court at the first opportunity. A consequence of PW's appearance on a Monday was that the case was not processed through the Specialist Domestic Violence Court (SDVC). The SDVC aims to provide much enhanced levels of service to victims in DV cases. All the relevant agencies are parties to the agreed operating protocols for the SDVC (see Appendix C). The protocols allow for overnight prisoners to be dealt with initially by a non-SDVC but require that at the first appearance, where a case is remanded, it should be remanded to the specialist court. At Thames Magistrates' Court, the specialist court sat (and still sits) only on Thursdays. In fact PW's case was never dealt with by the specialist court. HMC&TS regard the SDVC as a valuable resource, the capacity of which requires careful management. As a result of its own individual review of its process the HMC&TS has recognised that an informal practice had emerged to manage resources by allocating some "simple" DV cases to non-SDVC days, thereby reserving the intensive arrangements of the specialist court for those cases most in need of enhanced support. The view of the HMC&TS is that at the time, PW's case appeared to fall towards the bottom of the priority ranking. As has already been noted, the courts are not part of the MARAC partnership or CSP and that as such, even had LP case been referred to *MARAC that would not of itself have ensured that the case would be regarded as being of higher risk by the court administrators.* An

examination of PW's charge sheet sent by the police to Thames Magistrates' Court reveals that it was not even stamped as being a DV case (as required by the SDVC Protocol) but this did not prevent the court administrators recognising it as a DV case. This illustrates the point that the court administrators and the court itself rightly operate independently of the MARAC partners, as would be expected of a properly impartial and transparent judicial process.

2.29 When PW appeared before Thames Magistrates' Court the Associate Prosecutor's submission that the case should be committed to Crown Court was accepted and PW elected for a jury trial. The case was adjourned to 13th December 2010 to allow time for the committal papers to be prepared by the Prosecutor. The CPS objected to PW being granted bail on the basis of the grounds indicated by the Police (see para. 2.23 above). After hearing representations from the Defence, PW was in fact granted bail, conditional on him residing with his mother at 5 Oswell House and not contacting LP.

2.30 The address at 5 Oswell House was provided by PW, confirmed by his legal adviser and matched the address given to the police by PW when he was arrested/charged. There is no police record of this address being checked for its suitability as a bail address, though it is possible that a check was in fact made. Such a possibility is suggested by the fact that when completing the case papers for the information of the CPS, the OIC noted that, whilst objections should be made to the grant of bail by the court, if bail was in fact granted, then a condition of residence at 5 Oswell House should be sought – implying that some attention had been given to the suitability of the address. It is certainly the case that in November 2010, PW's mother lived at 5 Oswell House but it is also certain that PW's relationship with her was volatile and that at various times (most recently in September 2010 in a letter to the THSAU) she had indicated her unwillingness to have him living with her. There is no record of Thames Magistrates' Court having asked the police to verify the address and/or its suitability for bail. It should be noted that when considering bail, the courts are entitled to the assistance of both Prosecution and Defence representatives as well as that of the police, but that the role of the court is *inquisitorial* rather than its usual role of presiding over the adversarial process between Prosecution and Defence.

2.31 HMC&TS does not fall within the terms of the Domestic Violence and Victims of Crime Act 2004. Despite this, HMC&TS provided a very full IMR but with the explicit proviso that whilst its policies, processes and actions are within the scope of its review, judicial decision making is rightly independent and therefore not subject to comment.

2.32 A possible explanation for the decision to grant PW conditional bail is that at the first appearance on 1st November 2010, LP attended the court and indicated she no longer wished to support a prosecution. The court notes are unclear on how this fact emerged. LP's lack of support for the continued prosecution is also noted in the IMRs provided by the MPS and CPS although it is also clear that no formal withdrawal statement was taken from her. The SDVC Protocol envisages such circumstances and provides that in such a case, an adjournment should be granted (on the application of the Prosecutor) to allow the police to make suitable enquiries about the voluntariness of the withdrawal of support. There is no record of such an application and it seems unlikely one was made.

2.33 The fact that PW was granted bail despite Prosecution objections has a number of legal implications. First, the Prosecutor had the option of seeking to appeal against the decision. Where a decision to appeal bail is made, the court is put on oral notice of this and the case is then listed at the Crown Court for the appeal to be heard. Where oral notice is given of the Crown's intention to appeal bail, there is a legal requirement to record this in the court's written record. The absence of such a record suggests that no oral notice of the appeal was given. In addition, where a court grants bail against Prosecution objections, the Criminal Justice & Police Act 2001 inserted into the Bail Act 1976 a requirement to give reasons why bail has been granted (i.e. to justify the decision). There are no notes of the reasons why bail was granted to PW. The internal review conducted by HMC&TS suggested that the import of these amendments to the Bail Act were not widely appreciated amongst the magistrates' court's Legal Advisers.

2.34 The day after his court appearance PW attended the THSAU for a review with his Key Worker. He admitted to smoking heroin over the weekend (presumably before his arrest the previous Saturday) and the analysis of his urine sample showed positive for heroin and cocaine. The Key Worker noted that he had a scratch on his face. When asked about this, PW claimed he had had an argument with his girlfriend over cigarettes in which she had scratched and kicked him. He asked that henceforward his girlfriend should not be given information about him. Though it is a matter of speculation, PW's remarks to his Key Worker may indicate his intention to stay away from LP (as required by his conditions of bail). Medical records from the THSAU indicate that during the remainder of November and most of December 2010, PW persisted with his drugs treatment.

2.35 On 13th December 2010 PW answered to his bail for what was scheduled by the court to be a committal hearing. CPS records indicate that little progress had been made in the preparation of the case in the time since PW's first appearance. CPS

requests for the OIC to complete a full prosecution file of evidence met with no success, nor had the OIC dealt with the original Action Plan given to him at the point of charge. This eventually culminated in the CPS lawyer personally telephoning the OIC and requiring him to undertake the work forthwith. The prosecution file was finally sent to the CPS but it was not until 10th December (i.e. more than a month since PW's arrest) that a CPS lawyer was in a position to conduct the first formal review of the case. This review appears to have covered all salient points including consideration of the viability of sustaining the prosecution despite the reluctance of LP to support it. It is likely that the review also identified the absence of any statement from the independent witnesses to the assault and that therefore the case was not yet ready for committal. At the court appearance on 13th December the Prosecutor sought an adjournment of the committal on the basis of the missing evidence. This request was granted and the case remanded to 10th January 2011. No application was made by either Prosecution or Defence to change PW's bail status. *(Comment: the Prosecution is reliant on updated information from the police about the bail status of a defendant and details of any identified risks before inviting the court to revisit the question of bail. At this stage of this case, there was no new information available to the police to justify an application to change PW's bail status)*

2.36 Running in parallel with the legal processes relating to PW's alleged assault on LP, the Witness Care Unit (WCU), an MPS managed unit (comprising MPS staff and a single CPS administrator), had an important role in supporting LP as a victim/witness. The first recorded contact with LP was on 2nd November 2010 (i.e. five days after the alleged assault and three days after PW's arrest) when the WCU sent to LP its standard letter for victims which introduces the services of the unit and promises, inter alia:

- To keep you informed of important developments in the case as it progresses through the court, and
- To let you know about other people who might be able to support you such as Victim Support and its Witness Service.

The next recorded attempt to contact LP did not occur until some 4 months later, on 22nd February 2011, when a failed attempt was made to telephone her. Three further attempts were made to contact LP in which messages were left inviting her to call back but no actual contact was made. On 5th April 2011 it is recorded that the OIC informed the WCU that he had not spoken to the victim since she had hung up the phone to him when he 'phoned her to let her know that PW had been charged with assaulting her

(Comment: this call must have been made between 28th October and 1st November i.e. five months earlier).

2.37 There is no record in the WCU of LP being informed of any of the hearings of PW's case (including the breach of bail hearings). Nor is there any record in the WCU of LP being referred to any of the specialist support agencies, despite the fact that Tower Hamlets has an Independent Domestic Violence Advocate (IDVA) service (provided by Victim Support). Despite the absence of such records in the WCU, LP was in fact referred to the IDVA service by the police Community Safety Unit. LP first became a client of the IDVA in 2009 due to her becoming a victim of domestic violence in relation to another partner (i.e. not PW). As part of the 2009 case, although LP declined to engage with the IDVA she was ultimately referred to the MARAC under the "professional judgement" criteria without her consent.

2.38 LP had been referred by the CSU to the IDVA in September 2010 after the incident on12th September (referred to in para. 2.13) in which it was alleged that PW had assaulted her. There were further police referrals to the IDVA on 31st October 2010 (re. the alleged assault by PW on 28th October), 7th January (in relation to an allegation on 3rd January 2011 by LP that she was being harassed by neighbours sending her hostile text messages) and 10th February 2011(re the breach of bail by PW on 31st January 2011). On each of these occasions, efforts were made by the IDVA to contact LP. The attempts on 12th September and 31st October both failed. The later efforts to make contact; on 7th January 2011 and 10th February 2011 were successful but on both occasions, LP declined any support.

2.39 It is evident that there was a lack of co-ordination of effort between the WCU and the CSU. Such a lack of co-ordination and poor information sharing echoes the findings of the Her Majesty's CPS Inspectorate report on the performance of Tower Hamlets CPS (2009), which rated the service to victims/witnesses as "poor."

2.40 On 21st December 2010 PW attended the THSAU for a Key Worker review and a urine test. The results of the test were positive for methadone (which he was prescribed) and cannabis but showed no indication of opioids. PW was apparently keen to be able to show this test result to his mother and girlfriend – an indication that his relationship with LP might have resumed. Two days later PW's Key Worker completed an updated risk assessment. The assessment included risks related to PW's history of overdose, injecting risks, suicidal attempts and his history of violent, impulsive behaviour. There are no references to PW's offending behaviour, as might have been expected given that the THSAU records include the fact that he was in contact with the

Probation Service and had at various times disclosed to his Key Worker his experiences with the police. The extent to which the details of this assessment could be shared with partner agencies was severely constrained by medical confidentiality rules. What little information could be shared between THSAU and Probation was further limited by the fact that PW's Key Worker, though aware of the fact that PW was subject to the supervision of a Probation Officer, did not know her name.

2.41 On 10th January 2011 PW attended Thames Magistrates' Court for the planned committal proceedings. The proceedings appear to have been entirely routine and PW was committed to Snaresbrook Crown Court. No application was made by either side to vary PW's bail status which accordingly remained unchanged. *(Comment: Again, no updated information about the defendant's suitability for bail and/or identified risks were available to police that might have justified an application to revisit bail issues)*

2.42 On 31st January 2011 LP 'phoned the police. The Operator believed she sounded upset but having given her address, the call ended. Officers attended LP's flat to check on her welfare. She explained that she was going through a court case with her ex-boyfriend, PW, and that she had earlier heard what she believed to be him trying to gain access to her block of flats. She claimed to be scared of PW because he had beaten her up in the past. The officers checked that the doors and windows of the flat were secure and advised LP that should PW appear, she should not let him enter her flat but call 999 immediately. Before the officers left the scene, PW did appear and he was duly arrested for breach of his bail conditions, held in custody overnight and taken before Thames Magistrates' Court the following morning.

2.43 An Associate Prosecutor (AP) was assigned to deal with the breach of bail hearing on behalf of the CPS and sought instructions from a Senior Crown Prosecutor (SCP). It is important to note that the police had failed to provide the prosecution with any updated objections to bail and/or an updated risk assessment in respect of the victim. The AP was instructed to proceed with the breach of bail under section 7(b) of the Bail Act 1976 on the basis that this would enable the court to remand PW in custody or grant him bail subject to the same (or different) conditions. The SCP considered whether or not an appeal should be lodged in the event of the court remanding PW on bail. The SCP advised *against* an appeal and noted the following cumulative (rather than individual) reasons in support:

- There were no previous breaches of bail between 1st November 2010 and 1st February 2011. *(Comment: PW did, however have a history, extending over a number of years, of non compliance with court orders etc. The police did not,*

however, provide an updated risk assessment or updated information in support of any objections, which the CPS regard as a paramount consideration).

- The victim (LP) had indicated at PW's first court appearance on 1st November 2010 that she did not wish the assault charge to proceed and that she did not want to make an allegation of a breach of bail. *(Comment: whilst this is a significant factor, the non-co-operation of a victim of domestic violence is envisaged in CPS policy on dealing with such cases and does not necessarily preclude a successful prosecution –see www.cps.gov.uk/publications/docs/domesticviolencepolicy, para.5.12 et seq.)*

- The reasons the defendant gave for contact with LP was that they had gone shopping together and that he had gone to the flat to collect his belongings. *(Comment: if it were true that LP and PW had gone shopping together before returning to her flat, this implies that PW had broken the non-contact condition of his bail in a more substantial way than the arresting officer had realised).*

- The defendant's last conviction for violence was in 2007 and that was against a police officer *(Comment: whilst not a crime of violence, PW also committed arson with intent to endanger life or being reckless ….. etc by setting a fire in the lift of his mother's block of flats in 2007, for which he received a sentence of 21 months imprisonment in 2008. This information should have been provided by the police to the CPS by way of what is known as an updated MG7 document).*

- The defendant's last conviction was 8th October 2010 for an offence of shoplifting.

- Under the existing sentencing guidelines, the likely penalty for the ABH which resulted in minor, non-permanent injury was a starting point of a high level Community Order with a range between medium level Community Order and 26 weeks custody.

In formulating this advice the SCP would have been constrained by CPS legal guidance on the subject (see: www.cps.gov.uk/legal/a_ to _c/bail.#a60). The import of this guidance is considered within the analysis section of this report at para. 3.27.

2.44 The Legal Adviser in court on 1st February 2011 has since retired; consequently the review of what took place at the hearing is based on the endorsements on the court file. The standard administrative procedure for such cases is for the court administration team to create a new case entry on the Libra computer system. The

written procedure refers to the creation of a separate electronic case file for each case but does not deal specifically with the creation of a manual file to be used by the Legal Adviser in presenting the case to the court. It appears that there are differing expectations and practices in courts across London but some courts would expect the rather obvious precaution of ensuring that the original case file (i.e. for the offence for which bail was set, in this case the ABH on LP) is retrieved from storage and attached to the fresh breach of bail file. Although the HMC&TS Standard National File Cover Guidance in force at the relevant time provided a procedure to be followed when preparing manual case files in breach of bail cases, the guidance was not in an easily accessible form or location. It is obviously helpful if the original case file is before the court as it provides an opportunity for the Legal Adviser to provide additional information to the court to inform the bail decision, whereas if a fresh case file is prepared for each breach of bail hearing but not attached to all previous related files, there is a real danger of important details being overlooked. As a result of the internal review undertaken by HMC&TS, the national guidance on this aspect of case file preparation has been improved (see para. 4.2).

2.45 In the case on 1st February 2011 a fresh case file was prepared by the court administration team but it is not possible to say with any certainty that the original case file (for the ABH) was attached. Neither is it possible to say whether or not PW was asked to confirm his address as 5 Oswell House (as was recorded on the police charge sheet). It is usual practice for defendants to be asked to confirm their addresses and this fact to be recorded by a tick on the appropriate part of the court case file. *In PW's case there is no tick on the file.*

2.46 When the court considered PW's bail status, the Legal Adviser's note indicates that the CPS Associate Prosecutor (AP) confirmed that there were no objections to bail continuing on the same conditions plus an additional condition that PW should not enter Brymay Close/Wrexham Street E3. If this is what occurred it was subtly different from the course of action recorded as being advised by the SCP to the AP. The SCP's advice was simply to put the facts before the court and allow the court to make its decision, rather than what appears to have happened, i.e. that the AP made a submission to the effect of allowing the status quo plus an additional condition. The absence of an updated MG7 from the OIC or a fresh risk assessment clearly did not assist matters. It may be the case that the SCP's advice *against* any appeal against a court decision to grant bail was misinterpreted. There is no record of the new condition of bail (i.e. not to enter Brymay Close/Wrexham Street E3) being imposed, nor do the Legal Advisor's notes of the hearing indicate a reason for the rejection of the condition. In any event, PW was re-committed on conditional bail to Snaresbrook Crown Court for trial.

2.47 Although the exact date is unknown, at some point in February 2011, PW's mother vacated her flat at 5, Oswell House (which was subsequently re-let) and moved to a flat in London E1. She and PW had applied to the LBTH Housing Department to be re-housed many months before. Despite the fact that they had made a joint application, it would appear that relations between mother and son were still volatile. In March 2011 PW's mother sought a civil injunction restraining PW from going to her home or contacting her – although defects in the details and service of the injunction rendered it ineffective and he continued to harass her. The combined effect of these factors meant that, although the precise date cannot be ascertained, it is certain that by the end of February (at the latest) PW was no longer capable of complying with his bail condition of residence.

2.48 On 8th February 2011 PW attended the THSAU for a Key Worker review at which he was encouraged to also see the doctor at the Unit. The notes relating to this visit indicate that he was not managing to maintain progress in his treatment plan. He admitted smoking heroin and his urine sample analysis showed positive both for opioids and cocaine. PW mentioned that he had argued with his girlfriend (assumed to be LP despite the fact that his bail conditions precluded contact with her) and he was very remorseful at having "messed up" his treatment programme. His mental state was poor; described in the notes as "objectively depressed" with "intermittent suicidal ideation but without plans or intent but with no protective factors." Further evidence of PW's deteriorating mental state is provided by the fact that the following day, 9th February, whilst being treated at in hospital, he racially and verbally assaulted a fellow patient and was arrested for a public order offence. He appeared at Thames Magistrates' Court for this offence on 8th March 2011 and pleaded guilty.

2.49 Although the public order offence had no connection at all with LP, it is clear from the court record that the court was aware of the ongoing proceedings. PW indicated a plea of guilty and was formally convicted but the court declined sentencing jurisdiction and committed him to Snaresbrook Crown Court for sentence, to link with the ABH case for which he had already been committed. It would appear that in the absence of an updated MG7 from the police, no objections were raised to bail being granted in this new case and PW was remanded on unconditional bail to appear for sentence at the Crown Court.

2.50 In considering bail for the new offence, the court should have had regard to para. 2A, Schedule 1 of the Bail Act 1976 (as amended by s. 14 Criminal Justice Act 2003) which provides that where an offence has been committed whilst on bail, the defendant may not be granted bail unless the court is satisfied there is no significant risk of his

committing an offence while on bail. *(Comment: a brief examination of PW's extensive criminal history would surely have suggested a likelihood of further offences whilst on bail, not least because of his most recent breach of bail in relation to the charge of ABH).* It appears that whilst the court was clearly aware of the ABH case, it was not aware of the recent breach of bail in relation to that case. It is thus evident that judicial decision making on this occasion was severely hampered by the absence of a collated and coherent record being provided to the court from its own records and by the absence of an updated MG7 and risk assessment.

2.51 On 10th March 2011 the scheduled Plea & Case Management hearing was held at Snaresbrook Crown Court. PW attended in answer to his bail and a "not guilty" plea was entered in relation to the charge of ABH. A trial was fixed for the week commencing 13th June 2011 and it was decided that the racially aggravated public order matter should be heard after the outcome of the ABH trial. The Defence applied for PW's bail residence address to be amended but the court refused the application pending address checks being carried out on this new address. It was noted that PW was in fact already in breach of his bail condition of residence since he had already left the old address (see para. 2.47 above). It is not clear from the court record why the court considered that the old bail address was still available to PW but it was decided that he was to return there pending checks on the proposed new address. The court record indicates there were some (unspecified) concerns about a proposed new bail address and that these concerns should be investigated by address checks. PW was informed that he could lodge a new address before the court suitable to both parties for the variation to be dealt with administratively. He was then released on bail subject to the same conditions as before.

2.52 The court file shows that, PW's solicitors requested a variation to change the bail address to that of PW's mother's new flat in London E1 by means of a letter dated 11th March but received 16th March. The letter is annotated by a member of the court staff "listed 6th April as no response from CPS. OIC to attend" (it is usual practice for any bail application to be copied to the CPS for confirmation of agreement whereupon a judge will consider the matter administratively). In the event, the matter was not listed on 6th April. No reason for this is recorded. Accordingly the variation of bail conditions did not happen and PW remained on bail but subject to a condition that he live at an address that he had told the court was no longer available to him.

2.53 On 13th March 2011 a local police officer thought he saw PW riding a cycle in Brymay Close, near to LP's home. The officer was on foot and as such was unable to stop and speak to the man - thus there was insufficient evidence to positively identify

him. The officer did, however, submit an intelligence report on the basis that if it actually was PW, he may have been in breach of one of his bail conditions (in fact PW's mere presence in Brymay Close was not a breach of his bail conditions – see para. 2.46). The intelligence report did not meet the threshold for inclusion in the BOCU Daily Management Meeting (at which priority tasks are decided and allocated) and no further action on the report is recorded. Specifically, there is no indication that LP was contacted to discuss the possible sighting.

2.54 On 20th March 2011 at about 22.45 hours PW was arrested for a further breach of his bail conditions. Extensive searches have failed to discover the police file or paperwork for this arrest. A Custody Record and a single entry on the CPS case management system confirm the arrest, remand in police custody and subsequent court appearance. There is no police CRIMINT record or CRIS record and no record of the information about the arrest having been passed to the OIC dealing with LP.

2.55 PW was taken before Thames Magistrates' Court as an overnight prisoner on 21st March 2011. The Legal Adviser was interviewed as part of the HMC&TS IMR process and the notes made of the hearing were examined. Unfortunately these notes are relatively brief making it difficult to be certain what actually occurred during the hearing. In interview, she thought it highly likely that the court was not provided with the file from the earlier breach of bail hearing on 1st February or any earlier hearing. The address field on the case file for this hearing shows that PW refused to state his address.

2.56 The court case file contains notes of the representations made by the Defence as to PW's bail status but does not record any representations by the Prosecution. The police Charge Sheet stated that PW was arrested at 22.45 hours in Bryme Close E3 (this appears to be a typographical error for Brymay Close E3). The limited court notes indicate that PW explained the breach by saying that he had contacted LP because he was homeless and needed some clothes. This latter admission, combined with the fact that he had also refused to state his address might have been expected to lead the court to the view that he was also in breach of his residence condition of bail. *(Comment: in reality PW had breached both conditions of his bail and this was the second occasion on which he had been brought before Thames Magistrates' Court for doing so).*

2.57 In the absence of a note it remains unclear whether or not the court was provided with a list of previous convictions for PW. The information within such a list is of the greatest significance to bail decisions since it outlines the number and similarity of any

earlier offences, previous offences on bail and previous failures to surrender to bail. The record does not however contain information on previous arrests for breaches of bail conditions as these are not actual offences. These are key matters which, in the normal course of events, are set out within a police MG7 document and provided to the prosecutor in order that they can oppose bail properly. In this case there is no record of such an MG7 having been created and provided to the prosecutor on the day.

2.58 There is no record of the Prosecutor having made any representations as to bail. In the normal course of events, where such representations are made, the court is required to give reasons for granting bail (but see para. 2.33 above) and the Prosecutor would have been entitled to appeal the bail decision. It is not possible to be sure what actions the Legal Adviser may have taken to bring all these facts and requirements to the attention of the court but it is certain that PW was again released on bail on the same conditions i.e. residence at 5, Oswell House (an address to which he admitted he no longer had access), and non-contact with LP.

2.59 On the same day (21st March 2011) as his court appearance PW appears to have visited his GP because that day the GP wrote to the THSAU asking for an urgent assessment of PW at his own request because he was feeling particularly agitated. This request seems to have been overtaken by events because on 2nd April PW was found outside LP's home having taken an overdose of methadone and mirtazapine. He was taken by ambulance to the Royal London Hospital for treatment. While PW was being treated LP attended the hospital. She was described as being rude and abusive to the hospital staff often swearing and being aggressive in her manner.

2.60 On 3rd April 2011, a fax was written by an Emergency Mental Health Advice Liaison Service (EMHALS) nurse at Royal London Hospital to inform the intended recipients (THSAU and PW's GP) about PW's emergency admission. The fax includes the assessment that PW was "finding it difficult to control his anger in the last few months" and mentions under the heading of social history, the phrase "live together" *(Comment: presumably a reference to LP because he had given her address as his own).* The fax contains a brief treatment plan: to discuss the case with the Senior House Officer, continue with treatment at THSAU and a requirement for counselling alongside GP follow-up. Later in the fax a slightly different plan is mentioned suggesting PW requires a medication review by a psychiatrist as he feels mirtazapine "doesn't agree with him."

2.61 It is normal practice for faxes written by EMHALS staff for the information of other agencies not to be transmitted out of normal business hours because confidentiality at

the receiving end cannot be assured. The usual procedure is for these "out of hours faxes" to be left until the following morning when they are sent by the Team Administrator. On this occasion, however, there is no evidence that the fax relating to PW was transmitted to either of its intended recipients prior to it being sent by the EMHALS nurse who assessed PW on 20th April 2011, nearly two weeks later (see para. 2.64)

2.62 On 17th April 2011, two officers went to LP's flat as a result of a call from LP and her neighbour claiming that PW had gone to her flat in breach of his bail conditions. By the time the officers arrived PW had left. The officers made unsuccessful attempts to find and arrest PW. An hour later a second call from LP was received by police to the effect that PW had returned to her flat. The same officers attended but again PW had already left. The officers again tried, without success, to find and arrest PW. Neither officer completed and submitted an appropriate domestic violence report (Book 128D). In addition, though one of the officers did make an entry on a crime report, the entry did not come to the attention of the officer dealing with the domestic violence case involving PW and LP. (*Comment: as far as police were aware at the time, PW's presence at LP's flat was the third breach of his bail conditions and yet the reporting officers failed to bring this to the notice of the OIC. Had they done so, the OIC would have been required by MPS policy to reassess the risk against LP. After the deaths of PW and LP were discovered, the actions of these officers and a member of police staff working in the Crime Management Unit were investigated by the Independent Police Complaints Commission (IPCC) as a result of a referral by the MPS. The IPCC has recommended that both officers and a member of police staff be considered for disciplinary action*)

2.63 On 20th April 2011 at about 11.50 hours, PW "dropped in" (i.e. attended without a specific appointment) to the THSAU and was reviewed by his Key Worker. The notes of this review refer to PW having thoughts of killing himself but with no plan about how or when. He refused to provide a sample of urine for his routine drugs screening and admitted smoking some heroin. He said he had attended the A&E Department at the Royal London Hospital the previous day *(Comment: there is no record of this attendance)* but that he had been told by a nurse to go to the THSAU. The notes of his recorded attendance at Royal London Hospital (on 3rd or 19th April) were not requested at that time. PW was also seen by a Consultant to whom he admitted drinking up to 6 cans of strong cider per day and sourcing 40 mg of diazepam. He said he was having thoughts of suicide but with no specific plan and thoughts of hurting people in general, although nobody in particular. PW asked that someone from THSAU speak to his mother and sister about his condition. The Consultant discussed with him a safety plan in the event that PW had thoughts of killing himself out of hours and it was arranged that

he should be further reviewed on 26.04.11 with a view to a referral for alcohol detoxification and benzodiazepine detoxification if his dependency were established. Subsequently a call was made by THSAU staff to the person they believed to be PW's sister. The person they spoke to was probably, in fact, LP since she had called, claiming to be PW's sister and leaving her own 'phone number.

2.64 At about 00.14 hours on 21st April 2011 PW arrived at the A&E Department of the Royal London Hospital requesting a psychiatric assessment because he was feeling suicidal. He was seen by the Duty EMHALS nurse. The nurse recorded him as a patient with a history of low mood and substance misuse problems who had been seen on the Medical Assessment Unit following his admission due to an overdose. The plan then had been for PW to continue with his THSAU appointments but also attend his GP for counselling. Apparently PW had been under the impression that the GP counselling would happen automatically. The nurse explained that he would need to attend his GP surgery and PW agreed he would do so in the morning. Apparently by the time he was discharged, (after being seen medically regarding an abscess on his leg) PW said he was feeling much better and had no suicidal intent. The notes from PW's attendance were subsequently faxed to THSAU and PW's GP.

2.65 Later that same morning, PW's Key Worker at THSAU discussed the facts of his hospital attendance with the Consultant and it was decided that no action was required other than a telephone call to the pharmacy where PW routinely collected his methadone prescription. This call confirmed that he had in fact attended and had appeared cheerful. Subsequent enquiries by the MPS Homicide Team identified that at 11.50 hours that morning (21st April) PW and LP were recorded together on CCTV collecting PW's prescribed methadone from Bell Chemists, Roman Road E3.

2.66 Investigations by the MPS Homicide Team resulted in evidence from several of LP's friends and neighbours which have enabled the events of that day to be partially reconstructed. It appears that a friend of LP's went shopping with the couple around 14.00 hours before all three of them returning to LP's flat where they all smoked cannabis together. At around 17.00 hours, a neighbour saw LP, PW and the same friend sunbathing and having a barbeque in the communal gardens near to the flats. At some time between 20.00 and 21.00 hours, LP's friend recalls that the couple had argued, culminating in LP asking PW to leave, which he did. She also recalled that PW never had any keys to LP's flat although he did have a key to the communal area of the block so he could keep his bicycle there securely. At some time between 22.00 and 23.00 hours PW returned to LP's flat asking for his tobacco. Rather than allowing him to come into the flat, LP threw his tobacco to him out of a window and he left again. LP

spent the remainder of the evening with her friend watching TV and smoking cannabis. Both women slept the night in LP's flat.

2.67 LP's friend left LP's flat at about 07.00 hours on the morning of 22nd April 2011 leaving LP still asleep in bed. At about the same time, a neighbour recalls hearing the entry intercom being buzzed for LP's flat, after which he heard the door being released then voices in the stairwell which he assumed were LP and PW. At around 08.00 hours, the friend who had slept the night in LP's flat saw PW in Wrexham Road (very close to LP's flat), wheeling LP's bicycle. She spoke to PW who said that LP was in bed.

2.68 LP was not seen alive after 07.00 hours on 22nd April. Shortly after LP's friend had seen and spoken to PW, at 08.20 hours she received a text message from LP's mobile 'phone. The content of the message was the single letter "A". The friend became concerned and recalled that it was very unlikely that LP would have allowed PW to take her bicycle as it was her "pride and joy". The friend went to LP's flat and called up to her windows (this was the usual way in which they would make contact) but there was no reply and she stopped trying when a neighbour started to complain about the noise. The friend received a number of other texts from LP's phone during the morning. She tried to call LP but each time the LP's 'phone diverted to her answer phone. Later in the morning two other friends of LP's were seen calling at LP's door but neither received any answer.

2.69 At 07.00 hours on 23rd April 2011 PW was recorded on CCTV waiting outside Bell Chemists in Roman Road E3. This was the last sighting of PW alive. At about 1830 hours on Sunday 24th April, a member of the public found a man hanging from a tree with a ligature around his neck in a secluded part of Weaver's Field, E2. The body was identified as that of PW from documents found on it.

2.70 As a result of police enquiries, the body of LP was found in her flat on 26th April

2.71 On 27th April PW's body was the subject of a post mortem examination by a pathologist, Dr. Peter Jerreat. The provisional cause of death was determined as "suspension." Toxicological analysis indicated no alcohol in the blood but did show that PW had taken heroin and/or morphine, cocaine, methadone, cannabis and diazepam although it was not possible to determine exactly when he took each drug. The pathologist concluded that it is possible PW was under the influence of one or more of the drugs in the hours before his death.

2.72 Dr. Jerreatt conducted the post mortem examination of the body of LP on 28th April. Dr Jerreat determined that LP's death was the result of a stab wound to her chest. Toxicological analysis indicated that LP had taken cannabis before she died although it is not possible to say when it was last used or whether she was under its influence when she died.

2.73 Appendix A to this report consists of a consolidated chronology of the contacts between LP, PW and the various agencies from 2005 onwards.

3. Analysis

3.1 It is evident from the case history presented above that identifiable interventions would have rendered the deaths impossible. Both tragedies would have been prevented had PW been remanded and remained in custody until his planned trial at Snaresbrook Crown Court in June 2011. In that strict sense, the deaths were avoidable. The courts had several opportunities and adequate grounds for such a decision. At the time of his arrest for the alleged assault on LP in October 2010 (see para. 2.21), the MPS Custody Officer decided that he should be held in custody for the next available court rather than releasing him on police bail. After subsequent arrests, he was also held in custody by police for production at court but on each occasion he was released by the court on substantially the same bail conditions that he had already broken. By early March 2011, the address to which PW had been bailed was no longer even theoretically available to him because his mother had moved elsewhere. An attempt was made on his behalf to register this fact and seek an alternate bail residence condition but it appears administrative failures at the Crown Court prevented completion of this process. Later that same month, when PW appeared at Thames Magistrates' Court for the second time for breach of bail, despite himself admitting that he was homeless and could not comply with the residence condition, the Court still extended bail on the same terms.

3.2 A simplistic analysis which ascribes responsibility for the deaths to judicial processes would, however, obscure the role of other agencies. Worse, it would prevent an examination of the deeper causes of the double tragedy which might lead to improvements within and between the various agencies. The necessary improvements will be considered under three main headings: **information management**, **case management** and **bail management**. Analysis of the case history reveals inadequacies in some aspects of several agencies' operating procedures and processes as well as individual failures to comply with those processes. What is also clear, however, is that the agencies *did not and probably could not* know the nature and extent of the relationship between LP and PW. The decisions made within and between the agencies should thus be judged against what individuals actually *did know* and what they might *reasonably be expected to have known* rather than against the objective reality of PW and LP's relationship which they *could not have known*.

3.3 It is clear from enquiries made after the deaths that LP and PW sustained a relationship, albeit a stormy one, despite the pending assault charge against him and bail conditions precluding contact. Witnesses speak of LP living in some fear of violence from other previous partners. It appears that these fears may have been well-

founded as she had a history of becoming a victim of domestic violence with a number of former partners including her former husband. Apparently as a result of these fears LP had multiple locks fitted to her front door and was in the habit of hiding knives around her home in case she was attacked.

3.4 The volatility of the relationship between PW and LP is illustrated by evidence from a witness that a few days before the deaths she had been in LP's flat during a violent argument between the couple. LP had held a knife against PW and he had shouted at her to stab him. It seems very likely that despite his bail conditions, PW was a frequent and accepted visitor to LP's flat throughout the period from October 2010 to April 2011, albeit when the couple argued, police were sometimes called and if PW was still present when officers arrived, he was arrested. It is worth emphasising that the tenancy of LP's flat was hers and hers alone. Although she usually allowed PW to visit and stay there, witness evidence indicates that she was willing and able to exclude him from the flat at will and that he did not have his own set of keys to the flat. It is certainly the case that on 21st April 2011(i.e. one or two days before LP's death) LP and PW were on sufficiently amicable terms to sunbathe together, share a barbeque, go shopping together and later smoke cannabis with one of their friends in LP's flat.

3.5 The most appropriate starting point for analysing the development of this tragedy is an examination of overall **information management** and its impact on risk assessment. By August 2010 PW had embarked on a treatment plan for his substance misuse problems and appeared to be making progress. He and LP had re-established their relationship after his release from prison the previous year but already the couple were arguing and in August and September of that year police were called to LP's flat four times to what appear to be gradually escalating problems. Medical records from the THSAU indicate that towards the end of September PW was having increasing difficulties with his substance misuse problems and had been assessed as presenting a risk to himself and others which increased when he was intoxicated. On each occasion that police officers attended and reported domestic violence incidents, appropriate reports and initial risk assessments were completed, based on information provided by LP. Full compliance with MPS operating procedures was not consistently achieved, however: secondary risk assessments were not consistently completed, LP was not informed as she should have been when, after arrest, PW had been released from custody and additional information was input wrongly onto the police computerised crime reporting system (CRIS). This failure to input information correctly onto the CRIS system hindered the retrieval and collation of information for subsequent secondary risk assessments.

3.6 From a police perspective, matters came to a head in October 2010 when PW and LP argued in the street culminating in him assaulting her. PW was arrested two days later and charged with assault occasioning actual bodily harm (ABH). An officer in the police Community Safety Unit was appointed as OIC and a secondary risk assessment was undertaken. As mentioned previously (see para 2.28), LP was assessed as not qualifying as a high risk victim because, in the view of the OIC she did not meet any of the three referral criteria:

- The DASH risk assessment tool is completed with 14 or more positive responses, or,
- There have been six or more incidents/offences within the previous year (there had only been five), or,
- The OIC makes a professional judgment that the victim should be referred to MARAC

On the basis of the information available to OIC the first criterion was not satisfied and nor was the second. Whilst the third criterion clearly involves a high degree of subjective judgement it is on this basis that a referral might have been made (*Comment: on this criterion a referral should have been made*). The OIC could reasonably be expected to have knowledge of PW's previous convictions, including most notably his recent conviction for *arson with intent to endanger life (….. or being reckless as to whether life may be endangered)* for which he received a sentence of imprisonment for 21 months. This offence had been committed when he set a fire in the lift of his mother's block of flats after they had argued. This, combined with the history of five escalating DV incidents within the year might well have been regarded as adequate grounds for a high risk referral. Had it been appreciated at the time, there was an additional factor which would have contributed the conclusion that LP was at high risk: she had been the victim of domestic abuse from successive partners since at least 2003. Unfortunately, recognition of this vulnerability was hindered by the fact that LP had used a variety of different names (and dates of birth) when dealing with police.

3.7 Whilst it is arguable that knowledge available to the police OIC should have been sufficient to generate a MARAC referral, it is important to note that other agencies within the partnership also had additional information of great relevance to a robust risk assessment:

- The Probation Service was aware that PW had a conviction for arson, including the circumstances of the crime. The Probation Officer dealing with PW was also

well aware that he was receiving treatment at the THSAU for his drugs problems. Although there was only limited communication between THSAU and the Probation Service (PW's Key Worker at the THSAU did not even know the name of the Probation Officer), it appears that the Probation Officer concentrated her efforts on the drugs aspects of PW's case but failed to assess the risk he might pose in terms of domestic violence.

- The THSAU were aware of PW's drugs problems, mental problems and his social situation: he had only a problematic relationship with his mother, an unstable relationship with LP and as a consequence, he was at least intermittently homeless. The medical records show repeated risk assessments in which risks to himself as well as risks to others were considered and at various times, considered to be increasing.

3.8 Both the Probation Service and the health professionals at the THSAU are bound by regulations to ensure the proper confidentiality of information relating to clients but it is evident that in this case confidentiality militated against a robust, all-encompassing risk assessment. It is also clear that within each agency there was insufficient focus on addressing what limited information may be shared, with whom and in what circumstances. The internal review of the THSAU identifies the fact that there was a lack of communication between the THSAU Key Worker, PW's Probation Officer and the Drug Intervention Project, leading to an absence of information sharing even within these agencies. Improvements in this will require awareness-raising amongst staff (see Recommendation 2, para 4.10) but also the overhaul of systems and mechanisms to make *permissible* information sharing a practical reality (see para 4.2).

3.9 Even within the health sphere, weakness were identified and addressed by the internal review relating to the way in which information was collected by and shared between the Royal London Hospital, PW's GP and the THSAU. The internal review also identified that despite having obtained PW's consent to his condition being discussed with his family, and the fact that his "lady friend" *(Comment: assumed to be a reference to LP)* attended some of his appointments with him, the Key Worker made no attempt to obtain a detailed case history from them, nor to obtain LP's proper details.

3.10 Two separate risk assessments were conducted on PW by the THSAU. Both contained only limited historical details and neither included references to PW's spell of imprisonment for arson or his disclosures concerning the domestic abuse incidents. Neither of the risk assessments were used as the basis for a direct referral to MARAC

and nor was there any discussion with a Consultant Forensic Psychiatrist about the risks posed by PW.

3.11 In the absence of a referral from any of the constituent organisations of MARAC on the basis of professional judgement, the second way in which cases such as this would be more likely to be assessed as high risk would be to reduce the threshold of the DASH risk assessment tool. The threshold of 14 positive responses is not universally applied across the London. Whilst a lower threshold would potentially increase workloads across the Community Safety Partnership this is not an inevitable result.

3.12 The fundamental problem with the current arrangements for risk assessment is that each potential referring agency has only a partial view of the overall risk to the victim. Each agency may thus assess it's "portion" of the risk but in each case no single agency may reach the threshold at which other agencies are invited to contribute their information. The effect of Recommendation 1 (see para. 4.8) of this review is to place the collection and collation of information from all the agencies as early as possible in the risk assessment process and thus enable a comprehensive risk assessment to be made, based on the *composite knowledge* of all agencies. Thus a fully informed comprehensive risk assessment would be conducted within the secure environment of the MASH and the high risk cases identified. If those assessments are based on confidential information (e.g. information gathered in the course of medical treatment) it might be necessary for an appropriate agency to be tasked to seek out the information openly, e.g. by simply asking the right questions of a victim or suspect, before a formal referral to MARAC could take place.

3.13 Poor information management is also evidenced in the way in which PW's appearances at both the Magistrates' Court and Crown Court were handled. At the Magistrates' Court the administration team failed to collate the case files of previous appearances and it appears that this "common sense" approach was not incorporated into the national guidelines for staff. This issue has already been addressed as a direct result of this review.

3.14 Poor awareness of and compliance with the provisions of the Bail Act 1976 (as amended) and the Criminal Justice & Police Act 2001 by the Magistrates' Court Legal Advisers resulted in poor (or no) recording of the grounds for judicial decisions to grant and continue bail. Whilst a subsequent CPS decision to appeal against such decisions would be based on the *fact* that bail had been granted, an explicit record of the rationale for the decision would have been of material assistance to the CPS in the formulation of an appeal.

3.15 The combined effect of poor information management (both systemic and resulting from limited/non compliance with defined procedures) by and between the health professionals, Police and Probation Service resulted in an incomplete assessment of the risks posed by PW to LP. In making a judgement about the validity of the risk assessments that were carried out, it would be grossly unfair to condemn what was done simply on the basis that since the outcome was a double tragedy, then those assessing risk did so incompetently. Even without the wisdom of hindsight, however, it is clear that had it been possible to collate the totality of what was known collectively, an assessment of "high risk" would have been far more likely.

3.16 An assessment of LP as a victim at high risk would not, of itself, have been a guarantee of her safety. There is ample evidence that contact between LP and PW was far more frequent than came to the knowledge of the agencies and that LP was able to exclude PW from her flat when she chose to do so, whether by calling for police assistance or simply telling him to leave. The question therefore arises: what, if any, practical difference would an assessment of LP as a high risk victim have made to the eventual outcome? It cannot be simply assumed that a referral to MARAC would have improved the safety of the victim. In November/December 2009 (see Consolidated Chronology) LP was in fact referred to the MARAC as a result of a violent incident with another partner (i.e. not PW). Her allegations included being threatened with a firearm as well as actual physical violence. Having made the initial allegation she then declined DV support or to support a prosecution. The police CSU referred the matter to the IDVA service. A full risk assessment was conducted and a worker contacted LP and attempted to draw up a safety plan. Although the call was interrupted, when re-contacted, LP refused further contact with the IDVA. The case was referred to MARAC without LP's consent on the basis of the seriousness of the allegation. The only actions/outcomes recorded by MARAC were a check in all agencies for any traces of any of the parties to the case. It is unclear why such an apparently serious threat generated such sparse protective activity from the MARAC partners (*Comment: none of the people currently in post have any personal knowledge of this case but a plausible explanation may be that a short time later LP had resumed her relationship with PW and that in any case she had refused to participate in the formulation of a plan for her own safety*.)

3.17 It is worth noting that reports of domestic violence managed by the Tower Hamlets Police Community Safety Unit increased by 22% in the year to May 2011 with no commensurate increase in staffing. In common with all public sector agencies, resource constraints have become a difficult issue for the police, necessitating difficult choices in relation to the prioritisation of cases. In such circumstances, the more

complete and sophisticated the analysis of risk in each case, the more likely it is that what resources are available will be appropriately allocated. It is submitted that the identification of this case as presenting a high risk would have significantly raised the profile of the investigation/prosecution of PW, thereby securing improvements in **case management (including practice issues)** – the second main theme emerging from this review.

3.18 Case progression by the police OIC was, from the outset, slower than it should have been. The allocated MPS Witness Care Officer failed to provide the CPS with updates. The CPS appointed advocates never sought updates from the OIC about the victim's welfare and nor was any consideration given to the absence of a Victim Personal Statement (i.e. statement from the victim about the impact on her of the offence, rather than a strict evidential statement of what took place that constituted an offence). Such updates should be recorded on the MPS Witness Care Management System (WMS) but were not. Furthermore, updated MG7s[1] and updated risk assessments should have been provided to the CPS at each bail hearing.

3.19 At PW's first court appearance where he was produced from police custody, the court determined that he should be granted conditional bail. It appears from the court record that no appeal was lodged by the Prosecution advocate at this point. Had the case been regarded as high risk, this would surely have motivated at least an attempt to reverse this decision by lodging an appeal. Had an appeal been lodged, then the court would have been required to take a more structured approach to (and record the grounds for) its decision. These grounds would have been of some assistance to the Prosecution in formulating its appeal case.

3.20 Thames Magistrates' Court has an established Specialist Domestic Violence Court (SDVC). The operation of the SDVC is governed by a detailed protocol to which all the relevant local agencies are a party (most notably for the purposes of this review: Police, CPS, Victim Support, LBTH and Probation Service). It is intended that the SDVC should hear all cases concerning "any incident of threatening behaviour, violence or abuse between adults who are or have been intimate partners or family members…" The SDVC Protocol sets out in detail the various measures that should enable all DV cases to be dealt with by staff, advocates and officers (in all the relevant agencies) who have received additional training and experience in DV case work. The Protocol also

[1] The Form MG7 is a standard MPS form used to inform the CPS of the need for the Prosecutor to apply for a suspect to be remanded in custody or to have his bail conditions varied. The form is also used to provide the grounds to be cited in support of the application

provides for victims to have the services of Independent Domestic Violence Adviser IDVA) at and between hearings. In summary, the Protocol raises an expectation that DV cases and victims will receive an enhanced level of service from the criminal justice system. Because it is a resource intensive service, the SDVC only sits on Thursdays. An adverse consequence of PW being produced at court from police custody was that his case could not be considered in the SDVC and though the case was recognised from the outset as one which would have qualified for inclusion in the SDVC arrangements, in fact, it was never dealt with within that specialist court. The use and adequacy of the SDVC capacity was examined in some detail as part of the HMC&TS internal review process. It appears that it is common for the SDVC on Thursdays to be very heavily loaded with cases and that as a consequence, where the court capacity is exceeded, cases are transferred to other Thursday courts. Where this happens, there are existing mechanisms to ensure that the SDVC Co-ordinator receives information and results about any case allocated to a neighbouring (non SDVC) court. Arrangements are significantly less clear when DV cases are heard on other days of the week and this is a weakness which has been identified by HMC&TS as requiring attention.

3.21 As with other issues, had the case been identified as presenting a high level of risk, whilst PW would still have been produced at the Magistrates' Court in custody (i.e. still not at the SDVC) it would have increased the chances of him being remanded to the SDVC. Whilst there is no certainty that compliance with the SDVC Protocol would have made a significant difference to the eventual outcome, the physical presence IDVA support on SDVC days might have given LP a better chance to accept assistance.

3.22 In addition to the potential opportunity for IDVA support to be provided to LP at the court, further opportunities were created by the her direct referral to the IDVA by police (this happened several times– *see para. 2.37 et seq*). On each occasion either LP declined support or attempts at contact failed. The IDVA service has no legal powers to compel victims to engage and at the time, the established business process was to attempt to contact all direct police referrals three times within 48 hours but to close the case if these attempts were unsuccessful or support was declined. As a result of the renewed focus on DV in the borough, these processes have now been improved – see para. 4.2)

3.23 It is clear that within the IDVA service an awareness of the need improve client engagement has led to enhanced practices and the need for more effective use of the information gained during that engagement. Even with these enhanced practices, however, it must be acknowledged that adults have the right to make choices for

themselves even if, individual professionals or agencies consider these choices not to be in their best interests. In this respect, client consent cannot be overridden and nor can clients be forced to engage with services. The IDVA service should conduct a post implementation review to assess its effectiveness in exploring issues such as consent and engagement, considering an analysis of why individuals do not engage. It should also consider the enhanced practices, which envisage a process by which, if a client declines IDVA support, ultimately the matter will be referred back to the police. The review should also assess its effectiveness, in particular in terms of alignment with CAADA guidance on caseloads, the proportion of referrals which result in effective client engagement and the effectiveness of safety action planning (See Rec. 2). This case also highlights the need for greater awareness within all agencies (most significantly the Probation Service, Police Witness Care Unit and the Specialist Addiction Unit) of the need to consider the risks of and from domestic violence posed by all their clients. Recommendation 3 of this report is aimed specifically at this aspect of case management and is relevant to all agencies.

3.24 The perspective offered by friends of LP may help to inform the awareness raising requirements of Recommendation 3. LP's close female friend and neighbour describes a very strong and loving bond between LP and PW and insists that though she believed they were "bad for each other", there existed a mutual dependence, re-enforced and illustrated by the fact that PW would often go out and buy (or shoplift) gifts that he knew LP wanted. She insists that although LP often ejected PW from her flat, she always wanted him to come back to her. The friend described how the couple struggled to live together, often having violent arguments in which each threatened the other with physical violence, but that they found they could not stay apart. The friend insists she often advised LP to get rid of PW and tried to support her to go through with the various prosecutions against him (*the friend has some experience of these matters, her own partner is currently serving a term of imprisonment*). She believes that to some extent her support may have been part of the reason that LP declined support from "outsiders" (*i.e. the IDVA*) she did not know. A male friend and neighbour echoes these views. He had lent LP considerable sums of money in the past and allowed her to stay in his flat sometimes when she was afraid that PW and previous partners might harm her. He insists that he tried often to persuade LP to have nothing more to do with PW but that she would not or could not take his advice.

3.25 The first formal review of the case by a CPS lawyer did not occur until more than a month after the charge and only three days before the case was due to be committed for trial at Snaresbrook Crown Court. In fact, the planned committal did not take place due to the lack of timely and effective action by the OIC in dealing with the Action Plan

given at the point of charge or responding to CPS requests for submission of a full file.. The Prosecutor's review confirmed that the case seemed to have "slipped through the allocation net". This the first point at which, had the case been assessed in the high risk category, its formal review would (or perhaps *should*) have taken place earlier. An earlier review *should* have then identified the case as being of higher priority for the OIC, his supervisor and the CPS.

3.26 The initial delays in case preparation and progression continued into 2011. No evidential statements were obtained from the independent witnesses to the alleged assault and whilst photographs of LP's injuries were actually taken at the hospital when she was initially admitted, none were provided to the CPS. These delays and inadequacies in case preparation were never, it appears, raised by the CPS with the police supervisors of the OIC and there is no indication that the OIC's supervisors took a close enough interest in the case to identify the problems.

3.27 A second potential intervention point occurred when PW was arrested for breach of his bail conditions for the first time on 31st January 2011, held in custody by the police and produced at court on1st February 2011. Despite the absence of an updated MG7, the advice of the Senior Crown Prosecutor (SCP) was that a remand in custody should be sought but that if bail was granted there should not be an appeal against the decision (see para. 2.43). In formulating this advice the SCP would have been constrained by the CPS legal guidance based on the Magistrates Court and Bail (Amendment) Act 1993 as well as the CPS Policy on Prosecuting Domestic Violence Cases. The combined effect of the Act and the guidance is that whilst it is envisaged that bail decisions by magistrates in such cases *may* be appealed to a Crown Court judge, the cases in which it is appropriate to do so are limited. The guidance requires that when considering such an appeal the Prosecutor should apply an overarching test of whether or not there is (*inter alia*) a serious risk of harm to any member of the public. It requires that the seriousness of the alleged offence be considered and gives examples of personal violence such as murder, rape, robbery or aggravated burglary. It further suggests that evidence of violence or threats of violence to the victim or undue influence over the victim might justify the exercise of the right of appeal. An additional constraint within the guidance advises against use of the right of appeal simply because the defendant has no fixed address or settled way of life (*Comment: especially relevant to PW*). The overall tenor of the guidance is that the right of appeal against a magistrate's decision to grant bail should be used rarely and only in the most serious cases.

3.28 It is quite clear that the SCP formulated his advice carefully and attempted to balance the constraining guidance outlined above with the factors from the case which

would have indicated that an appeal should be mounted. With the benefit of hindsight it would have been preferable to mount an appeal against the bail decision. However, given the absence of an updated MG7 document and risk assessment, on the limited information available to the SCP at the time (especially the unwillingness of LP to support a prosecution and the extent of her injuries) the case must have appeared as one at the lower end of the spectrum of seriousness and thus not one which satisfied the "overarching test" contained within the Bail (Amendment) Act guidance. Had the case been graded as high risk and had all the information which might have been included in a comprehensive risk assessment been available, it is more likely than not that the SCP's advice would have been to take a more robust line as regards the application for PW's remand in custody and about the positive requirement on the advocate to lodge an immediate appeal should the court decide against the application. In the event, the court record of the hearing suggests strongly that the Associate Prosecutor (AP) may have misinterpreted the SCP advice, since the court notes record that the AP was content for bail to continue subject to a further condition that PW not enter Brymay Close: a condition which was not, in fact, imposed.

3.29 A third opportunity arose for the courts to intervene in the tragic course of events when PW appeared on a charge (unrelated to LP) of a racially aggravated public order offence, on 8th March 2011. On this occasion, PW had been granted bail after charge by police and, because the ABH matter had already been committed to Crown Court, bail issues as regards that offence had become matters for the Crown Court itself. Whilst the Prosecution raised no objection to bail being granted, the court itself had a duty under the Bail Act to be satisfied that there was no significant risk of further offences whilst on bail. Had a fully informed risk assessment been completed and kept up to date and supplied to the CPS, the Prosecution would have been in a far better position to assist the Court in its *inquisitorial role* of seeking out all relevant information when considering bail decisions.

3.30 The Pleas & Directions hearing at Snaresbrook Crown Court was a further opportunity on which a more robust Prosecution advocate, motivated and informed by a "high risk" assessment, might have taken a stronger line on the bail issue. In this hearing, a strong Prosecution stance against granting bail would have been greatly assisted by the fact that PW himself admitted that he no longer lived at the address to which his bail conditions referred.

3.31 When PW was produced at Thames Magistrates' Court on 21st March for breach of bail conditions, he was again re-bailed on the same conditions as before despite, for the second time, admitting he no longer lived at his assigned bail address. Court

records indicate that it was provided with little or no information about his past appearances either by its own administration team or by the Prosecution. Again, no updated MG7 setting out such information was ever provided to the Prosecutor. No appeal was lodged against the decision to continue conditional bail.

3.32 In parallel with the processes of the criminal justice system, health professionals continued to support PW in his attempts to comply with his treatment plan with respect to his substance abuse problems. Some deficiencies have been identified by the THSAU in the way in which its staff followed up and shared information within the limits permitted by the rules of medical confidentiality. There is insufficient evidence, however, to conclude that any of these issues were a significant contributory factor to the eventual tragedy.

3.33 As is clear from the analysis so far, incomplete information sharing leading to inadequate risk assessment resulted in no referral to the support potentially available via the MARAC and poor management of the case through the criminal justice system. Judicial decision makers were thus not provided with the best possible information on which to make decisions about the **management of bail** for PW pending the planned trial of his case in June 2011.

3.34 The police are the primary source of information regarding a person's suitability for bail and, where appropriate, grounds on which conditions might be attached. The provision of such information at the start of any case is an essential component of the case file and it is equally important that information relevant to a person's bail status (including in respect of the threat they may pose to others) is updated in preparation for court appearances. Such information should be provided to the courts via the Prosecutor. In this case it is evident that updated MG7s were not provided by the police to the CPS and that, as a consequence, additional information which might have influenced judicial decision making did not reach the courts.

3.35 Despite the absence of updated MG7s, it is quite clear that when formulating his advice to the Associate Prosecutor (AP), in preparation for the breach of bail hearing on 1st February, the SCP recognised the need for a remand in custody (see para. 3.27, above) and advised the AP to make such an application. On this occasion (at least) the Prosecutor had an awareness of the fact that the information available to the court was incomplete. When considering bail issues, the court processes change from their normal adversarial mode to an inquisitorial one in which all parties (including the Defence) have a duty to seek and provide full and accurate information. Indeed this joint responsibility is recognised in the then extant Thames Magistrates Court SDVC

Joint Protocol at para 6.2 (See Appendix C). It must be a matter of speculation whether or not different bail related decisions would have been made by either the Senior Crown Prosecutor or the courts had they been kept supplied with updated information but the absence of such information and the need to rectify it must be regarded as a shared responsibility.

3.36 Both Crown Courts and Magistrate's Courts have powers to grant bail, with or without conditions, or to withhold it. The role of the courts in this respect is inquisitorial but relies heavily on the assistance of the police for the provision of information about defendants, their alleged offences, previous convictions, the extent to which they have complied with previous court orders and their social circumstances. That said, the courts are required to maintain their own records of appearances and decisions. The internal review undertaken by HMC&TS identified a variety of weaknesses in the record keeping, administration, collation and retrieval of information held by the courts, as well as a lack of awareness amongst Legal Advisers as regards the provisions recent legislation. One particular weakness revealed by this case is the need for clearer and more explicit standing arrangements to ensure that the suitability of addresses for bail purposes are properly checked by the police. This is especially important in cases (such as that of PW) where police have retained a person in custody for reasons unrelated to his address (e.g. a record of failing to appear at court, breaching court bail or committing further offences whilst on bail). The new standing arrangements should also ensure that the *continuing suitability* of an address for bail purposes is *reassessed* at least prior to each court appearance. As is well illustrated by this case, it cannot safely be assumed that because a particular address is suitable at the time of an initial arrest, it will remain suitable until the case is finished.

3.37 Enforcement of bail conditions is primarily a matter for the police. This case highlights weaknesses in the systems which applied at the time across London to enable patrolling officers to know what conditions may be attached to a person's bail. The availability of information on bail conditions for individuals is already being addressed as part of an ongoing MPS IT project. Greater availability of bail information will not, of itself, however improve the management of bail. Such improvements will only come about, however if the information is *actually used* to inform the enforcement of conditions. For this to happen, Tower Hamlets Police will need to review current tasking arrangements.

3.38 The information available to Police, CPS and courts in relation to a person's history of compliance with bail conditions is poor. Because breach of a bail condition is not of itself an offence, instances of such breaches are not recorded on a person's

criminal record (held on the Police National Database). Such details may be available on a local basis from local police or court records but as this case illustrates, even these can be somewhat unreliable. In circumstances where an individual has lived in a variety of different police/court areas it is quite possible to envisage circumstances in which a person with a serious history of non-compliance with bail conditions and/or other court orders in one (or even several) areas of the country would nevertheless be granted conditional bail by a court in ignorance of the facts. *Clearly this systemic weakness needs to be addressed at the national level*.

4. Conclusions & Recommendations

4.1 The purpose of this review is to identify the opportunities for improving the ways in which the various agencies operate separately and together to reduce the incidence of domestic homicide. The case history reveals several examples of poor and/or non-compliance with established policies and procedures by officers/staff in Tower Hamlets Police, Probation Service, the Specialist Addiction Unit and HM Courts &Tribunals Service. It is a matter for each agency to deal with these individuals according to its own procedures. The conclusion of this review is that in relation to the two deaths, the identified failings of individuals should be regarded as incidental rather than causal. This conclusion is based on the judgement that the essential weakness of the overall response to the case resulted from the fact that within each agency, individuals could only base their actions and decisions on the incomplete picture that was available to them. Some of those decisions were, *with the benefit of hindsight,* questionable and some actions (and omissions) are already the subject of management and/or disciplinary action. It must be accepted, however, that at the time, the case was simply one of a large number within a heavy overall caseload. None of the agencies and certainly no individual within any single agency knew that despite the bail conditions imposed by the courts and the urging of LP's friends, she and PW were in frequent contact right up to the time of her death.

4.2 A number of problems were identified by the agencies in their individual reviews which provided immediate opportunities for improved performance. The following issues have already been addressed without waiting for outcome of this review:

Joint Action

- Since the commencement of this review, the Chief Crown Prosecutor for London commissioned a joint working group to examine ways in which the attrition rates of domestic violence cases across London might be reduced. The working group included representatives of CPS, Police, HMC&TS, Probation and others.

- The performance improvement plan agreed by the working group is included at Appendix D of this report. The plan seeks to address the performance failings within the CPS, Police and courts which have identified in this report: essentially aiming to improve performance of and compliance *with the existing processes and procedures, specifically in relation to case management and bail management*. The plan implies the need to review the adequacy of staffing arrangements by all the agencies, albeit difficult choices will need to be made to

comply with current spending constraints. The improvement plan is already being implemented across East London and will shortly be considered by the London Criminal Justice Partnership with a view to its implementation pan-London.

Police

- Tower Hamlets Police have already issued urgent instructions to all officers that on any occasion where a breach of bail is detected or a domestic violence incident is reported, a new crime report should be created rather than information being added to existing closed crime reports. This instruction has been promulgated MPS-wide to ensure the same errors do not occur elsewhere.
- Tower Hamlets Community Safety Partnership has launched a "One Stop Shop" to offer people from hard to reach groups and repeat victims of domestic violence easier access to services to reduce their vulnerabilities.
- Tower Hamlets Police have relocated the Book 124D register to the Community Safety Unit (CSU) office. This is intended to encourage greater interaction between patrol officers who make the initial investigations, risk assessments and reports of domestic incidents (using the Book 124D) and officers from the CSU who will then take over responsibility. The change should also enable CSU supervisors greater scope to advise and where necessary challenge reporting officers.
- The MPS has given advice to all front line supervisors and secondary investigators on the correct recording of risk assessment and management including the availability of IT-based tools to identify repeat victims. This is especially useful when dealing with victims who have used different names and/or dates of birth when dealing with Police.
- The MPS have introduced coloured stickers on case paper file covers, marked Medium/High Risk to ensure that CPS and courts are alerted to the fact that a case involves domestic violence and the risk level has been assigned to it.

East London NHS Foundation Trust (THSAU)

- A monthly meeting has been arranged for a local forensic consultant to provide input to the THSAU to discuss risk management in particular cases.

- Operational policies of the THSAU have been revised to ensure that Key Workers and other professionals proactively engage families, significant others and any relevant agencies to enhance assessment and treatment. This will be especially important in gathering information for care planning, risk assessment and risk management. Family members or others functioning as carers should be routinely identified and have their needs assessed through a carer's assessment and/or other documented support mechanisms. The THSUA acknowledges that compliance with these policies is an ongoing management challenge and thus requires continuing and frequent attention by supervisors.
- The EMHALS Operational Policy has been completed and includes an assurable mechanism for the safe and secure transmission and reception of faxed information between the various health professionals.
- The Supervision Policy for the THSAU has been revised to ensure that all service users are discussed at a minimum frequency and that the actually frequency correlates with their assessed level of risk. Additionally, operational criteria have been devised to enable THSAU clinicians to know when to include or remove clients from the High Risk List presented at weekly clinical meetings. These systems are auditable.
- Front line staff of the Trust now have access to agreed protocols about information sharing.

Crown Prosecution Service

- An assessed electronic instruction course on dealing with custody time limits and breaches of bail has been introduced which will be completed by every CPS Prosecutor.
- Awareness raising sessions for CPS Prosecutors/staff in respect of the issue of bail appeals has taken place locally at Tower Hamlets and across the CPS district.
- A Local Implementation Team has been established to examine the whole subject of electronic working and the transfer and storage of all hard copy documents/case papers (including papers re. breach of bail) with a view to full implementation by April 2012.

- Robust instructions in respect of the notification procedures for breaches of bail have been issued to all staff across the district.
- Performance monitoring of Associate Prosecutors at Tower Hamlets and across the district has taken place and feedback provided to the individual Associate Prosecutors.
- Robust instructions emphasising the CPS Guidance on the appropriate standards in respect of the quality of reviews in DV cases have been issued to all staff across the district.
- Robust instructions setting out what to do when failures in case progression are identified have been issued to all staff across the district.

HM Courts & Tribunals Service

- Management discussions have taken place with relevant staff about the need to ensure adequate notes are taken of bail hearings.
- National Guidance on case file preparation has been amended to require that details of previous court appearances in respect of related cases (including breach of bail appearances) are available to the Legal Advisers. In fact, some guidance on this issue already existed but it was difficult to access, this has now been rectified.

Victim Support (IDVA Service)

- A new business process has been introduced for handling direct Police referrals in DV cases. Clients are contacted by DV trained Victim Care Officers (VCOs) who make all initial calls and carry out the CAADA DASH risk assessment.
- The VCOs will make two attempts at contact within 48 hours – thereafter further attempts by other workers will carry on for a week after which time the case is classified as inactive but passed to the local office for monitoring
- After a week the referring agency is contacted and informed of the status of the case

- Agencies then explore alternative methods/agencies to support the victim and only if there is no other means to establish engagement is the case finally closed
- Regular high risk case review meetings are held where the IDVA team meet the Team Manager to discuss high risk cases in order to identify any further risks or needs and address any other concerns the IDVA may have about a particular case

4.3 The fact that PW was repeatedly granted conditional bail by the courts, despite his poor history of compliance, amply illustrates the need for a record to be maintained of persons' compliance (or otherwise) with conditions imposed by courts. The extent of a person's prior compliance with bail conditions (as well as other orders of the courts) should also be considered when risk assessments are being made in relation to DV cases. Such records would need to be maintained on a national basis to ensure that bail decisions may be properly considered by the courts in light of a person's full history of compliance, irrespective of where breaches may have occurred. The obvious receptacle for these records is the Police National Database.

4.4 The central feature which emerges from the analysis of the circumstances surrounding the deaths of LP and PW is the absence of a risk assessment which was as complete and all-encompassing as possible. An opportunity was missed at the THSAU to have a forensic consultant psychiatrist assess PW and even the information that might have been shared with partners was retained confidentially within the health sphere. Similarly, Police and Probation failed to research/assess the case thoroughly and then to share information.

4.5 Inadequate assessment of the vulnerability of LP and the risks posed to her by PW left all agencies in a poor position to prioritise her protection or the prosecution of PW. The Specialist Domestic Violence Court protocol sets out high and commendable standards for the ways in which DV cases should be managed and prosecuted but its provisions are highly resource intensive. Underpinning the Protocol, the CPS Policy for Prosecuting DV Cases and the MPS Domestic Violence Standard Operating Procedures provide detailed instructions for officers and staff engaged in DV cases but these too envisage the availability of considerable resources for DV work. It is evident that in the current financial climate where demands for such services are growing but resources are, at best, static, careful prioritisation is essential.

4.6 In this case, it is evident that poor risk assessment left the prosecution of PW and protection of LP as a low priority for all agencies. The prosecution was poorly pursued and the court processes poorly informed. The limited (and largely unsuccessful)

attempts of the MPS Witness Care Unit to support her could only have worsened her attitude and increased her vulnerability. The IDVA service made appropriate attempts to contact LP and offer assistance but in the face of her refusals to accept it there was little that could be done under the then extant business processes. These business processes have since been enhanced (see above) it is not certain that even the enhanced processes would have been sufficient to engage LP. The IDVA service (quite rightly) has no coercive powers; thus ultimately, the acceptance or otherwise of support will always be a matter of free choice on the part of the potential client. Face to face contact with LP might have proved more effective but this would only have been a practical possibility had PW appeared at the SDVC (or at least at an ordinary court on an SDVC day).

4.7 It is within this context that the judicial decisions concerning PW's bail should be viewed. Had PW been remanded in custody pending his trail at Crown Court he would obviously have been incapable of killing LP and himself. This might have been achieved if an all-encompassing risk assessment had been completed, leading to the prosecution being more thoroughly and robustly presented to the courts. However, systems and practices enabling more complete information being better presented to courts would almost inevitably result in the more widespread withholding of bail and thus greater restrictions on the freedom of individuals. In any particular case that ends in tragedy, it is easy with the benefit of hindsight to say that a remand in custody would have been the correct and obvious course. General application of such a precautionary approach, however, would change the balance between security and liberty. Whilst the maintenance of this fundamental balance must be left to the independent judiciary, it is for other elements of the criminal justice system and Community Safety Partnership to ensure judges are in the best position to make these difficult decisions.

4.8 ***The principal recommendation of this review is therefore aimed at maximising information sharing between the agencies***. The concept of a Multi-Agency Safeguarding Hub (MASH) originates in Devon. A MASH has been operating there since June 2010. The experiment was singled out in the Munro Review (published 11 May 2011) as good practice. The Devon MASH was established to improve inter-agency information sharing, principally in relation to the protection of children. MASHs bring together, in one secure room, statutory and non-statutory safeguarding professionals to share and collate information with a view to identifying where vulnerable people may be at risk. MASHs can thus deliver an information product on an individual or family based on the entire safeguarding partnership's collective knowledge. Thus risks may be identified earlier even where no single agency has enough information to reach its own threshold for referral into MARAC. The single most

important (but resource intensive) process required is that when any agency becomes aware of even a moderate level of risk to others as a result of its contact with a person, research is conducted within the secure environment of the MASH to determine what information other agencies may have relating to that person or to others with whom s/he has contact. A key feature of the MASH is that whilst all information on a vulnerable person may be shared and assessed within the room, nothing is passed outside the room without the consent of the agency "owning" the information. This gives all partners more confidence to share even the most sensitive material. MASHs also assist agencies to reconcile the necessary and healthy tensions between privacy and safety, so that the fullest information picture can be assembled. MASHs provide a secure environment in which agencies can exercise the tensions enshrined in the Human Rights Act, Data Protection Act and the Caldecott Rules. Even where the agency supplying sensitive information is unable to allow its release outside the secure environment, the fact that the existence of the information has been "signposted" can enable others to gather it through normal routes, safe in the knowledge that an effective risk assessment has already been completed.

4.9 A project encompassing the establishment of MASHs in various boroughs is already underway under the auspices of the London Congress of Leaders. To date, the project has been focussed solely on the protection of children due to the perceived difficulties of incorporating mental health professionals and the perspectives they are able to bring to a potential risk scenario. This review, however, identifies the compelling need for the MASH concept to be applied to the reduction of domestic violence not least because of the mental health aspects. What this would mean in practice is that where any agency becomes aware of a DV incident or a person at risk of DV, a referral to the MASH would be made to find out what relevant information might be held by other agencies. All available information (including previous convictions and the history of compliance with bail conditions etc.) may then be collated and assessed within the secure environment of the MASH. If this indicates referral to MARAC on the "professional judgement" criterion, then the case may be referred. **It is therefore recommended that Tower Hamlets be used as the site of a MASH pilot to focus on DV reduction [Recommendation 1].** Recommendations within the THSAU IMR concerning the establishment of interface meetings with Probation and the Drugs Intervention Project, for Adult Mental Health Teams to access THSAU clinical data and for making referrals to MARAC are subsumed within this recommendation to institute a MASH.

4.10 Additional & Subsidiary Recommendations

Recommendation 2

A post implementation review by the IDVA service to examine issues relating to client consent and engagement with the IDVA service, in light of the changed processes and (possibly) increased caseloads. In particular the review should consider the extent to which the service is achieving the CAADA standard of engagement with clients: 70-75% of referrals. The review should also consider the need for specific protocols for encouraging clients to engage with the service.

Recommendation 3

The establishment of a DV focussed MASH in Tower Hamlets will provide an ideal context for an inter-agency awareness raising programme about the new capabilities and the need for all professionals to consider the DV aspects of incidents they deal with and clients they assist. Whilst the judiciary and administrators of the courts *must* remain independent of the MASH arrangements, judicial decision makers and Legal Advisers must be informed of the new capability and its potential impact on court workloads.

Specific awareness raising should be targeted at supervisory officers and staff in relation to ensuring better compliance with existing protocols, policies and operating procedures in relation to the management of domestic violence cases.

Recommendation 4

The MPS has identified the need to enhance the information held in its Emerald Wanted Management System (EWMS) to include information for officers about the bail status of individuals and the conditions attached to their bail.

Recommendation 5

The Home Office commissions a feasibility study with a view to individuals' bail compliance histories being incorporated into the Police National Database.

Notes

Action Plan

Recommendation	Scope (national or local)	Action	Lead Agency	Key Milestones	Target Date	Completion Date
Recommendation 1 Establish a domestic violence focussed Multi-Agency Sharing Hub in Tower Hamlets as a pilot for other London boroughs	Local but as part of the existing London-wide project to introduce MASH with the primary focus on child protection	LBTH already operates a similar concept focussed on children but to date police have not been incorporated and neither have mental health professionals. First steps will be to allocate staff and IT to the project. Provisional costing completed.	Police (Tower Hamlets BOCU)	Business case for expenditure already completed and concept agreed with CSP partners A working group to be formed before 8th Feb 2012 Implementation expected by June 2012	June 2012	
Recommendation 2	Local	Post implementation review by the IDVA service of the reasons for client non-engagement and assessing alignment to CADDA guidance and standards	IDVA Service	Establishment of the review Completion and presentation to the DV Forum.	Dec 2013	

Recommendation 3 Multi-agency training of the new facilities and capabilities for inter-agency working in the MASH	Local, as for Rec. 1	The operating protocols for the new MASH will need to be developed by the working group before a suitable training package can be developed.	CSP	Development of the working protocols Training needs analysis Training design Training delivery	Dec 2012	
Recommendation 4 Enhancement of the MPS Emerald Wanted Management System	London-wide	The EWMS upgrade project forms an integral part of the overall MPS IT programme.	Comm. Sue Fish (MPS)	See MPS IS/IT programme	Dec 2012	
Recommendation 5 Incorporation of the bail compliance histories of individuals into PND records	National	As an initial step, a feasibility study, outline costing and business case should be commissioned by Home Office.	Home Office			

Appendix A

Consolidated Chronology

Date	Organisation/IMR ref.	Event	Comment
2005	MPS (IMR page 11)	PW and LP meet in a drugs rehabilitation clinic after which they move into the home of PW's mother to live together	
4 January 2006	MPS(IMR para 5.11)	PW's mother approaches Police to report PW has assaulted LP by punching her in the face. Reported as ABH. PW is arrested, admits the assault but LP refuses to provide a statement. The risk to LP is assessed as "medium". On the authority of a Detective Inspector PW was cautioned for the offence.	This matter appears to heave been dealt with appropriately.
March 2006	LBTH Housing Dept.	PW and his mother are the registered tenants at 5 Oswell House (LBTH housing stock). They jointly apply for a change of accommodation.	
27 March 2006	MPS (IMR para 5.14)	LP alleges PW had assaulted her by punching and slapping, only being restrained by his parents. Form 124D completed and the risk assessed as "high". LP refuses to assist police in taking the case to court and it appears is rude and will not listen to the OIC. The OIC then downgrades the risk assessment to	It is not clear that the risk assessment should be changed on the basis that the victim of an assault is unwilling to support a prosecution.

		"medium" Having discussed the case with his supervisor, he attempts to obtain supporting statements from PW's parents but they too refuse on the basis that LP and PW are now reconciled.	
28 March 2006	MPS	LP makes a new allegation that she has been assaulted by PW. He had allegedly followed her to the bus stop near to her home, head-butted her in the mouth and kicked her in the stomach when she fell to the ground. PW made off before police arrived. A form 124D is completed but no risk assessment is recorded on the crime report.	There is no obvious justification for the absence of a risk assessment especially as this was the third reported DV incident in three months
30 March 2006	MPS	LP was contacted by the same IO as in the previous case. She refused to substantiate her allegation. No further action was taken by Police in this matter	This was the second violent incident alleged to have happened over two days. MPS policy at this time was that in such cases PW should have been arrested despite the wishes of the victim.
April 2006	LBTH Housing Dept.	LP is apparently living at 5 Oswell House with PW and his mother. She applies to LBTH for housing	
27 April 2006	MPS	PW's mother calls police to report PW for making threats to cause criminal damage. PW has threatened to burn his mother's house down to reinforce demands that she	

		finances his and LP's drug and alcohol abuse. PW had left the house prior to arrival of police. Form 124D was correctly completed and the matter assessed as "standard" risk. PW's mother is prepared to support a prosecution.	
15 May 2006	MPS	LP calls police to her (new) flat at 38 Charles Dickens House E2. She alleges that whilst talking to PW outside they had started to argue. He had grabbed her hair and punched her in the eye. He had followed her into the flat where he had ransacked the flat then threatened to kill her and burn her flat if she called the Police. Two crime reports correctly completed and the matter risk assessed. Graded "low" on the basis that LP was now to stay with a friend at a different address. Arrest enquiries failed to locate PW. PW not circulated as wanted until 27 December. Local intelligence indicated he was sleeping rough in the stairwell of his mother's block of flats and he was arrested 2 days later.	This case appears to have been allowed to drift with only ineffectual supervision until the circulation as wanted brings about an arrest within 2 days. Given the history of violence between PW and LP, the risk assessment of "low" was somewhat surprising and short-termist.
29 December 2006	MPS	PW arrested but denied the assault on LP. He accepted a caution for the offence, however. PW also admitted the offence of threatening to	

		burn his mother's home down and accepted a caution.	
07 January 2007	MPS IMR	PW causes criminal damage at his mother's home after she refuses to give him money to buy drugs. He is charged with the offence.	
Feb to Aug 2007	LBTH Housing Dept.	LP is living in privately rented accommodation at 9 Bailey House E3	
30 May 2007	MPS IMR	LP had been having an affair with a workmate. After a suggestion she had undergone a termination of pregnancy, she became the victim of threats to her and her home. Prior to this LP had made threats and threatening phone calls to the man's wife. Arrests were made. The suspect denied the offences. There was clearly provocation on both sides. LP became abusive to the investigating officers. The suspect was issued with a Harassment Warning	
04 August 2007	MPS	LP reports that a window in her flat had been smashed by persons unknown. No information as to possible suspects. Case closed	
08 August 2007	MPS	LP reports to police that while she was asleep her dog was locked in the kitchen. Apparently one of her windows was found open and her car keys and car were missing. A suspect known to LP was	

		identified having been seen by police driving LP's car. He was arrested as wanted for recall to prison. LP refused to provide a statement or assist with the investigation.	
19 September 2007	MPS	Police called to an assault by LP on another female who had allegedly called LP a "Paki lover". LP arrested and admitted the offence and was cautioned.	
16 October 2007	Police National Computer MPS London Probation Trust	PW commits arson at his mother's block of flats (Oswell House) by setting a fire in the lift. Subsequently charged with *arson with intent to endanger life or whereby life may be endangered*.	PW was arrested for and admitted this offence on 28.02.08
Feb 2008	LBTH Housing Dept.	LP moves to 7 Brymay Close, which is privately rented accommodation	
30 April 2008	Police National Computer	PW convicted of Arson at Snaresbrook Crown Court and sentenced to 21 months imprisonment	
02 November 2008	MPS	LP call police to her home claiming boyfriend (not PW) has assaulted and threatened her and damaged property. Both parties had been drinking and were aggressive. The suspect was arrested for common assault but LP declined any form of outside help and refused to provide a statement. Case NFA'd	

26 January 2009	Police National Computer	PW convicted of shoplifting (on 24.01.09) at Highbury Corner Mag.	This is the first evidence of PW's re-entry into society; 9 months after the imposition of the 21 month sentence of imprisonment for arson
26 November 2009	MPS	LP alleges her boyfriend (not PW) of 2 weeks had head-butted her then threatened her with a firearm. Suspect was stopped as he left the flat but no firearm was found. In interview suspect alleged LP had had her arms around his throat but denied assault. LP later refused to make a statement and became aggressive to the officer. She refused any DV support. Case NFA'd	
30 November 2009 to 11 December 2009	Victim Support (IDVA)	As a result of the above incident LP phoned by an IDVA who carried out a risk assessment which scored 15 "ticks" i.e. putting LP into the high risk category which would merit referral to MARAC. The IDVA attempted to draw up a safety plan but LP was unable to continue the call. LP was re-contacted on 09.12.09 but declined any further involvement with Victim Support. On 1.12.09 the case was referred to MARAC despite the lack of consent from	The suspect in this case was not PW

		the victim.	
08 February 2010	Police National Computer	PW convicted of shoplifting (on 21.12.09) at Highbury Corner Mag.	
15 March 2010	MPS	LP called Police after a phone argument with her ex-boyfriend (PW). CSU officers invited LP to discuss the situation to refer her to support but she declined the offer and case NFA'd	
26 May 2010	Police National Computer London Probation Trust	PW convicted at Thames Mag. of failing to comply with a Community order imposed on 08.02.10 Community Order with a Drug Rehabilitation condition imposed for 12 months (i.e. to 26.02.11) supervised by London Probation	London Probation completed risk assessments and risk management plans but these contain acknowledged defects. Primary focus of Probation Officer was PW's drugs habit and mental health issues. In consequence the DV risk assessment tool was not used and no MARAC referral or partnership checks were made
13 July 2010	Tower Hamlets Specialist Addition Unit (THSAU)	Referral of PW from GP surgery to THSAU. Details of current drug use (methadone, heroin, crack & alcohol plus cigarettes and cannabis). - History of self harm and symptoms of severe depression, anxiety and possible personality disorder.	

		- Currently on a Drug Rehabilitation Referral with a Probation Officer and supervisor on a Drug Intervention Project. - No mention of any partner but described as "effectively street homeless"	
22 July 2010	THSAU	- Assessment of PW by Key Worker notes use of heroin and crack/cocaine, requiring specialist prescribing. - Previously untreated. - Gave mother's address where he lives. - "No relationship but has a lady friend".	The "lady friend" is believed to be LP
28 July 2010	THSAU	- SAU takes over prescribing for PW from GP: methadone 90 mg daily. - Treatment Outcomes Profile completed	
29 July 2010	THSAU	- PW attended Unit with "lady friend", agreed to start treatment, made appointments and given a script for Methadone 90ml	
9 August 2010	THSAU	- Medical review of PW with consultant. - Had abstained from heroin for 2 weeks but used Diazepam and Temazepam daily. - Risk assessment: risk to self and others both high and increased when intoxicated. - Plan: supervised script issued, key worker review, further medical review, contact with Probation –	

		message left with Cambridge Heath office	
16 August 2010	THSAU	- PW Urine Drug Screened (UDS): negative for opioids and cocaine. - Requesting reduced methadone. Advised to discuss Diazepam use with GP	
22 August 2010	MPS	PW calls police to LP's home because LP is throwing his property out of her home. No offences apparent	This is the first time police were called to LP and PW after his release from prison
23 August 2010	THSAU	- PW's UDS negative for opioids and cocaine. - Methadone reduced at his request to 80ml daily	
26 August 2010	THSAU	- PW Did not attend medical review with consultant. -Rebooked	
1 September 2010	THSAU	- PW Attended a day late for his review. - Demanded his script be reduced to 75ml daily but no doctor available and he wouldn't wait	
8 September 2010	MPS	Police are called to LP's home where they find LP and PW arguing. PW is drunk. He wants to retrieve his property from the flat. Police took PW to his mother's flat. The incident was correctly reported and risk assessed as "standard" LP declined any referrals	
11 September 2010	MPS IMR	Police are called to LP's flat on three separate occasions. LP claims that PW has assaulted her and then made off. On their 3rd	

		attendance PW is present and is arrested. LP confirmed to the officers that she would support any police action against PW. The incident was graded "low/standard" on the basis that PW had been arrested. PW admits hitting LP but alleges LP had assaulted him by hitting him on his ulcerated legs. CPS advise no further action	
12 September 2010	MPS	A few hours after PW's release from police custody police are called back to LP's flat where PW had attempted to gain entry believed so that he could retrieve his property. He was not present when police arrived. LP had taken refuge in a neighbour's flat. LP told the officers she thought PW was in custody. She stated she was scared of PW and what he might do to her. Subsequently (date unknown but within the month) LP attends the LBTH "One Stop Shop" and told the staff she had been assaulted by an unnamed person who had climbed in through her window. She	This incident should have been reported on a new CRIS report but it is recorded that the officers were advised by the CSU to add the details of this incident to the report generated by the 11th September incident. No secondary risk assessment was completed

		claimed she had reported the matter to police and provided a crime number to substantiate her claim. She was advised to contact the Housing Department but there is no record of her having done so	Had LP sought LBTH housing, there is no guarantee she would have been regarded as a high priority case. As such would have received no immediate offers of alternate housing
13 September 2010	THSAU	- PW attended GP surgery tearful, claiming no support from SAU. - Having thoughts of suicide & self-harm - Consultant decides if safety net in place to prescribe Citalopram 20mg -PW's mother writes to SAU: she is unable to have him living with her: he is suicidal and needs professional help	
14 September 2010	THSAU Victim Support (IDVA)	PW's Key Worker attempted to speak to Nurse Practitioner and left message. - PW attended the Unit with the letter from his mother - Citalopram prescription discussed and advised to continue for 4-6 weeks - PW said his girlfriend had reported him to police for battery A direct referral received from Police to Victim Support for ABH (re incident on 11.09.10). Three 'phone attempts	

		made to contact LP made but without success.	
15 September 2010	THSAU	- Retrospective note by PW's Consultant re discussion with Nurse Practitioner and Key Worker	
22 September 2010	THSAU	- Drug Programme Co-ordinator informs SAU that PW had attend the programme with a black eye after a fight. - His drinking was chaotic - Coordinator trying to secure crisis admission of PW to City Roads - PW attends SAU saying he'll have telephone assessment with City Roads and inform SAU if he's admitted -PW informed of his Consultant's appointment for the following day - Methadone script issued for 70mg	
23 September 2010	THSAU	- PW fails to attend Consultant appointment for medical review	
24 September 2010	THSAU	- SAU phone PW. He states he failed to attend medical review due to attendance at a police station reporting an assault/theft - PW claims to be "losing his mind" and suffering blackouts since starting Citalopram - Denied having to drink daily - PW is "lukewarm" about proceeding with referral to City Roads - SAU recommended blood pressure, urea and	

		electrolytes be checked when he next attends GP surgery.	
28 September 2010	THSAU	- PW attends key Worker appointment, smelling of alcohol - Care plan: PW no longer injecting; encourage appointment with Blood Borne Virus team; suffering depression/low mood(Citalopram prescribed); monitor compliance & impulsive/suicidal behaviour; liaison with GP & Probation - Pressure for PW to leave mother's flat. Working with HOST re housing issues - Assessed as at risk of suicide. - To have medical review if any suicidal ideation or intention is expressed with psychiatric admission if necessary.	
4 October 2010	THSAU	- Letter from PW's Consultant to Nurse Practitioner: PW phoned to cancel medical review and it would be rebooked - PW attended later appointment with key Worker: stable in mental state and wants medical review in a few weeks	
18 October 2010	THSAU	- PW meets covering Key Worker: he had smoked 5-9 lines of heroin that day after an argument with his mother - Briefly discussed physical violence with other drug	

		users - Not taking Citalopram due to blackouts - Cover worker to discuss with team issue of mood stabilizers as his mood is fluctuating - PW requires MHA assessment to get back onto DDR programme: to be communicated to Probation Officer	
19 October 2010	THSAU	- PW discussed at clinical meeting which includes an Adult Mental Health psychiatrist - PW requires medication review in 2 weeks	
28 October 2010	MPS IMR CPS	PW allegedly assaults LP by punching her on the back of her head causing her to fall from her bicycle. He then allegedly punched and kicked her until a member of the public wrestled him to the ground. Police called but PW had left. Details of two independent witnesses are taken but no statements. Photographs of the injuries are taken	The policy of the Community Safety Partnership in Tower Hamlets is that cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) by the OIC by means of a referral on the CRIS system. Referrals are monitored by a dedicated MARAC Co-ordinator (a police officer). There are 3 trigger criteria for a referral: the case scores 14 or more "ticks" on a risk assessment , there is an escalation of 6 or more incidents/offences within the previous 12 months or the OIC feels that as a matter

			of professional judgement the case should be referred. In this instance there had been only 5 incidents within the previous year BUT in addition, LP had expressed her fear of PW – this would have formed adequate ground for a referral to MARAC but there is no indication on any of the CRIS reports that a referral was made
30 October 2010	CPS MPS	PW arrested. He admitted punching LP but claimed self defence. He denied kicking or stamping on her. LP's injuries are photographed and she made a statement supporting prosecution. Circumstances of PW's arrest referred to CPS for charging advice. Based on the threshold test, as Police had not obtained any independent witness statements, charging decision given and PW was charged then held in custody overnight for Thames Mag. Court. The MG7 by police gives grounds for remand in custody but no specific reference to risk of further offences against LP. MG7 also gives suggested conditions should he receive bail from court.	

		CPS advice makes specific reference to risk of offences against LP and interference with her as a witness	
31 October 2010	Victim Support (IDVA)	Victim Support received direct referral from Police re ABH (re incident 28.10.11). Three attempts made to contact LP but without success	
1 November 2010	Thames Magistrates' Court	- PW produced in court as an "overnight" prisoner - Represented - CPS representations that case be tried at Crown Court. - Not guilty indicated - CPS objected to bail - Remanded on bail conditions: of residence at Flat 5 Oswell House, Farthing Fields London E1W 3RU and not to contact LP directly or indirectly - Case adjourned to 13.12.10 for committal - ***LP attended court & indicated she was not supporting the prosecution***	This was a DV case but not heard in a specialist DV court (SDVC) due to PW being produced as an overnight prisoner Case not adjourned to SDVC as required by DV Protocol, a common practice due to excess demand Not apparent that bail checks had been completed No note of IDVA or OIC providing information re bail As a result of the CPS objection to the grant of bail, the Criminal Justice & Police Act 2001 inserted into the Bail Act 1976 requirements for the courts to provide reasons when granting bail in such circumstances. No notes can be found on

			the court files to show that reasons were given. Evidence from the Legal Advisers suggests widespread ignorance of these requirements.
2 November 2010	THSAU	- PW "dropped in" to SAU for Key Worker review - PW had a scratch on his face and claimed his girlfriend had scratched & kicked him over 10 cigarettes - Admitted smoking heroin & crack over the weekend - UDS positive for heroin & cocaine - PW didn't want his girlfriend to know anything about him from today onwards -Reminded he had missed 3 medical reviews	
	CPS	CPS administrator sent a request to the OIC for a "full file" to be created in relation to the case with a follow-up memorandum the same day. No action by the OIC	
	CPS	Witness Care Unit (MPS) write standard letter to LP	The WCU does not attempt to contact her again for nearly 4 months but at that time all recorded efforts failed despite messages being left
17 November 2010	THSAU	- PW attends Key Worker review - Mental state assessed as	

		stable -Refused to give urine sample - Remains on 70mg methadone daily	
4 November 2010	CPS	Follow-up e-mail sent by CPS to OIC to create a "full file" for PW's case. No action by the OIC	
7 November 2010	CPS	Reviewing lawyer in PW's case personally phones OIC to require preparation of the case file previously (twice) requested. Action then followed	
25 November 2010	CPS	Case papers allocated to a CPS Paralegal Officer some 24 days after it had been set down for committal	No further work appears to have been done on the file until the lawyers review on 10 December 2010
26 November 2010	THSAU	PW attends medical review - He is homeless but "staying with friends" - Reported feeling suicidal 10 weeks before and taking drugs/alcohol but without effect - Wanted methadone reduced to 45mg daily and was spitting out some of his current dose - He'd stopped the Citalopram due to blackouts but they have stopped now - Drinking 12 units alcohol daily - Requested anti-depressants - Suicidal ideation but no suicidal intent - No homicidal intent - Considering rehab/detox - Agreed to be booked in	

		for a longer review Plan: to discuss methadone with Key Worker, include in team meeting & rebook review Subsequently methadone reduced to 45mg daily UDS positive for methadone, cannabis & amphetamine	
10 December 2010	THSAU CPS	- PW attends Key Worker Review - he is well & mental state stable - No abnormal thoughts or suicidal ideation - Asked for further methadone reduction but this was refused due to positive UDS for opioids - 45mg methadone given First formal review of the case against PW conducted by CPS (over a month after charging). The prosecutor notes that the case ”slipped through the allocation net”	The CPS IMR regards this review as full and covering all salient points
13 December 2010	Thames Magistrates’ Court	- PW answered bail - Prosecution case not ready: adjourned to 10.01.11 - Bail conditions remained as before	Delay due to statement not having been taken from an independent witness to the assault Case again adjourned to a non SDVC hearing
21 December 2010	THSAU	- PW attends Key Worker review - UDS positive for	

		methadone& cannabis - PW wants to show this result to his girlfriend & mother - Script given for 45mg methadone	
23 December 2010	THSAU	- PW has updated risk assessment by Key Worker: risks mentioned included history of overdose, injecting, suicidal attempts & self-harm, impulsive & violent behaviour - Housing issues identified - No entries made under offending behaviour Updated care plan: mental health needs re suicidal ideation and intention to be dealt with through careful monitoring while drug use is stabilised. Medical review as necessary. Methadone to reduce by 5-10 mg fortnightly when UDS negative. - Awaiting HOST decision re housing	PW's impulsive and violent behaviour, as well as his potential for self harm were considered but the absence of entries under "offending behaviour" was a weakness. This was a potential referral point to MARAC
6 January 2011	THSAU	- PW attends Key Worker review - Had been drinking alcohol over Xmas - UDS positive for methadone & cannabis - Methadone to 35mg daily	
7 January 2011	CPS	Second CPS formal review of the case against PW.	CPS IMR acknowledges that this review failed to address a range of key issues

	Victim Support (IDVA)	Direct referral by Police to Victim Support for non DV harassment. Contact successfully made but LP declined any support	
10 January 2011	Thames Magistrates' Court	- PW answered bail - Committed to Snaresbrook Crown Court - Bail conditions remained as before	
20 January 2011	THSAU	- PW attends Key Worker review - Clarified that he only attends SAU to see his Probation Officer. The Probation Officer is female but otherwise unknown to Key Worker who now seeks to get her name - Methadone script now 25mls daily	
25 January 2011	THSAU	PW fails to attend his medical review with SAU specialist doctor - Pharmacist confirms he is collecting his script	
31 January 2011	CPS MPS	LP calls police because someone trying to gain entry to her address. Police attended and found PW in the building and arrested him. LP claimed she did not know it was PW. PW held in custody overnight. Police MG7/8 submitted in support of a remand in custody but the evidence *did not include direct evidence of contact with LP*	

		(i.e. that PW was in breach of his bail conditions) An Associate Prosecutor was briefed to proceed with the breach of bail matter to give the court power to remand in custody or grant bail on the same or different conditions. The AP advised to seek an additional condition of bail that PW not go to LP's address. A Senior Crown Prosecutor advised *against* an appeal if bail were granted	The rationale for the decision to advise against an appeal was fully documented and is considered in the Analysis section of the overview report
February 2011	LBTH Housing Dept.	At a date unknown this month, PW 's mother moves to a new address in London E1, a two bedroom flat on the basis that PW will also live there	Despite this move, PW still remains bailed on a condition of residence at 5 Oswell House – which is now not available to him. The fact that PW's mother had sought an injunction barring PW from the flat is a strong indication that the new address was not available to him either
1 February 2011	Thames Magistrates' Court **First Breach of Bail**	- Produced at court for an admitted breach of non contact condition of bail - The CPS IMR indicates that the instructions to the advocate should oppose bail but the Courts IMR indicates the advocate did not oppose bail & was content to continue it with an additional condition: not to enter Brymay Close E3 (not imposed)	HMC&TS Standards National File Cover Guidance is unclear on procedure for manual files relating to this type of case. There is a conflict of evidence here unless the Associate Prosecutor simply did not deal with matters as instructed

		- PW re-committed to Snaresbrook Crown Court to appear 10.03.11 Neither the breach of bail nor the outcome was recorded on the CPS Case management System. The CPS Unit was not notified on the day of PW's release LP was never shown on CRIS as having been notified of the result by the OIC	Apparently the original case file was not incorporated into this new case file.
8 February 2011	THSAU	- PW's Key Worker reviews. - Encouraged to see SAU doctor. - No script issues since 03.02.11 - Smoking heroin & buying methadone - UDS positive for opioids, methadone cocaine & cannabis - PW's consultation is written up in a letter by the SAU doctor mentioning he'd defaulted on his 02.02.11 script for 25ml methadone - PW said he's argued by phone with girlfriend due to personal & domestic hygiene - Admitted smoking heroin since defaulting on his prescription - Complaining of chronic low mood, poor motivation, suicidal ideation, and low self – esteem.	

		- reported his previous overdose at his grandmother's house 5 years before - Denied alcohol use - Unkempt, tearful, objectively depressed with biological features - Intermittent suicidal ideation but without plans or intent but with no protective factors - Remorseful re messing up his treatment programme - Methadone 20mg daily Started on mirtazapine 30mg daily -Next review 22.02.11	
10 February 2011	Victim Support (IDVA)	Direct referral of LP from Police to Victim Support. LP contacted successfully. She appeared upset and claimed Police were not protecting her and asked why Victim Support had not contacted her. It was explained to her what services Victim Support could provide and that several attempts had been made to contact her but to no avail. LP Declined support and advocacy on her behalf	LP had had contact with Victim Support in late 2009 in relation to DV problems with and threats from another partner. Despite being referred to MARAC as a high risk case without the consent of the victim, when contacted with offers of support she had declined and did not wish to engage with the organisation
22 February 2011	THSAU	- SAU doctor unable to review PW (reasons unclear) -Mirtazapine script not collected from GP surgery - Methadone to 15mg daily & mirtazapine 30 mg daily PW had lost his script & a duplicate issued after making a police record	

26 February 2011	London Probation Trust	Probation Service supervision of the Community Order (with drugs rehab condition) ends.	
25 February 2011 to 1 March 2011		PW admitted to Royal London Hospital following an RTA in which he was hit by a taxi - Treated for cellulitis & an abscess - Given diazepam as he's sourcing it from the streets - last dose of methadone at RLH on 01.03.11	
1 March 2011	THSAU	PW's Key Worker review - DATIX form completed reporting RTA - UDS positive for benzodiazepines, opioids, cocaine & methadone - Methadone 15 mg daily	
2 March 2011	THSAU	- E-mails from RLH to THSAU confirming the level of diazepam prescribed to PW at the hospital and asking SAU to take over prescribing. - Consultants e-mail asks key worker to review and recommends diazepam withdrawal programme	
3 March 2011	THSAU	-PW attends Key Worker review - Discusses diazepam withdrawal - Reduction programme agreed - Gave new address (that of his mother)	
8 March 2011	CPS	The Trial Brief for Prosecution Counsel is prepared ready for the	

		hearing on 10.03.11	
	Thames Magistrates' Court	- PW appeared charged with racially aggravated public order offence, unconnected with LP (on 09.02.11) - Pleaded guilty & convicted - Remanded on unconditional bail: no objection from CPS - Committed for sentence to Snaresbrook Crown Court to link with ABH case.	Court does not appear to have considered that Mr. Wright committed this offence whilst on bail or that he had already repeatedly breached his bail re the ABH charge. It appears unlikely that the court had the files of previous cases before it. Para. 2A Schedule 1 Bail Act 1976 as amended by s.14 Criminal Justice Act 2003 requires that in these circumstances the court must be satisfied there is no significant risk of committing further offences whilst on bail. There is no evidence that the court performed this inquisitorial role as required
10 March 2011	Snaresbrook Crown Court , Plea & Case Management Hearing	- PW answered bail - Not guilty plea entered - Trial fixed for w/c 13.06.11 - Defence applied for bail address to be changed: the court refused pending suitability checks & PW bailed as before to old address	It appears PW had already left his old address (i.e. breached bail) some time in the previous month before seeking permission. This was ignored and bail extended on the same conditions as before: to live at an address at which he admitted to no longer

			living
13 March 2011	MPS IMR (para 5.35)	Police officers thought they saw PW riding a bike near LP's address. If it was him he would have been arrestable for breach of bail conditions. A CRIMINT report was created but there is no record of further action or that LP was notified of the possible breach	This is a clear indication of some dysfunction in the police management of intelligence in relation to bail management
15 March 2011	THSAU	- PW interviewed by Police re altercation at SAU with another user - NFA by Police - DATIX form completed re this incident - Discussed recent RLH admission and his wish to change Key Worker (refused for now) - Requested to see a psychologist and agreed Key Worker would arrange this - Mental state stable - Methadone 15ml daily Next Key Worker appt. 13.04.11	
20 March 2011	CPS MPS	PW arrested for further breach of bail and held in custody overnight for court.	A custody record and single entry on the CPS Case management System confirm the arrest, remand in police custody and subsequent court remand on conditional bail. No traceable Police/CPS file or paperwork for this.

			There is no CRIMINT record or CRIS record or of the information being passed to the OIC
21 March 2011	THSAU	- GP letter to SAU asking for urgent assessment of PW at his own request because he is particularly agitated	
21 March 2011	Thames Magistrates' Court **Second Breach of bail**	- PW brought before court in custody for an admitted breach on non-contact bail condition - There is no record of CPS objections to bail. ***- LP attended court and stated (for the second time) she was not supporting the prosecution case*** The hearing and outcome were not recorded on the CPS Case Management System nor was the CPS Unit notified. The CRIS report records no information to LP	Again considered on a non SDVC day. Highly likely that previous breach of bail file not provided to court by its own administration team and that the court was unaware of the full history of the case(s) PW refused to state his current address despite it being a contentious condition of bail. No evidence of proper scrutiny of this issue by the court Court case file records no representations by prosecutor re bail – as would usually be required to give the facts & circumstances of the breach of bail An error on the charge sheet (Bryme Close E3 rather than Brymay Close E3) may have confused the court as to where the unlawful contact with LP had taken place.

			PW admitted to being homeless No evidence that PW's list of previous convictions provided to the court – very unusual to make a bail decision without such information. Prosecutor made no representations or appeal against what appears to have been a very unusual bail decision: no reasons recorded for the bail decision.
23 March 2011	Statement of PW's mother to MPS	PW's mother obtained a civil non-molestation order to prevent PW coming to her home and contacting her	The order related to PW's mother's new address and thus has no direct bearing on the suitability of 5 Oswell House as a residence for bail purposes
2 April 2011	MPS	PW overdoses using Methadone & Mirtazapine and is found outside LP's home. Taken by ambulance to RLH. He is visited by LP who is described as being rude and abusive to hospital staff.	
3 April 2011	Royal London Hospital	- Fax re PW is written at Royal London Hospital to inform the *intended recipients that* PW had presented and been admitted at the RLH	

		yesterday (02.04.11) following an overdose of methadone (15ml) and mirtazapine (2x30mg tablets). PW had been found by passers by - Social problems include a restraining order by his mother. - "Finding it difficult to control his anger for past few months. He has not attacked members of the public" Social history: reports "living together" - Plan: discuss with Duty Senior House Officer and continue with SAU. Requires counselling alongside GP follow up, discharge home. - Later in fax, slightly different plan: requires counselling with SAU and medication review by psychiatrist as he feels mirtazapine doesn't agree with him, GP follow up - Advised to return to A&E - The fax header sheet was written by the EMHALS nurse who completed the assessment but it appears the fax was not transmitted to either SAU or the GP PW gave his address as that of LP, his partner	
5 April 2011	CPS	E-mail sent by OIC to Witness Care Unit stating "the victim never really	This key information should have been disseminated earlier

		engaged with the police in the first instance" and that she became "anti-police" when informed that PW had been charged.	and especially to the CPS
12 April 2011	THSAU	- PW attends a Key Worker review - Mood good, mental state stable - Wanted to reduce methadone - Script given for 15ml daily - Letter written to support Housing application - To see again 24.04.11	
17 April 2011	MPS CPS	Police called by LP's neighbour who claimed a disturbance by PW at LP's address. Police attended, made enquiries but no arrest. An hour later LP herself called Police to allege a breach of bail by PW. No arrest was subsequently made. The officers record details of the incident on a form 124D which included them attending PW's mother's home in an attempt to arrest him (he wasn't there). The officers sought CSU advice and were told to record the information on the original CRIS report which had given rise to the bail conditions being imposed. They did not create a new CRIS report or CRIMINT report. The form 124D was not	

		submitted to the CSU for review. Because the CRIS report was closed and the form 124D not submitted, the OIC was not automatically informed of the incident	The actions of the reporting officers and a member of police staff have been investigated by the IPCC. The IPCC has recommended that one officer be considered for gross misconduct action and that a second officer and a member of police staff be considered for misconduct action
20 April 2011 11.50 hours	THSAU	- Key Worker review because PW had "dropped in" - Having thoughts of killing himself but no plan as to how or when - PW says he'd been to A&E yesterday and a nurse had told him to come to SAU - PW says he's been taking methadone & mirtazapine - Refuses UDS - Telephone call to RLH where there is record of him being seen on 03.04.11 but NOT on 19.04.11 - Notes of attendance at A&E Not requested by SAU at that time. - Seen with consultant - Admitted to drinking up to 6 cans per day and sourcing 40mg diazepam - Taking Mirtazapine regularly from GP - Thoughts of hurting people in general but no one in particular	

		- Thoughts of suicide but no plan - Would consider alcohol detox and benzodiazepine detox - Admitted smoking some heroin - Wants SAU to speak to sister and mother about how he is - Court case at Snaresbrook next month re an assault on him - Discusses safety issues with methadone when he visits his sister who has young children - Discusses safety plan if thoughts of killing himself out of hours - Plan: Review on 26.04.11, refer for alcohol detox and benzodiazepine detox if dependency is established. - Left message for Nurse Practitioner at GP - Called PW's sister who advised against calling his mother (it appears this person was actually LP who had given her phone number claiming to be PW's sister)	
21 April 2011 00.14 hours	Royal London Hospital (A&E)	- Entry made by EMHALS nurse of PW's arrival at A&E requesting psychiatric assessment as feeling suicidal - Seen by duty EMHALS nurse - Patient with a history of low mood and substance misuse problems - Seen on Medical Assessment Unit on	

		04.04.11 (actually it was 03.04.11) following overdose. The plan then was to continue SAU appointments and GP for counselling - PW believed this would happen automatically - Nurse explained that he needs to attend - PW says he feels much better and will go to GP in the morning - No suicidal plan or intent - Plan to fax today's and 04.04.11 notes to SAU and SAU - PW discharged once seen medically re leg abscess - Given Revaxis	
21 April 2011	THSAU	- Key Worker discusses info from RLH fax re PW's attendance at RLH on 20 (actually 21st)04.11 with Consultant - No action required - Phone call to pharmacy verified PW had collected his script this morning and had been cheerful	
11.50	Statement to MPS of CCTV record	LP & PW are shown on CCTV at The Bell Pharmacy collecting PW's prescription	
About 14.00	Statement of friend of LP to MPS	Friend meets LP & PW, both riding bikes. They go shopping. PW gets methadone but all three return to LP's flat where they smoke cannabis together	
About 17.00	Statement to MPS of a neighbour	PW and LP are seen in the communal area of Brymay	

		Close apparently having a BBQ	
About 19.00		PW is seen calling up to LP to let him into the flat	
Between 20.00 & 21.00	Statement of friend of LP to MPS	LP & PW have an argument culminating in PW being told to leave, which he does. PW has keys to the communal area but never had keys to LP's flat.	
About 21.30	Statement to MPS of a neighbour	LP has a phone conversation with a friend which he describes as "a normal chat"	
Between 22.00 & 23.00	Statement of friend of LP to MPS	PW returns to the flat but leaves again, witness believes he slept rough that night. Friend and LP sleep in LP's flat overnight	
22 April 2011 Bank Holiday (Good Friday)			
About 07.00	Statement of friend of LP to MPS	Friend leaves to go home having spent the night at LP's flat	
About 07.00	Statement of neighbour to MPS	Neighbour believes he hears the communal intercom buzzing and that he hears LP's and PW's voices and believes they both entered LP's flat.	
About 08.00		Neighbour believes he hears someone leave the building	

About 08.00 to 08.20 08.32	Statement of friend of LP to MPS	Friend sees PW walking away from Brymay Close with LP's bike Friend receives a text message from LP's mobile phone: "A". Friend returns to LP's flat and shouts up to her window but receives no reply	
23 April 2011 07.00	Statement to MPS of CCTV record	PW is seen at The Bell Pharmacy shortly before it opens	
24 April 2011 (Easter Sunday) 18.30	MPS	Police called to Forest Wall, Weaver's Field E2 where The body of PW was found hanging from a tree. There is limited information on his person by which his address can be identified. On the body is a set of keys which are subsequently found to be the keys to LP's flat	
25 April 2011 Bank Holiday (Easter Monday)		Correspondence on PW's body enables his mother to be contacted. They are taken to where PW's body has been found. PW's family do not want LP informed.	
26 April 2011	MPS	Officer s attend LP's home to do a welfare check and having received no answer, gain entry using keys found on PW's body. They find	

		the dead body of LP, naked but covered by a blanket. She has a knife in her chest, multiple stab wounds and a bike chain around her neck.	
27 April 2011	Statement of Pathologist	Post mortem examination of PW's body indicates "suspension" as the provisional cause of death.	Pathologist: Dr. Peter Jerreat
28 April 2011	Statement of Pathologist	Post mortem examination of LP's body indicates the stab wound to her chest as the cause of death.	Pathologist: Dr. Peter Jerreat

Appendix B

Risk Assessment form

This risk assessment form should be completed in all cases where the DV1 has flagged concerns about risk (4 or more ticks on the DV1 risk section), or where you as a professional have concerns about the risks to any member of the household, particularly any risks to children.

- In all cases scoring 14 or more on the risk assessment or where you as a professional judge any individual to be at significant risk of harm, a referral should be made to the Tower Hamlets Safety Planning Panel (SPP). Please send the signed DV1 form and Risk Assessment form to the Domestic Violence Team (domesticviolence@towerhamlets.gov.uk)

- Where there are children present in the household - In all cases scoring 14 or more on the risk assessment, where any of the shaded questions on the form are present, or where the professional has significant concerns about the safety of any children in the household, a referral should be made to the Integrated Pathways and Support team.

Name of Victim:

Name of Perpetrator:

Date RA completed:

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. **Tick the box if the factor is present. Please use the correct box under the questions to expand on any answer.** **It is assumed that your main source of information is the victim. If this is <u>not the case</u> please indicate in the right hand column.**	**Yes** **(Y)**	**No** **(N)**	**Don't Know** **(DK)**	**State source of info if not the victim e.g. police officer**
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)				

Comment:				
2. Are you very frightened?				
Comment:				
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s),..)might do and to whom, including children)				
Comment:				
4. Do you feel isolated from family/friends i.e. does (name of abuser(s)…….) try to stop you from seeing friends/family/doctor or others?				
Comment:				
5. Are you feeling depressed or having suicidal thoughts?				
Comment:				
6. Have you separated or tried to separate from (name if abuser(s)….) within the past year?				
Comment:				
7. Is there conflict over child contact?				
Comment:				
8. Does (….) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)				
Comment:				
9. Are you pregnant or have recently had a baby (within the last 18 months)?				
Comment:				

10. Is the abuse happening more often? **Comment:**				
11. Is the abuse getting worse? **Comment:**				
12. Does (…) try to control everything you do and/or are they excessively jealous? *(In terms of relationships, who you see, being 'policed at home', telling you want to wear for example. Consider 'honour-based' violence and specify behaviour.)* **Comment:**				
13. Has (…) ever used weapons or objects to hurt you? **Comment:**				
14. Has (…) ever threatened to kill you or someone else and you believed them? (If yes, highlight who.) * You * Children * Other (please state)				
15. Has (…) ever attempted to strangle/choke/suffocate/drown you? **Comment:**				
16. Does (…) do or say things of sexual nature that make you feel bad or that physically hurt you or someone else? *(If someone else, specify who.)* **Comment:**				
17. Is there any other person who has threatened you or who you are afraid				

of? *(if yes, please specify whom and why. Consider extended family if HBV)* **Comment:**				
18. Do you know if (…) has hurt anyone else? *(Please highlight whom including the children, siblings or elderly relatives. Consider HBV.)* * Children * Another family member * Someone from a previous relationship * Other (please state)				
19. Has (…) ever mistreated an animal or the family pet? **Comment:**				
20. Are there any financial issues? For example, are you dependent on (…) for money/have they recently lost their job/other financial issues? **Comment:**				
21. Has (…) had problems in the past year with drugs *(prescription or other)*, alcohol or mental health leading to problems in leading a normal life? (*If yes, please specify which and give relevant details of known.)* **Comment:**				
22. Has (…) ever threatened or attempted suicide? **Comment:**				
23. Has (…) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? *(you may wish to consider this in relation to an ex-partner of the perpetrator if relevant.)* * Bail conditions * Non-Molestation/Occupation Order * Child contact arrangements * Forced Marriage Protection Order * Other				
24. Do you know if (…) has ever been in trouble with the police or has a criminal history? (If yes, please highlight.)				

* DV * Sexual violence * Other violence * Other (please state):				
Total 'yes' responses				

Supplementary child risk assessment questions: **Please complete this section of the form in all cases where domestic abuse has been disclosed and where there are children in the household.**	**Yes (Y)**	**No (N)**	**Don't Know (DK)**	**State source of info if not the victim e.g. police officer**
1. Has the child/ children directly intervened in or witnessed any incidents of domestic abuse and/ or been physically injured in the course of any incidents of domestic abuse? **Comment:**				
2. Has (…) made any threats or attempts to abduct the children? **Comment:**				
3. Are there any emerging concerns about the impact the abuse is having on the children? *(consider factors such as poor school attendance, bed wetting, signs of significant distress)* **Comment:**				
4. Are there any additional factors related to the child/ children that would increase their level of vulnerability to the abuse? *(e.g. child/ children has a disability, child/ children are not the perpetrators')* **Comment:**				
5. Is any member of the household at risk of forced marriage or honour based violence? **Comment:**				

6. Professionals – Do you have any concern as a professional about minimisation of the abuse by parent(s) and/or lack of parental engagement with support services?				
Comment:				

Appendix C

THAMES SPECIALIST DOMESTIC VIOLENCE COURT

1 Introduction

1.1 This Protocol is an agreed document between agencies that are committed to participate in Thames Magistrates' Court's Specialist Domestic Violence Court for dealing with domestic violence cases starting October 2009.

1.2 Thames Magistrates' Court deals with cases arising from the London Borough of Tower Hamlets and London Borough of Hackney. All identified domestic violence cases coming before Thames Magistrate's Court will be subject to the Protocol.

1.3 The Specialist Domestic Violence Court (SDVC) is part of the co-ordinated community response to domestic violence in Tower Hamlets and Hackney. Thames SDVC aims to increase the effectiveness of the judicial system by:

- Providing better protection and support to victims and witnesses of domestic violence
- Applying appropriate sanctions to perpetrators
- Reducing delay in the prosecution process through effective case management and by
- Improving the co-ordination of agencies involved in supporting victims and witnesses and dealing with perpetrators

1.4 While acknowledging that each agency maintains its independence, Thames SDVC Steering Group aims to ensure that all the agencies involved work in an integrated and co-ordinated way to achieve the objectives of the project. Each agency has committed itself to closer working practices with other member agencies, sharing information and providing the best possible service to survivors and their families within the roles, responsibilities and resources of individual agencies and ensuring that any gaps in service are identified and addressed.

1.5 All signatory agencies have agreed that the aim of the protocol is to improve the Criminal Justice System management of domestic violence cases and it is acknowledged that all agencies will work in accordance with the Criminal Procedure Rules and its overriding objectives when dealing with cases.

1.6 It is acknowledged that the judiciary remains independent and nothing in this document is intended to interfere with judicial discretion.

2 Definition

2.1 The court that will hear the domestic violence cases will be referred to as the "Specialist Domestic Violence Court (SDVC)."

2.2 The definition of the domestic violence for the purposes of the SDVC is:

"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality".

2.3 The SDVC will also hear any cases under this definition where the victim is under the age of 18 and where the case has been identified that it should be heard by the SDVC.

2.4 Any cases where domestic violence exists as a background factor in the charge will be designated to the SDVC.

3 Members of Thames SDVC Steering Group

3.1 The SDVC Steering Group will initially meet on a monthly basis during the first six months of the Court's operation. Thereafter, the SDVC Steering Group will meet on a bi-monthly basis.

3.2 Role of the Thames SDVC Steering Group

a) Target setting and Performance Management
b) Safe practice guidance
c) Overseeing and directing the effective implementation of protocols and guidelines and review of such protocols
d) Defining accountability of all key partner agencies for their work in connection with the court
e) Review of data collection and analysis/identification of trends etc.

3.4 Agencies signing up to this protocol are:

a) Tower Hamlets and Hackney Crown Prosecution Service
b) Tower Hamlets Victim Support
c) London Borough of Tower Hamlets
d) London Borough of Hackney
e) **the nia project**
f) Tower Hamlets Children's Services
g) Hackney Children's Services

h) Tower Hamlets Adult Protection
i) Hackney Adult Protection
j) Tower Hamlets Police
k) Hackney Police
l) Probation Service - London Probation Area
m) HMCS Thames Magistrates' Court
n) Thames Court Witness Service
o) Tower Hamlets Community Health Service

3.5 Quorum for meetings of SDVC Steering Group - there must be at least 50% of members in attendance at SDVC Steering Group meetings in order for a meeting to be quorate. There is an expectation, however, that members will endeavour to attend all meetings, and will send an appropriate deputy of the lead member to attend.

4 Operational Group

4.1 Role of the Thames SDVC Operational Group

a. Meet on a monthly basis to monitor service coordination.
b. Each agency to provide agreed monitoring.
c. Monitor compliance with protocols and find ways to address any arising problems from the process.
d. Keeping victims informed – proactive information giving.
e. Overseeing that all cases that meet the MARAC threshold are being referred to the appropriate MARAC.

4.2 The purpose of the Operational Group is for all agencies involved in cases that are going through the SDVC to address any delays or problems in the process and provide regular feedback on cases.

4.3 Membership of the Operational Group will consist of a delegated named lead person from each participating agency.

4.4 Membership should be reviewed regularly to ensure effectiveness and compliance with the protocols.

4.5 The SDVC Project Manager will co-ordinate this group.

5 Case Identification

5.1 Tower Hamlets and Hackney Police including the Community Safety Unit (CSU), the Criminal Justice Unit (CJU) and all other teams will ensure that all domestic violence case papers, including the charge sheet are clearly marked as a DV using the DV stamp provided.

5.2 CSU officers will also ensure that they email the court on: gl-thamesmcdomesticviolence@hmcourts-service.gsi.gov.uk with the defendant's **name, DOB, URN and first hearing date** before each trial day.

5.3 Thames Magistrates' Court and the Crown Prosecution Service will also clearly mark on their files to identify the case as a DV related case at the first hearing and subsequent hearings. The CPS will also use specialist coloured jackets for all their DV files.

6 Criminal Case Management

6.1 Thames Magistrates' Court will convene a SDVC on a Thursday each week to deal with identified domestic violence cases. There is an expectation all hearings for a defined domestic violence case will be listed before the SDVC when the intensive support and other inter agency arrangements are in place. It is accepted that for good reason some hearings will be listed on other dates e.g. to ensure an early hearing for a trial or where a Magistrate/District Judge is disqualified; where a defendant appears overnight in custody. Thames Court will endeavour to try and list the case with a Magistrate/District Judge or Legal Advisor that has received DV training.

6.2 At the victim reporting point Tower Hamlets and Hackney Police will complete a 124D, secure and present the best evidence possible to maximise the possibility of a positive court outcome for the victim without entirely relying on victim/witness statements.

6.3 All defendants charged with a defined domestic violence offence and released on bail from the Police Station will be bailed to the SDVC on a Thursday at 1.30pm. All cases charged on a Monday after 12pm will be bailed to the SDVC day in the following week (10 day bail).

6.4 All defendants charged with a domestic violence related offence and remanded in custody from the Police Station will appear at court in accordance with the normal procedures but where appearances are on a Thursday this will be listed for the SDVC.

6.5 Where the defendant appears in custody from the Police Station on any day other than when the SDVC is sitting, the defendant will be remanded to the next available date for the SDVC.

6.6 Thames Magistrates' Court will ensure the District Judges, Magistrates, Legal Advisers and Staff have received special training in the area of domestic violence.

6.7 The Crown Prosecution Service (CPS) will assign prosecutors to the SDVC who are trained and experienced in dealing with the complexities of domestic violence cases.

6.8 In each prosecution, the CPS will give consideration to the best way for the witness to give evidence including the use of interpreters, an application for screens and by remote witness video link, if necessary.

6.9 Early Guilty Pleas - Where the defendant pleads guilty and is remanded for a pre-sentence report, he/she will be remanded to the SDVC for sentence.

6.10 Where the defendant pleaded not guilty on a day when the SDVC is not sitting, he/she will be remanded to the next available SDVC for a **Case Management Hearing** to be conducted and for a date to be fixed.

6.11 Where possible the trial date should be fixed for hearing before the SDVC but it is accepted this may not always be possible and the need for any early hearing date must be taken into account.

6.12 All DV trials to be given an appropriate listing unless the victim specifically request, via the CPS, a morning or afternoon listing, this is to allow consideration for childcare.

6.13 Thames Magistrates' Court will provide a directions form for the SDVC to ensure all relevant issues are considered before a trial date is fixed. It is anticipated that all cases will be placed in a case management hearing once the trial date is set and should not be listed within 21 days for those in custody and 28 days for those on bail. In all cases the case management hearing should not be listed within 14 days of the trial date.

6.14 All signatory agencies have agreed to proactively inform each other as soon as possible of any issues likely to affect the effectiveness of a fixed trial.

6.15 Tower Hamlets and Hackney Police will provide an MG10 giving full witness availability including that of the victim at the first date of hearing.

6.16 Where a trial is adjourned part-heard for whatever reason the Court will fix the earliest possible resumed date after hearing representations from the parties on their availability.

6.17 The court will endeavour to appoint a Case Progression Officer to ensure that cases are progressing, unnecessary delays are avoided and SDVC time is best utilised.

6.18 The CPS will appoint a Case Progression Officer to ensure that cases are progressing, unnecessary delays are avoided and SDVC time is best utilised.

6.19 Breaches of bail conditions will be dealt with in any court as they must be dealt with within 24 hours of arrest, but every effort will be made to bring him or her before the SDVC.

6.20 Breaches of Community Orders made in the SDVC or orders that Thames Court is supervising will be heard in the Probation Court.

6.21 Arrest on warrant for breach will be adjourned to the SDVC. Where a breach arrest hearing is adjourned it should also be heard in the probation court.

6.22 Where a Pre-Sentence Report is ordered the Probation Service requires three weeks (21 days) to prepare the Report, allowing time for full enquires to be made.

6.23 The IDVA/caseworker will maintain contact with the victim / witness and update them with the outcomes of the case as it progress through the court system.

CASE MANAGEMENT HEARING

1. At the case management hearing where an application is being heard it will take place before a tribunal of Law.
2. Once the trial date is set the case management hearing should not be listed within 21 days for those in custody and 28 days for those on bail, as this time is needed for case papers to be prepared. In all cases the case management hearing should not be listed within 14 days of the trial date.
3. The defendant will be invited to the Case Management Hearing.
4. The Police will provide any MG16 with evidence, MG2 with supporting statements, together with any requested evidence for any hearsay application 14 days before the Case management hearing.
5. The CPS will ensure that the applications for bad character, special measures and any hearsay applications are made in good time for the case management hearing, by serving the notices on the defence and Court at least 7 days prior to the Case management hearing.
6. The MG6c, d and e schedules should be completed by the Police 14 days before the case management hearing.
7. The police will appoint a case management officer who will attend and liaise with the CPS and Court at the case management hearing
8. The case management hearing will be attended by a DV trained CPS prosecutor, defence representative, Police case management liaison officer and trained legal advisor.

9. Applications for special measures, bad character and hearsay (if any) will be made at the Case Management hearing. Provided that documents are served as mentioned above.
10. The defence will be expected to comply with the Criminal Procedure Rules.
11. The CPS will confirm to the Court of those witnesses they will call to give live evidence, those to be read sec 9 and those which the CPS will not rely upon, and thus tendered to the defence.
12. In readiness for the CMH, the CPS case progression manager will confirm with witness care which witnesses have been warned for trial and whether they have confirmed their attendance.
13. Other issues will be confirmed at the case management hearing will include the need for interpreters; special needs of victims and witnesses, and re confirm anticipated length of trial.

7. Provision of support by the IDVA, Witness Care Unit and Witness Service to the Victim of DV through the SDVC

7.1 Tower Hamlets CSU will refer all cases subject to the CPS process – where permission has been given, to Victim Support Tower Hamlets.

7.2 Hackney CSU will refer all cases where permission has been given to **the nia project**. **the nia project** will then contact each client within 24 hours and complete a risk assessment over the phone. If the client is assessed as high risk, they will be allocated to an IDVA at **the nia project**. All standard risk clients will be referred to Hackney Council's Domestic Violence and Hate Crime Team (DVHTC), unless otherwise stated by the client.

7.3 All IDVA's/caseworker will make contact with the DV victim within 24 hours of receipt of the CSU or **the nia project** referral to provide safety-planning casework to address their safety needs and help manage the risks that they are living with throughout the Criminal Justice Process. IDVA's will update the OIC in high risk DV cases of steps taken to manage the risk.

7.4 It is the role of the IDVA/caseworker to keep the victim informed of the outcomes of all the court hearings of their case leading up to the trial.

7.5 The Witness Care Units in Tower Hamlets and Hackney will write a letter to the victim to inform them of the date of trial within seven days of the first hearing. The Witness Care Units will copy this letter to the IDVA/caseworker with details of the Casework Clerk. The IDVA/caseworker will liaise with the Casework Clerk to keep the victim informed of the progress of their case throughout the Criminal Justice System.

7.6 If the victim needs a pre-trial court visit to familiarise themselves with the court the IDVA/caseworker will liaise with the Witness Service to provide this service and attend with the victim if necessary.

7.7 The IDVA/caseworker before and on the day the victim is required to attend the court hearing, will liaise with the Witness Care Unit, OIC and the Witness Service to ensure that the following are carried out:

- Locating and confirming with the victim that she/he will be attending court,
- Facilitating transport for the victim if required,

- Facilitating childcare for the victim if required,
- Arranging for a secured entrance to the court and a secured waiting place if required.
- Meet and greet the victim on the day of the trial and any other subsequent hearing where the victim is required to attend.

8 Cover for Court

8.1 On the day of the SDVC Tower Hamlets and Hackney CSU will have an officer available via a direct telephone line to answer any queries from the CPS or any other partner from within the SDVC.

8.2 Where applications for bail or bail variations are heard on non-SDVC days, the court will release all result within 1 hour of the decision being made on an action sheet to the Police Liaison Officer. It is the responsibility of the PLO to then email these results to the respective CSU's, Victim Support Tower Hamlets and **the nia project** on their designated email addresses.

8.3 One OIC from Tower Hamlets and one from Hackney will be advised the day before the SDVC sitting that they are the single point of contact for any queries regarding SDVC matters. This officer will present himself/herself to the CPS and SDVC court staff on arrival at court and will provide contact details and keep them updated as to their whereabouts throughout the day. The CPS will also ensure that all prosecutors are at court to liaise with the OIC's as needed.

8.4 There will always be an IDVA made available by both Victim Support Tower Hamlets and **the nia project** to attend every SDVC day.

8.5 On the day of the SDVC arrangements will be made where appropriate for a qualified Probation Officer; dedicated to the afternoon SDVC session, to attend whenever possible but the Court will always have access to a qualified Probation Officer at Court.

9 Bail Conditions

9.1 Where a defendant is released on bail (condition or unconditional) at any stage in the proceedings but especially where he/she is released from custody or bail conditions are varied subsequent to the first hearing, the OIC will inform the victim/witness as soon as possible to discuss and implement safety planning measures**.** It remains the OIC's responsibility to manage any risk that is posed through the bailing of any DV suspect and they will be supported in this by the IDVA.

9.2 On SDVC days a copy of the bail form will be supplied to the SDVC Coordinator by the Legal Adviser as soon as the case is completed in the courtroom who should in turn inform the IDVA as

soon as possible. On non SDVC it is the responsibility of the PLO to email these results to the respective CSU's, Victim Support Tower Hamlets, **the nia project** and SDVC Coordinator on their designated email addresses.

9.3 There are currently no arrangements made with the Crown Court or Civil Court at the start of the SDVC project. This will be reviewed in the future.

9.4 In cases where a person has received conditional bail to attend a Probation assessment and fails to attend, the Probation Service will inform local police (CSU and the OIC) who will prioritise finding and arresting the defendant.

10 Withdrawal of Domestic Violence Cases

10.1 Where a victim wishes to withdraw their complaint the victim will be referred to the OIC in the case where a full withdrawal statement will be taken on the MG11 Form.

The statement will include:

a) The reasons for wishing to withdraw the complaint;
b) Establishing whether they are saying the offence did not occur or whether they are saying that they do not wish the investigation or prosecution to continue;
c) Whether any pressure, directly or otherwise, has been placed on them;
d) Who they discussed the case with;
e) Whether any civil proceedings have been instigated;
f) The impact on their life and that of any children.
g) Understanding that they still may be compelled to attend court.

10.2 The OIC taking the statement of withdrawal will inform the CPS lawyer of their view on:

a) The truthfulness of the reasons given;
b) How they consider the case should be dealt with;
c) How a victim might react to being compelled; and
d) Safety issues relating to the victim and any children.

10.3 The OIC taking the withdrawal statement should be in a position to make their own statement about surrounding circumstances covering the issues of duress, state of fear of victim and other surrounding circumstances and should be prepared to attend Court to give such evidence orally, in the case of an application being made under the Hearsay Provisions of the Criminal Justice Act 2003.

10.4 With the most appropriate sensitivity, the victim should be told that making a withdrawal statement does not necessarily preclude them from the requirement to attend Court and give evidence if necessary. In such cases the victim may be invited to make a Victim Personal Statement to express their views as to why they do not support a prosecution and their views now on the incident/relationship/defendant. In appropriate cases the CPS may determine that, notwithstanding the victim's withdrawal, it is in the public interest to proceed with the prosecution and in some instances it will not be possible to proceed without the complainant's evidence.

10.5 Tower Hamlets and Hackney Police will continue the investigation despite the fact that the victim indicates his/her unwillingness to attend Court, as the CPS will consider:

a) If witness summons is appropriate;
b) Whether the procedure in under the Hearsay Provisions of the Criminal Justice Act 2003 is appropriate to make an application to read the witnesses' statement in his/her absence;
c) If there is sufficient evidence to proceed without the victim;
d) In certain circumstances, after careful consideration, applying for a witness warrant.

10.6 In cases where the first indication that the victim wishes to withdraw the complaint arises at Court, the CPS will:

a) Invite the Court to grant an adjournment for the MPS to make proper enquiry into the genuine wishes of the complainant. The length of the adjournment will depend on the nature of the enquiries and whether the defendant is in custody. If appropriate, the CPS will seek the same bail conditions during this process, but in any case the Court will inform the PLO as soon as possible should these conditions vary;
b) If an adjournment is granted, notify the CJU immediately for the OIC to instigate an enquiry into the complainant's genuine wishes.

11 Role of Tower Hamlets and Hackney Police

11.1 The Borough Commanders of Tower Hamlets and Hackney Police are the signatories to this protocol and are responsible for ensuring the following:

a) Provide a named lead officer to liaise with the SDVC partner agencies to ensure the smooth flow of information and process.
b) Ensure officers reporting or attending a domestic violence incident gather and preserve the widest range of evidence and not focus solely on the evidence that the victim has to offer

and/or the willingness of the victim to give that evidence. Evidence of what officers see and hear at the scene could be significant in a subsequent court case. As per the DV SOP.

c) Take a detailed statement from victim/witnesses of domestic violence on the Form 124D or a MG11, Achieving Best Evidence if appropriate.
d) Clearly mark all domestic violence case papers including the Charge Sheets with a DV stamp.
e) Secure and present the best evidence possible at the scene of a domestic violence incident by taking, for example, photographs of the victim and/or the scene to maximise the possibility of a positive court outcome for the victim.
f) Consider/request evidential copy of the 999 tapes for all DV cases being prosecuted.
g) Make an assessment of victim's/witnesses willingness to attend court and inform the Crown Prosecution Service (CPS) immediately if decision is changed. Provide an MG10 giving full witness availability including that of the victim at the first date of hearing. Also, provide an MG 6 to the CPS stating if the victim/witness want to attend a morning/afternoon trial and the reason for this request.
h) Following consultation with the victim assess the need for an application for special measures and submit a MG2 form to CPS where needed at first referral to the charging centre.
i) Provide a Victim Impact Statement where the victim is agreeable for the purpose of sentencing.
j) All victims will be offered a referral to IDVA services at Victim Support Tower Hamlets (VSTH) or **the nia project**. Officers will obtain victim consent, allowing personal details to be passed to the above agencies and record the victim's consent (or refusal) on CRIS.
k) The referral will be by fax to VSTH or **the nia project** on the same day (within 24 hours) of the charging using the DV1 form or **the nia project's** referral form.
l) Liaise on case details with VSTH, **the nia project** or DVHCT.
m) Ensure that the PLO's email all bail results to the nominated email addresses by the end of each working day.
n) Send the CPS case files in accordance with agreed deadlines when a charge has been made.
o) Carry out additional investigation at the instigation of the CPS.
p) Liaise with the CPS as necessary concerning an update on all cases.
q) Participate in monthly Operational Group meetings and bi-monthly Steering Group meetings convened by the Project Manager.
r) Provide agreed monitoring data to the monthly Operational Group meetings to map the SDVC process.

11.2 <u>Witness Care Unit</u>

a) The Witness Care Units in both Tower Hamlets and Hackney will write a letter to the victim to inform them of the date of trial within seven days of the first hearing. The Witness Care Unit will copy this letter to the IDVA/caseworker with details of the Casework Clerk. The IDVA/caseworker will liaise with the Casework Clerk to keep the victim informed of the progress of their case throughout the Criminal Justice System.
b) Liaise with IDVA/caseworker or the Witness Service to make Special Measure arrangements as necessary including the remote video link.
c) Call all OIC's attending the SDVC the day before to advise them to be there by 9am.

d) Contact victims/witness to inform them of attending court. Locate victims/witnesses not contactable by the IDVA/caseworker and arrange for them to attend court.
e) Facilitating childcare provisions as appropriate.
f) Facilitating transport provisions as appropriate.
g) Arrange for withdrawals statement to be taken as appropriate.

12 Role of HMCS Thames Magistrates' Court

12.1 The Justice Clerk for the North and East London area, is the signatory to this protocol and is responsible for ensuring the following:

a) Provide a named lead officer to liaise with the SDVC partner agencies to ensure the smooth flow of information and process.
b) Convene a SDVC on a Thursday each week to deal with the identified domestic violence cases. There is an expectation all hearings for a defined domestic violence case will be listed before the SDVC when the intensive support and other inter agency arrangements are in place. It is accepted that for good reason some hearings will be listed on other dates e.g. to ensure an early hearing for a trial or where a Magistrate/District Judge is disqualified; where a defendant appears overnight in custody.
c) All DV trials to be given an appropriate listing unless the victim specifically request, via the CPS, a morning or afternoon listing, this is to allow consideration for childcare..
d) Ensure the District Judges, Magistrates, Legal Advisers and Staff have received special training in the area of domestic violence.
e) Ensure that the first hearing takes place at the earliest Thursday.
f) Where a trial is adjourned part heard for whatever reason the Court will fix the earliest possible resumed date after hearing representations from the parties on their availability.
g) If a bail application or application to vary bail has been made on a day when the SDVC is not sitting, the Court will provide a copy of the bail application to the PLO within 1 hour of the decision being made, who is to then email these to the SDVC Coordinator, CSU's, Victim Support and **the nia project.**
h) Breaches of Community Orders made in the SDVC or orders that Thames Magistrates' is supervising will be heard in the Probation Court.
i) Fast track not guilty pleas for Case Management hearings no less then 14 days before the trial date.
j) Wherever possible, a domestic violence trial will be listed on its own. If this is not possible, every effort will be made to avoid listing it with anything that has been listed for trial before and it will be given priority on the day.
k) It is acknowledged that if a defendant is in custody and needs to appear via video link, the court will have to hear these cases in a different court room to that of the SDVC, due to that facility not being available within the SDVC.
l) Provide agreed monitoring data to the monthly Operational Group meetings to map the SDVC process.

13 Role of Tower Hamlets and Hackney Crown Prosecution Service (CPS)

13.1 Borough Crown Prosecutors for Hackney and Tower Hamlets, are the signatories to this protocol and have the responsibility to ensure the following:

a) Provide a named lead officer to liaise with the SDVC partner agencies to ensure the smooth flow of information and process.
b) Assign prosecutors to the SDVC who are trained and experienced in dealing with the complexities of domestic violence cases.
c) Appoint a CPS Case Progression Officer to ensure that cases are progressing, unnecessary delays are avoided and SDVC time is best utilised.
d) Consider the best way for the witness to give evidence including the use of interpreters, an application for screens and by remote witness video link, at the earliest opportunity.
e) Where a defendant applies for bail or to vary his bail conditions and introduces new information not previously known to the CPS, the prosecutor will consider seeking an adjournment so that the Police can make enquiries.
f) Ensure that sentencing takes into full consideration the victim's perspective and safety CPS will provide the Probation Service with the documents listed to assist with the Pre-Sentence Report:
    - MG5,
    - MG16,
    - Victim Impact Statement
g) In cases where the first indication that the victim wishes to withdraw the complaint arises at Court:
    - Invite the Court to grant an adjournment for the Police to make enquiries into the wishes of the complainant. The length of the adjournment sought will depend on the nature of the enquiries and whether the defendant is in custody. If appropriate, the CPS will seek the same bail conditions during this process;
    - If an adjournment is granted, notify the CJU immediately for the Investigating Officer to instigate an enquiry into the victim's genuine wishes.
h) Write to the victim to explain any decision to not proceed with the original charge or any substantial amendment to the original charge.
i) En sure that on SDVC days that all prosecutors are at court by 9am to liaise with the OIC as needed.
j) There are currently no arrangements made with the Crown Court at the start of the SDVC project. This will be review in the future.
k) Provide agreed monitoring data to the monthly Operational Group meetings to map the SDVC process.

14 Role of Probation Service

14.1 The local manager of probation offender management, is the signatory to this protocol and is responsible for ensuring the following:

g) Provide a named lead officer to liaise with the SDVC partner agencies to ensure the smooth flow of information and process.
h) Prepare the Pre-sentence Report (PSR) taking into consideration the victim's perspective and safety and information from the MG5, MG16, Victim Impact Statement and social services check on the welfare of any children affected.
i) Complete the PSR within the agreed 21 days timescale.
j) Where the court adjourns the matter for sentence and a community penalty is a stated option; the Probation Service will consider requiring the defendant to attend for assessment as to his/her suitability for attendance on the recommended offender program. Where such attendance is required and the defendant is granted bail the Probation Service will recommend that the court consider making it a condition of bail where appropriate.
k) The Probation Service will enforce orders in accordance with the National Standards.
l) In the event of an offender failing to provide an acceptable/verified reason for non-attendance on two occasions, within five working days, on either the programme or individual session with the case manager, breach proceedings to be initiated.
m) In the event of the whereabouts of the offender being unknown, and / or where there are active risk concerns and where the risk is estimated as high or imminent a warrant will be applied for at the earliest opportunity.
n) Whilst breach proceedings are pending, if appropriate, the offender will continue to attend any offender programme.
o) Provide agreed monitoring data to the monthly Operational Group meetings to map the SDVC process.
p) Liaise with Social Services regarding any child protection concerns and participate in any interagency meetings regarding the safeguarding of children's interest and risk to women and the public in general.

15 Role of the Independent Domestic Violence Advocacy Service and Hackney Council's Case Workers

15.1 Independent domestic violence advocates (IDVAs) are trained specialists whose goal is the safety of their clients. While advocacy/advice services will accept all referrals, their focus is on providing a premium service to victims at high risk of harm to address their safety needs and help manage the risks that they face. They also act as institutional advocates, for example through their work with individuals, they are constantly assessing

the processes and effectiveness of other agencies dealing with this group and working with these agencies to improve their services.

15.2 IDVAs' casework focuses on risk and risk management; directly working with victims of domestic violence to provide guidance and support to enable them to access a range of legal and non-legal services and resources, and engage proactively in multi-agency work, ultimately to help victims of DV and their children move safely towards living violence-free lives.

15.3 A per the arrangements in Hackney all high risk cases will be monitored by **the nia project** and all standard risk cases by Hackney Council Domestic Violence and Hate Crime Team (DVHCT). Hackney CSU are to fax all referrals to **the nia project**, who will then contact the victim within 24 hours and complete a risk assessment over the phone to determine the client's risk.

15.4 On receipt of referral from the CSU/ **the nia project**, the IDVA/caseworker will make attempts to contact the 'victim' within a 24-hour time frame as agreed in the SDVC protocol.

15.5 Victim Support Tower Hamlets Borough Manager, Chief Executive of **the nia project**, and the Head of Safer Community Services at Hackney Council are the signatories to this protocol and have the responsibility to ensure the following:

a) Provide a named lead officer to liaise with the SDVC partner agencies to ensure the smooth flow of information and process.
b) Ensure new IDVAs are made available to undertake the CAADA training.
c) On receipt of a DV1/referral from Tower Hamlets Police, Hackney Police, WCU or the **nia project**, the IDVA/caseworker will make contact with the victim within one working day to explain the Criminal Justice process and the SDVC to the victim.
d) Carry out full risk assessment and implement action plan to secure victim's immediate safety.
e) IDVA is to maintain all high risk cases until risk is reduced.
f) IDVA/caseworker is to make sure that all cases that meet the MARAC threshold are referred to the appropriate MARAC.
g) Maintain clear up-to-date contact logs with the victim and provide them for the court hearings if instructed to do so by the court.
h) Assess the need for special measures and inform the CSU to make the application if this has not yet been done.
i) Liaise with the Witness Service to arrange a pre-trial visit when appropriate.
j) Accompany the victim to all hearings where they are required to attend.
k) Monitor the progress of the case until the final hearing/trial and keep victim informed of every step of the court process including DV Pre-Trial Reviews
l) Provide the CPS prosecutor with any information they are able to share that may be relevant to the prosecutor in relation to bail hearings. They will make this information known to the prosecutor before the bail hearing commences.

m) Provide agreed monitoring data to the monthly Operational Group meetings to map the SDVC process.
n) Liaise with the Witness Care Unit to ensure Special Measure applications/arrangements have been made.

16 Role of Tower Hamlets Council

16.1 The Corporate Director of Communities, Localities and Culture, is the signatory to this protocol and is responsible for the following:

16.2 Employ and line manage the SDVC Project Manager until the 31st March 2010 who has the role to:

a) Provide ongoing progress reports to the Steering Group.
b) Take the lead for the Operational Group
c) Develop local protocols agreeing roles and responsibilities within the partnership;
d) Develop local protocols agreeing information sharing between agencies;
e) Organise systems for administration of both groups, e.g. regular minutes and follow up actions;
f) Organise monitoring systems across the specialist DV court system to track and evaluate cases.
g) Track each case from the start of its life through to the end of the court sentencing.

16.3 The Project Manager will also undertake to:

g) Ensure there is agreement on common data collection on victim and defendant profile in relation to gender, ethnicity, age, disability and sexuality
h) Develop and agree a system which will ensure that each case is tracked through the system
i) Develop and agree an Information Sharing Protocol which outlines the system for Data collection on victim and defendant profile in relation to gender, ethnicity, age, disability and sexuality
j) Ensure a system is in place to hold partner agents accountable for their data, sharing of information and responses.
k) Ensure that there is clarity that case flagging is the responsibility of all agencies.
l) Improve communication flow among participating agencies.
m) Provide co-ordination between participating agencies.
n) Ensure consultation with member agencies on all matters of policy in relation to the work of Thames SDVC.
o) Provide overall administration for Steering Group meetings.
p) Provide agencies with annual reports.
q) Keep all agencies informed of decisions taken by Steering Group.
r) Provide data to evaluate the overall effectiveness of the community response.
s) Analyse information produced and provide feedback to agency and/or the Steering Group.

t) Provide member agencies with up-to-date information on cases (when necessary).
u) Alert practitioners to cases that have become stalled within the system.
v) When possible, alert practitioners to extremely dangerous abusers and alert victim advocates to high-risk situations.
w) Inform practitioners of case outcomes.
x) Allow a review of actions taken by individual practitioners and agencies to ensure compliance with agreed-upon policies and protocols.

17 Role of the Witness Service

17.1 The Witness Service will liaise with the IDVA to deal with cases that don't want the services of the IDVA and to keep the victim informed of the outcomes of all the court hearings of their case leading up to the trial.

17.2 When requested, Witness Service will offer pre-trial visits during which staff will give individual witnesses a tour of the court, explain trial procedures and likely outcomes including sentencing and discuss any worries that the witness may have about attending court. IDVAs and any other supporters of witnesses are welcome to attend pre-trial visits.

17.3 The Witness Service will discuss any safety concerns with the witness and may offer safe entry to and exit from the court building and explain Special Measures. The Witness Service may liaise with Police Officers to assist in this.

17.4 The Witness Service will ask witnesses if they wish to be referred to an IDVA and will make such a referral if the witness so wishes. If the witness does not wish to be referred the Witness Service will offer support.

17.5 If a witness who has refused a referral to an IDVA wishes to make a withdrawal statement on the day of the trial the Witness Service will discuss the implications of this with the witness then inform, the Prosecutor, liaise with the CSU officer, OIC or PLO and offer to sit in with the witness while she/he makes a withdrawal statement.

17.6 In appropriate cases the Witness Service will offer the witness referral to a local agency for post court support.

17.8 Video Link Trials – Resources permitting, a member of Witness Service will accompany adult witnesses in the video link room. Witness Service will always provide this service for young witnesses (under 18).

17.9 The Witness Service will maintain stocks of relevant information leaflets and display them in the Witness Room.

17.10 The Witness Service will attempt to obtain feedback from witnesses both formally and informally.

17.11 The Witness Service will provide the IDVAs with use of its office at the start of each court session. IDVAs may also use a computer terminal when the Witness Service does not need it. Tea, coffee and water are available to all witnesses free of charge in the Witness Room.

18 Reporting and Evaluation

18.1 All member agencies are required to submit the agreed monitoring data on every case going through the SDVC at the monthly Operational Group Meetings. The Project Manager will collate and provide quarterly monitoring updates on the objectives, targets and performance to the Steering Group.

19 Equality & Diversity Issues

19.1 SDVCs need to address good practice in relation to a range of equality and diversity issues and information covering ethnicity, gender, disability, sexuality, religious belief and age will be monitored on an ongoing basis.

19.2 The SDVC Project Manager will carry out an annual Equality Impact Assessment of the SDVC process as a whole as instructed by the SDVC Steering Group.

20 Information Sharing Agreement

20.1 While acknowledging that each agency need to maintain its independence, members of the SDVC Project aim to ensure that all the agencies involved work in an integrated and coordinated way to achieve the objectives of the project. Each agency has committed itself to liaise closely with other member agencies, sharing qualitative and quantitative information within the relevant legislation to achieve the aims of the project.

The party considering sharing the information should ensure that they satisfy themselves of any applicable legislation in force at the time. Legislation that may assist includes, but is not limited to, Children Act (1989) (2004), Adoption and Children Act (2002), Human Rights Act (1998), The Crime and Disorder Act 1998 S.115, Data Protection Act 1998 and The Human Rights Act 1998 Article 8

20.3 **Sharing data without consent:** Data should be shared with consent, however the Home Office gives guidance on conditions when information can be shared other than with consent:

a) In matters of life and death or to prevent serious harm to the individual

b) For the administration of justice

c) For public/statutory functions

d) For the prevention or detection of crime, or the apprehension or prosecution of offenders

e) For the purpose of child protection. If consent has not been given to share information or there is no disclosure required by a court order, information may still be shared if the public interest in safe guarding the child's welfare overrides the need to keep the information confidential.

20.4 Consent should be obtained from relevant individuals as a matter of good practice, and where appropriate and possible, explicit consent should be sought and freely given by the individual.

20.5 **Purpose of Information Sharing for Thames SDVC. The purpose of the Information Sharing Agreement is to provide partner agencies with up-to-date information on cases for the following reasons:**

a) For practitioners to share personal information to improve the safety of victims and their children.
b) Provide data to monitor and evaluate the overall effectiveness of the SDVC Project in achieving its aims through the analysis of domestic violence incidents and court data
c) Maintain systematic data sharing procedures to ensure consistency in the flow of information
d) Inform practitioners of case outcomes

e) Allow review of actions taken by individual practitioners and agencies to ensure compliance with agreed-upon policies and protocols
f) Share anonymous data and monitoring data with funding bodies for the purposes of funding
g) Share anonymous data with the public via the publication of reports
h) Share anonymous data for the purpose of evaluation or research.

20.6 **Responsibilities of Thames SDVC partner agencies.**

a) Each agency undertakes to ensure that it complies with all relevant legislation, this protocol and its own internal policies on disclosure. The points listed below are specifically pertinent to the SDVC Partnership:
b) The disclosing partner agency's permission will be sought if any of the agencies receiving personal information needs to share it for any purpose other than that set out in this protocol
c) The disclosing partner agency's permission will be sought if any of the agencies receiving personal information needs to share it with a third party that is not a signatory to this protocol
d) Each agency will ensure that the data it holds is as accurate and up to date as possible
e) Each agency will seek its own legal advice in relation to data sharing
f) Agencies will only disclose sufficient information to enable partners carry out the relevant purpose for which the data is required
g) Partner agencies are responsible for understanding and exercising their legal obligation to share data, with or without consent
h) Each partner agency will appoint an Operational Group delegate who can control the flow of information and maintain the integrity of a data sharing system. In the absence of the delegated person, it will be the responsibility of each agency to provide a named individual to cover during this period.

Appendix D

Joint Domestic Violence Performance Improvement Action Plan

	Objective	Action	Action Owner	Target Date	Rationale
1	Identify strategic and practical areas of improvement in the investigative and charging process	a) (Strategic) Set up joint working group to review and update the DV Service Level Agreement , revise the format of Police MG3s and MG7s to reflect key requirements of DV evidence gathering and Bail.	CPS/MPS	3rd Jan 2012	**The SLA is a highly useful guide which commits agencies to observe key minimum standards of case handling. Anecdotal evidence from boroughs which previously observed its contents robustly suggests marked improvements in the quality of case handling and outcomes. The current MG3 does not reflect key aspects of DV evidence gathering and MG7s do not reflect the needs of subsequent Bail applications**
		b) (Strategic) Complete review and update of SLA			
		c) (Strategic) Sign off and implementation of updated SLA	CPS/MPS	1st Feb 2012	
		d) (Strategic) DV/Harassment checklist and Aide memoire to be circulated to			

		all duty prosecutors for robust application and compliance to be monitored through monthly CQSMs	CPS/MPS	1st Mar 2012	**Both documents are very succinct and helpful guides which encapsulate all key considerations and act as very useful prompts and reminders**
		e) (Strategic) CPSLD to adopt the comprehensive CPSD CQS DV Prompt charging guidance	CPSD/LD	3rd Jan 2012	
		f) (Strategic) CPSLD/D DV Specialist Co-ordinator (eg. CPSLD level D manager) to be nominated as point of reference/specialist opinion			
		g) (Strategic) Joint CPS/CSU local awareness raising sessions to be conducted on borough targeted at investigating officers and Response teams re evidence gathering and the recording and significance of the same in relation to victimless prosecutions and hearsay applications.	CPSLD	3rd Jan 2011	**Anecdotal evidence suggests that having a single point of contact/expertise for both DPs and OICs to approach for guidance during the charging phase proved invaluable at Borough level**
		h) (Strategic) CPS to engage with MPS CSU DIs at MPS quarterly meetings via guest speaker	CPSLD	3rd Jan 2012	**Good practice identified - Localised Borough joint awareness raising involving Local Council Services to around 'DASH' training**

		i) (Strategic) E-Learning DV refresher course to be created and to include sharing of good practice and relevant case law			
		j) (Practical) All prosecutors to complete DV refresher course	CPS/MPS	31st Jan 2012	
		k) (Practical) Cascading of key instructions to all officers based on the detailed guidance at paras 4 and 5 of the SLA			**MPS meetings are held with all CSU DIs and this would be a prime opportunity for information sharing and strategic awareness raising**
		l) (Practical) Upgrade in photographic equipment for use in recording injuries, crime scenes etc (good practice identified at Barking - local authority funding obtained for the purchase of new cameras)			
		m) (Practical) Full and meaningful MG2s to be provided by OICs at point of charge including risk of withdrawal and merits of a witness summons and arrest warrant (in line with CPS Policy)	CPS/MPS	From Jan 2012	
		n) (Practical) Full and meaningful assessments to be conducted by			

		prosecutors and endorsed on MG3 advices re the merits of a victimless prosecution in light of risks identified in MG2s	CPS (learning & Development) CPS MPS MPS	31st Jan 2012 31st Jan 2012 31st Jan 2012 31st Jan 2012	**Inconsistency across London has been identified with some local forces using digital equipment while others use Polaroid cameras resulting in poor quality evidence of injuries/damage in some areas**

			MPS CPS	31st Jan 2012 1st Jan 2012	
2	Identify strategic and practical areas of improvement in the Case progression and Witness Care process	a) (Strategic) Each agency to draft and implement an action plan along the suggested lines of the LCJP Review report to address the thematic issues identified in the 2010 LCJP WCU Thematic report focusing on the following: • The **WMS system** not being used properly or to its full potential	CPS/MPS/WCU /CSU	1st Feb 2012	

		• **Monitoring** of WCUs adherence to VCOP and WC is sporadic • There are instances of **paper logs** being used and WMS not being utilised at all • **Initial Needs Assessments** are not completed by officers, nor recorded on the statement or WMS system • **Detailed Needs Assessment** are neither being completed, nor evidenced as being completed on WMS • **WMS recording** of Detailed Needs Assessments Cases are purely completed after trial to finalise the case on the system • **DV victims** are not being identified by the police or WCU officers as likely to be vulnerable or intimidated • Heavy reliance on **communication by letter** with victim/witness rather than by more effective methods such			

		as personal contact by telephone • **Predominance of e-mail** as preferred method of communication between agencies, even when co-located • **Victim personal statements** are not being taken • **Court familiarisation visits** are not being offered or taken up • **Witness summons** are issued and served late, with little success b) (Strategic) Each CPS and WCU Borough Unit to appoint an identifiable experienced DV Champion as a point of local contact/reference c) (Strategic) Monthly Borough PTPM meetings to include DV attrition and reasons as a standing agenda item for discussion			

		d) (Strategic) Joint monthly meetings between DV Champions, CSU and WCU managers either via the PTPM forum or separately to discuss and agree rolling actions to address reasons for attrition e) (Strategic) Facilitate joint Area WCU/CPS/CSU seminar for learning and sharing of best practice f) (Strategic) WCU to develop links with key Local Services/community groups to assist with witness care and contact via WCU DV Champions g) (Strategic) Initial Needs Assessments (INAs) - ERO Supervision of OIC INAs and need for a check & challenge system of quality assurance to be embedded h) (Strategic) Victim Personal Statements (VPS) - ERO supervision and a check & challenge system of ensuring that VPSs are obtained needs to be embedded			

		i) (Practical) Case Progression managers to monitor timeliness of special measures applications on a monthly basis and feed into local strategic meetings at (b) and (c) above for action			
		j) (Practical) The robust identification by OICs of the need for special measures meetings between prosecutors and victims and the holding of the same where recommended ought to be reinvigorated	CPS/WCU	1st Jan 2012	**Anecdotal evidence suggests that this provides a point of expertise for the police as well as borough prosecutors and having a WCU DV Champion will ensure greater awareness and focused attention on DV issues of withdrawal, summonsing, S/M meetings**
		k) (Practical) Witness Care Managers to monitor timeliness of notification of special measures (making/granting) applications to all victims and feed into local strategic meetings at (b) and (c) above for action	CPS/MPS	1st Jan 2012	
		l) (Practical) Witness Care Managers to conduct monthly dip sampling of 'needs assessments' for quality and completion on WMS and to feed into local strategic meetings at (b) and (c) above for action	CPS/CSU/WCU	1st Jan 2012	

		m) (Practical) Cascading of key instructions to all WCU staff based on the detailed guidance at para 7 of the SLA			**A session for 200 staff can be arranged at Empress House before March 2012.**
		n) (Practical) Cascading of key instructions to all officers based on the detailed guidance at para 8 of the SLA	CPS/WCU/MPS	Jan/Feb 2012	
		o) (Practical) Refresher training for WCU officers on the use of WMS	WCU/MPS	March 2012	**Anecdotal evidence suggests that where such links exist eg. via local IDVAs, these can prove instrumental in maintaining meaningful contact and care of victims**
			MPS	31st Jan 2012	**Anecdotal evidence suggests that Victim Personal**

			MPS	31st Jan 2012	**Statements (VPS) often have the added benefit of enabling a victim to feel engaged with the process and in turn, encourages attendance/support for the process. VPSs also assist Probation assessments re intervention**
			CPS	1st Jan 2012	

			CPS/MPS	1st Jan 2012	
			WCU	1st Jan 2012	
			WCU	1st Jan 2012	

			WCU	1st Jan 2012	
			MPS	1st Jan 2012	**The 2010 LCJP Thematic Review of WCUs identified the poor use of WMS and the need for training as a key gap and action**
			MPS	31st Jan 2012	
Objective		**Action**	**Action Owner**	**Target Date**	**Rationale**

3	Identify strategic and practical areas of improvement in the Court process	a) (Strategic) SDVC and Main stream model follow up review to be conducted by LCJP with recommendations and action plan	LCJP	March 2012	**There has been no review of the effectiveness of SDVCs and the Mainstream Model since their roll out. With the new court clustering and potential impact of the same as a result of cross borough work (ie boroughs without SDVC status being clustered with those who have), such a review is vital.**
		b) (Strategic) Robust application of the CPR with all key issues and applications addressed at an early stage in line with the stop 'Stop Delaying Justice' initiative.	HMCTS/CPS	3rd Jan 2012	
		c) (Strategic) Refresher DV training for all Magistrates and Legal Advisers around the 'DASH' risk			
		d) (Strategic) reinvigoration of the monthly JPM meetings examining ineffective trials and agreeing rolling actions to reduce the same below 15% for DV cases	HMCTS	March 2012	
		e) (Practical) Legal Advisers to record			**Anecdotal evidence suggests that DV victims are less likely to attend court on a second or third adjourned**

		reasons for ineffective trials accurately on CIVT forms ensuring that all parties endorse and sign the same. Monitoring of compliance and quality via JPMs	HMCTS/CPS/ MPS	28th Feb 2012	**occasion**
		f) (Practical) MPS to ensure that MG7s in all breach of bail cases are updated with the full history of the case including any previous breaches			**Anecdotal evidence suggests that incorrect codes are often used and forms are poorly completed by all parties or non existent. Accurate data will enable the true reasons for ineffective DV trials to be addressed.**
		g) (Practical) CPS to ensure that files and CMS are updated with the full details of any breach of bail hearings/decisions	HMCTS/CPS	1st Jan 2012	
		h) (Practical) HMCS to ensure that court file endorsements are detailed in relation to breach of hearings			**A recent DV Homicide/Suicide case revealed a catalogue of oversights in the breach of bail process**
		i) (Practical) MPS to ensure Notification of Breach of Bail decisions to victims within 24hrs via local PLO [in line with VCOP]: Good practice identified is the notification of Local DV Support Services who, in turn, will notify victims.	MPS	1st Jan 2012	

			CPS	1st Jan 2012	
			HMCS	1st Jan 2012	
			MPS/CPS	1st Jan 2012	
4	Identify strategic and practical areas of improvement in the Post	a) (Strategic) DV Strategy to be drafted and formalised for the London Probation trust	Probation	31st Jan 2012	

	Court/ Rehabilitation phase	b) (Strategic) Toolkit for Female perpetrators and same sex offenders to be finalised	Probation	31st Jan 2012	
		c) (Practical) Probation Officers to make enquiries with MARAC or with the Local Council DV Co-ordinator pre-sentence so as to inform recommendations for sentence	Probation	31st Jan 2012	**Identified good practice shows that such enquiries with MARACs/local DV services provides Report writers with a wealth of key information about the victim and offender which often puts into proper context, the true risk of an offender and any misleading assertions made by them**
		d) (Practical) OICs to conduct 5yr history checks on offenders as this feeds directly into Probation Offender Management Programmes and how to break the cycle of re-offending	Probation	3rd Jan 2012	
		e) (Strategic) Improving the number, quality and timeliness of CPS 'Direct Communication with Victim' (DCV) letters in line with set Ambitions/targets			

		f) (Strategic) Increase the number of applications sought and granted for restraining orders on conviction and acquittal through joint multi agency awareness raising with the involvement of Local Support services	CPS HMCTS/CPS/ MPS/Local Authority DV Support Services	31 Jan 2012 28th Feb 2012	
Objective		**Action**	**Action Owner**	**Target Date**	**Rationale**
	Identify	a) (strategic) A clear and consistent	LCJP/HMCTs/		**Consistency across London of how Local Cluster**

5	strategic and practical areas of improvement via local forums and criminal justice groups	steer is required in relation to the format of Local Borough Criminal Justice Groups due to the impact of Clustering and how performance will be measured and tracked. b) (Strategic) Local SDVC Operational meetings and Local Cluster Criminal Justice Groups (for areas without an SDVC) to explore, monitor and agree rolling actions to address: • underlying issues faced by borough specific communities affecting DV and victim/Witnesses • listing practices and impact on DV cases • examine data accuracy recording by each agency • Provision and level of support by IDVA, WCU and Witness Service • Level and number of Referrals to IDVAs for support and referrals to Witness Service for pre-trial visits c) (Strategic) Local Cluster Criminal Justice Partnerships to identify and develop joint community engagement	CPS/MPS/ PROB SDVC Forums and LCJGs	28th Feb 2012 28th Feb 2012	**Criminal Justice Groups will operate under the new Judicial Clustering is vital to the monitoring and managing of DV performance and local issues.**

		strategies to improve reporting and support for the Criminal Justice process.	CCJGs (to include a member from the local authority)	28th Feb 2012	**Direct Multi Agency engagement with local community groups and Refuges has been shown to anecdotally increase confidence and encourage reporting and support for the prosecution process**

Glossary of Abbreviations

AP	Associate Prosecutor
BOCU	Borough Operational Command Unit
CAADA	Co-ordinated Action Against Domestic Abuse (a national charity)
CRIMINT	Criminal Intelligence System
CRIS	Crime Reporting Information System
CSP	Community Safety Partnership
CPS	Crown Prosecution Service
CSU	Community Safety Unit
DHR	Domestic Homicide Review
DV	Domestic Violence
DVT	Deep Vein Thrombosis
ELNHSFT	East London National Health Service Foundation Trust
ELPT	East London Probation Trust
EMHALS	Emergency Mental Health Advice & Liaison Service
EWMS	Emerald Wanted Management System
GP	General Practitioner
HMC&TS	Her Majesty's Courts & Tribunals Service
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
IPCC	Independent Police Complaints Commission
LA	Legal Adviser
LBTH	London Borough of Tower Hamlets

MARAC	Multi Agency Risk Assessment Conference
MPS	Metropolitan Police Service
OIC	Officer in the Case
SCP	Senior Crown Prosecutor
SDVC	Specialist Domestic Violence Court
THSAU	Tower Hamlets Specialist Addiction Unit
VS	Victim Support
WCU	Witness care Unit