OVERVIEW REPORT INTO

THE DEATH OF CP

ON 15 July 2012

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Safer Harlow Partnership

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

1; Introduction;
This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of CP in Harlow, Essex on 15 July 2012. Essex Police were called to a domestic incident at CP's house. CP's eldest son had gone to a neighbour for help and the neighbour informed police that a woman was being stabbed at the child's address.

MG was found guilty of the murder of CP in June 2013, and has been sentenced to life imprisonment, with a minimum term of 15 years.

2; The Review Process;
This summary outlines the process undertaken by the Harlow Domestic Homicide Review Panel in reviewing the death of CP.

On 17 July 2012 Essex Police notified the Chair of the Safer Harlow Partnership of the death of CP as the circumstances of the death fitted the Home Office criteria for the establishment of a Domestic Homicide Review. The Review was conducted in accordance with the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews 2011.

The Home Office was informed of the intention to conduct a DHR on 27 July 2012 and the panel first met on 2 October 2012.

The process has been completed and a report was submitted to the Home Office in September 2013.

The first meeting of the panel included all agencies that potentially had contact with CP, MG or the extended family. Further panel meetings were held in January, March, and June 2013.

Agencies initially contacted and asked to supply any known information to the review were;

- ECC Schools, children and families
- ECC Safeguarding Children's Board
- National Probation Service
- Essex Police
- Central Essex Community Services
- NHS North Essex
- Anglian Community Enterprise
- NHS South Essex
- N E London NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust

- Mid Essex Hospital Services NHS Trust
- Princess Alexandra Hospital
- Basildon and Thurrock University NHS Foundation Trust
- North Essex Partnership NHS Foundation Trust
- South Essex Partnership University NHS Foundation Trust
- East of England Ambulance Services NHS Trust
- CAFCASS
- ECC Adults health and community wellbeing
- ECC DAAT
- Braintree District Council
- Basildon Borough Council
- Brentwood District Council
- Castlepoint District Council
- Chelmsford City Council
- Colchester Borough Council
- Epping Forest District Council
- Harlow District Council
- Maldon District Council
- Rochford District Council
- Tendring District Council
- Uttlesford District Council
- Thurrock Council
- Southend-on-Sea Borough Council
- Safer Places
- Victim Support
- Essex Change
- ECC-Youth Offending Service
- West Essex CDAT
- Southend University Hospitals NHS Trust
- Stewards Academy
- Kingsmoor Primary School
- Lister Medical Centre
- The Elsenham Practice

From the information initially requested, only 7 agencies had significant records of contact with the victim, her family and the perpetrator. As a result the following were requested to submit a full IMR (Individual Management Review):

- ECC Children's Social Care
- Princess Alexandra Hospital
- Lister Medical Centre
- The Elsenham Practice
- NEPFT (North Essex Partnership Foundation Trust)
- Essex Police

- Stewards Academy

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. The same request was made to agencies re contact with MG, especially health practitioners. In accordance with the Terms of Reference, the DHR has covered the 3 year period of CP and MG's known relationship in detail. Agencies were further requested to include any other information, outside of the agreed timeframe, that was or could be relevant to the review. In some cases therefore, history and context has been submitted going back to the birth of the victim's first child in 1992.

During the review of the IMRs it became clear that more information was required regarding agency involvement with the children of CP, and a further request for information was made to SEPT (South Essex Partnership Foundation Trust) who supplied a chronology of Health Visitor and School Nursing engagement since the birth of each of the victim's children.

In addition, and at a later date, information was requested from Harlow District Council in relation to MG's SIA (Security Industry Authority) license and the associated processes and checks, and also to HDC's housing dept. in relation to the rented property that CP occupied, and into which MG had moved shortly before her death.

All agencies have given a chronology of interaction with the victim and her family, including what was done and/or agreed. They further reported on whether internal procedures relating to adult safeguarding, specifically domestic abuse, were in place, and were followed. Each agency was further requested to draw their own conclusions on the internal responses to their dealings with CP, MG and the family, and to identify any good practise. Alternatively agencies were requested to make their own recommendations as to how things could or should have been done differently.

Within the reports some of the individual accounts have more significance than others. Some span a greater time period and have a greater involvement with the victim and her family and/or the perpetrator.

None of the victim's contact with the individual agencies prior to her death was associated with a referral or a concern relating to domestic abuse, and she was not known to Essex Police or to Safer Places (the Harlow women's refuge) in the context of her relationship with MG.

DHR OVERVIEW REPORT

OVERVIEW OF AGENCY INVOLVEMENT WITH CP (Victim) This report also includes agency involvement with MG (Perpetrator)

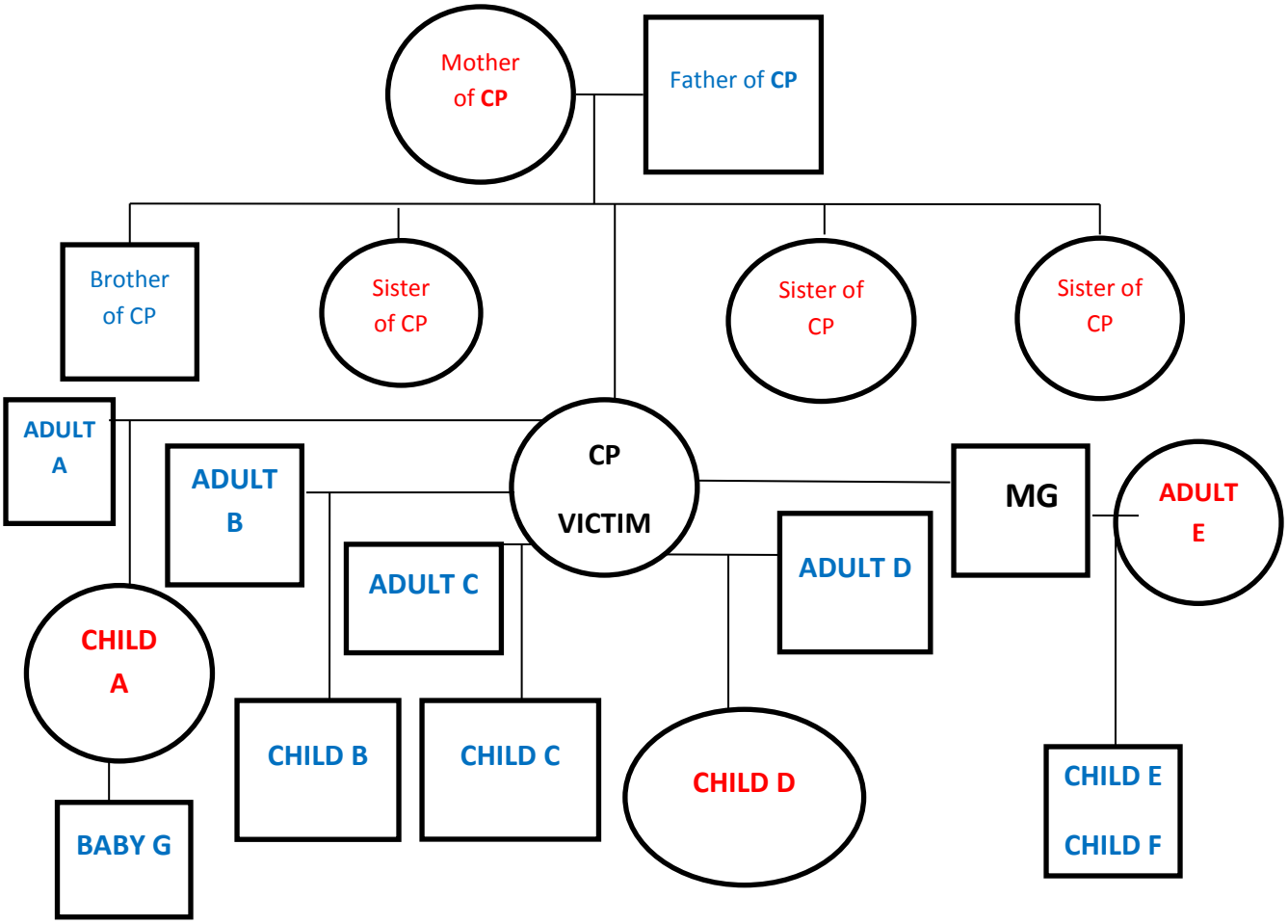
Scope of the review;

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of CP in Harlow, Essex on 15 July 2012.
The review has been conducted in accordance with the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews 2011.
As part of the review process, agencies were requested to supply information related to any contact with the victim or alleged perpetrator, where the IMR author felt that the information could help to identify vulnerability issues relating to CP or to the family; and in addition, to provide detailed information and analysis about all contacts that took place since January 2009, which is the approximate time that CP is said to have commenced the relationship with MG.
Agencies were also requested to include further details and analysis of any relevant significant events or incidents which occurred outside of the time period, but which are, or could be, relevant to the review.

Details of victim, perpetrator, family members and significant others;

CP, Victim
MG, Perpetrator
Child A, Victim's daughter, DOB 09-02-92
Child B, Victim's son, DOB 11-05-99
Child C, Victim's son DOB 27-12-03
Child D, Victim's daughter DOB 22-03-07
Adult A, former partner of CP and father of Child A
Adult B, former partner of CP and father of Child B
Adult C, former partner of CP and possible father of Child C
Adult D, father of Child D
Adult E, former partner of MG
Children E and F, sons of MG and Adult E
Baby G, son of Child A,

Genogram;



Timeline;

CP was married to Adult A and separated when Child A was 3 years old (1995).
CP married Adult B before Child B was born, but the initial assessment notes following Child B's birth, state that CP had already separated from Adult B.
Child C was born in 2003 whilst CP was still married to Adult B, and he is named as the father on the birth certificate.
CP married Adult D in 2005. They separated around 2009, after having been together a total of 8 years.
CP commenced the relationship with MG around early 2009.

Agency involvement;

1; Essex County Council (ECC), Children's Social Care (CSC);
This particular IMR goes back to 1998, when the first contact was made with Essex CSC in relation to CP and Child A.

1.1; Agency involvement relating to CP and her children (children A, B, C, and D);
1.1.1; In November 1998, Adult A contacted Essex CSC to express concerns about Child A's welfare as there had been alleged domestic abuse incidents perpetrated by CP's new partner, which had been witnessed by Child A. Adult A stated that he was taking matters through the courts and therefore there was no further action taken by CSC at this time. Adult A also alleged that CP had had 5 abusive partners since their separation.
1.1.2; CP was interviewed at the CSC offices a total of 3 times to September 1998, but denied that there was any physical violence, though police records indicate a violent assault by Adult B against CP in August 2008 which resulted in a split lip. CP stated that she was pregnant and wanted charges against Adult B dropped. There is no record of any follow up action from CSC following these interviews.
1.1.3; In February 1999 CP was again interviewed at the CSC offices following 2 further police reports of domestic abuse. CP was allegedly pushed to the ground and bitten by Adult B, but she claimed that this incident was her fault as they had been arguing about Adult A having contact with Child A. CP stated that she had been drinking but that she was not drunk. Notes refer to the home being "in a state" but it was noted that CP and Adult B were decorating. CP said that she did not need any help or support and therefore CSC closed the case.
1.1.4; CSC officers met with CP again in January 2000, following 3 domestic abuse incidents which had been reported to CSC by the police. The police reports were dated September 1999, November 1999, and January 2000. All involved CP and Adult B. CP stated that Adult B was angry due to grief as he had not accessed counselling following a bereavement. CP then said that she had since parted from Adult B and there were no plans for reconciliation unless he (Adult B) went for counselling. There was no further action taken by CSC following this interview.
1.1.5; There was an anonymous referral to CSC in January 2002. This was made by a former neighbour of CP's. The complaint alleged domestic violence between the resident parents (CP and Partner), expressed concerns about alcohol, school attendance, and children screaming. A home visit was made and CP stated that her relationship with Adult B had ended "over a year ago". Child B was observed playing with toys and the home was said to be in a clean and tidy condition. In February 2002 another visiting social worker noted the presence of a male through the window, though the door was not opened. The social worker, having noted the previous domestic abuse incidents, subsequently made a recommendation for a CIN (Child in Need) plan, however this was not actioned and the case was closed in March 2002.
1.1.6; Another assessment was instigated on 21 November 2002 following a further police report, which stated that Adult B had put his foot on CP's throat and kicked her in the face causing a cut. Two separate home visits were attempted on 3 and 19

December but there was no response at the home address. On 31 December, CSC sent a letter to CP and Adult B stating that no further action was to be taken.
1.1.7; In August 2007 there was a domestic abuse incident at the then home of MG and Adult E which was reported to the police. There was no further detail regarding the incident noted on the file.
1.1.8; In March 2007 Adult D contacted CSC as he wanted to know about his daughter's (Child D) welfare, as there had been no contact from her mother (CP) or CSC. Adult D claimed that he had not seen his daughter for over a year since CP had accused him of sexually assaulting the child. Adult D claimed to have been beaten up and abused by CP's new partner, and spat at in the street. He had then made the decision not to see his daughter at that time. File notes question whether this was in fact the date that Adult D made contact as it is Child D's date of birth. It is assumed therefore that this date has been recorded incorrectly. CSC took no further action following this call.
1.1.9; A referral was received in November 2009 from Essex Police who stated that Adult D had been to the police station and stated that his ex wife (CP) was harassing him. He stated that CP had accused him of sexually abusing their daughter (Child D) whilst she was staying at his home in Hertfordshire. These visits took place every other weekend. Essex CSC took no further action as the alleged incident took place in Hertfordshire.
1.1.10; Adult D made contact with CSC to raise concerns about CP's new partner, but he did not state what the concerns were. He also stated that he had been in touch with Essex Police regarding the allegation made by CP involving his daughter (Child D). This information was noted, and Adult D was advised to contact Hertfordshire Police.
1.1.11; In December 2009 Essex CSC received a referral from Hertfordshire CSC relating to the alleged incident, but Essex CSC decided not to take any further action believing it to be the responsibility of Hertfordshire, as that is where the incident had allegedly taken place.
1.1.12. Between December 2009 and May 2010 there was continuous contact between Essex CSC and Hertfordshire CSC regarding a joint strategy meeting to review the Child D allegation. This was never convened.
1.1.13; From January 2010 and May 2010 there was correspondence between solicitors and CSC regarding the private court application made by Adult D with regard to his request for contact with Child D. Essex CSC responded that they had no concerns for Child D whilst she was in the care of her mother (CP).
1.1.14; The court report was completed in August 2010, and stated that as the alleged incident took place in Hertfordshire it would have been normal procedure for them to conduct the investigation. It was noted that there was no disclosure by Child D, and no report to Essex CSC by CP. By this time CP and Adult D were going through a divorce, but no risk to Child D was identified whilst she was in her mother's (CP) care. There was no contact with CP or Adult D and therefore the case was closed to Essex as it was felt that there were no grounds for further action.

1.2; Analysis of internal procedures and good practice

1.2.1; During the period under review it was noted that review and assessment information was held on paper files as well as the "SWIFT", IT system. Practitioners commented that the system was difficult to navigate and made it difficult to link siblings.

Paper based files were often misplaced, sometimes lost, and as a consequence key information was not accessible at the appropriate times.
1.2.2; Whilst referrals were responded to in a timely way in terms of contact and visits there was a consistent failure to link past incidents, or to take an holistic look at the family situation.
1.2.3; At times during the review period the CSC dept. appeared to be in disarray, with cases becoming “old” before they were allocated. Essex CSC was placed under special measures between 2009-2010 and this was due in part to the high number of unallocated cases. At times the Harlow office was being managed from the Epping office which created further problems, and these were exacerbated by a consistently high turnover of staff.

1.3; Issues for further consideration;
1.3.1; There were many issues involving CP and her family recorded for over a decade, but each ended with no further action being taken. There were acknowledgements that domestic abuse was present within CP’s relationships, and this was admitted by CP during the various interviews and assessment processes. As it is recognised that family function, lack of parental control, and use of alcohol are all part of a bigger picture, and often as a consequence of domestic abuse, it is difficult to comprehend why all the investigations ended with no further action being taken and the cases being closed.
1.3.2; From the very first referral there was no attempt to interview Child A. Even though there were a number of allegations made by Adult A regarding her welfare, the investigations did not include the child at the centre of the disputes. During other subsequent incidents of domestic abuse after Child B was born, again there are no records of any interview with CP’s children, even though they were living in the house with CP and the alleged perpetrator. In addition, there is no record of any family member being approached in order to gain a wider perspective, both on the impact of the alleged abuse to CP and to the children.
1.3.3; All CSC officers accepted CP’s version of events on each occasion when there was a formal interview or assessment completed. There is no record of question or challenge being made, just case sign off, and eventual case closure.
1.3.4; Full assessment opportunities were missed, particularly when the domestic abuse was admitted during interview, and the alcohol use disclosed. Knowing these facts, there was no follow up to the aborted home visits, even though an unknown male was seen in the premises where the children were living
1.3.5; There was an ongoing failure to link the past incidents of domestic abuse within the family unit, and to each of the children as they were born. This is partially due to the fact that they all used and were sometimes known by different names. There is evidence on file that Child D was treated as the only child in the household due to the fact that she too was known by a different surname to the two older boys.
1.3.6; There was a complete breakdown in communication between the Essex and Hertfordshire CSC teams in relation to the allegation made against Adult D, in 2010. After 5 months of trying to establish a joint strategy meeting both sides failed to take this issue forward. Essex assumed that it would be a Hertfordshire responsibility as the alleged incident took place in that county, but there was no formal follow up procedure

actioned in order to ascertain who or which department would be taking the lead, and on what.

2; Princess Alexandra Hospital (PAH);
This summary relates to CP, MG, and Child D. PAH have CP listed with 3 different names and Children B and C are listed in hospital records with a different name to that recorded at the GP practice where CP and the children are registered.

2.1; Agency involvement
2.1.1; Hospital records note that during the timeframe of the IMR, CP had a number of recorded appointments at the hospital. The majority of these were in relation to planned procedures. There were 4 visits to A&E (Accident and Emergency) during this time but there is no evidence recorded that the injuries were as a result of anything other than as CP claimed they had occurred. PAH noted and raised no concerns regarding domestic abuse, and CP made no disclosures during these appointments.
2.1.2; MG also had 4 A&E attendances in the same period, but again there is no evidence that this was in any way connected to domestic abuse incidents.
2.1.3; Child D had hospital attendances during the same period. These were planned appointments for an elective procedure following a referral from Child D's dentist.
2.1.4; MG is referenced in the hospital notes as Child D's father.

2.2; Analysis of internal procedures and good practice;
2.2.1; There is a draft adult safeguarding policy awaiting ratification at Board level, though domestic abuse is not covered as a specific topic within this policy. However safeguarding alerts are routinely cascaded throughout the hospital up to senior management level and safeguarding training is mandatory for all staff, with regular refresher training offered each year to ensure compliance and up to date knowledge.
2.2.2; PAH have undertaken partnership working with Safer Places, who have provided domestic abuse training to staff.
2.2.3; Staff are aware of the SET guidelines for safeguarding adults, and the escalation process if there are concerns. Staff also have access to the in house safeguarding team.
2.2.4; The named midwife for safeguarding attends the MARAC (Multi Agency Risk Assessment Conference) in Harlow. However this information is not automatically cascaded throughout the whole of the organisation, but is shared with the A&E dept. (Accident and Emergency) as a front of house entry point.

2.3; Issues for further consideration;
2.3.1; The adult safeguarding policy has been in draft form for some time, and whilst there is a stated intent to prioritise adult safeguarding training, without a policy to underpin the process, this could become less of a priority.
2.3.3; Whilst it is commendable that the midwife with the adult safeguarding lead is included and attends MARAC, it is imperative that all information is shared internally, so that all departments and in particular A&E have access to any relevant data.

3; Essex Police;

3.1; Agency involvement

3.1.1; In the time frame covered within this IMR, Essex Police have no record of any reported incidents of domestic abuse relating to CP and MG.
3.1.2; Police records do however contain references to a history of domestic abuse for both CP and MG, albeit with different partners.
3.1.3; Police have 2 recorded incidents of domestic abuse involving CP and Adult B in 2000, and further incidents in 2001 and 2002. There was another domestic abuse incident recorded in 2004, this involved Adult D and CP.
3.1.4; MG was arrested for a domestic assault against Adult E in 2007 and was cautioned for common assault.
3.1.5; In 2008 MG was one of 2 people arrested on suspicion of GBH. He was placed on police bail but following a review of the case, bail was cancelled, and there was no further action taken.
3.1.6; The final police file entry covers the fatal incident and CP's subsequent death. The police report states that Child B went for help alleging that his father was stabbing his mother. Child B also disclosed to police during interview, that he and Child C were regularly and routinely locked in their bedroom each night by MG. This fact was not recorded by any other agency, nor mentioned in any of the IMRs therefore it has to be assumed that nobody else had seen the children's living conditions. During interview CP's parents stated that the only ever went into the "living" areas of the bungalow, and that the boy's bedroom was at the far end of the house and therefore you couldn't just see it in passing.
3.1.7; Both were given a fixed penalty notice on 17 November 2011 for not wearing a seat belt. This occurred during a routine stop search.
3.1.8; After her death, Police discovered that CP had disclosed a previously unreported assault (by MG), to a family member on the day of her actual murder.

3.2; Analysis of internal procedures and good practice;

3.2.1; Essex Police reviewed and updated their Domestic Abuse policy and all associated procedures following two domestic homicides in 2011.
3.2.2; Currently Essex Police deal with circa 32,000 incidents of reported domestic abuse incidents every year, approximately 88 per day. These figures have increased from 10,000 per year five years ago.
3.2.3; The change of policy initiated a Domestic Abuse Intelligence Team within the Force Control Room. Once a domestic abuse incident has been reported, officers within this team are responsible for researching police databases to update attending officers regarding past or ongoing calls to the relevant address or involving people previously known to the police.
3.2.4; In November 2012 a Central Referral Unit was established to provide a central point of contact for domestic abuse reporting. This ensures accurate recording, grading and intelligence gathering in relation to all cases of domestic abuse.
3.2.5; Information regarding domestic abuse incidents from the DV/1 form are logged promptly onto the internal database. The form DV/1 is completed when a victim advises police that they are being stalked, harassed or threatened.

3.2.6; All police officers and contact staff undertake DASH (Domestic Abuse, Stalking and Honour Based Violence) training.

3.3; Issues for further consideration;
Given the lack of police involvement with CP and MG as a couple, there are no issues within the IMR or stated processes that require further consideration regarding Essex Police, other than the generic issue of how information is shared across agencies.

4; Lister Medical Centre-Primary care GP practice;
This section of the report relates to CP only, who re-registered as a patient at the practice in July 2004, having previously left in May 2002. Children B, C and D are also registered at the practice, though it is noted that Child B and C are registered with a different surname to Child D.

4.1; Agency involvement relating to CP
4.1.1; During the time period covered by this IMR, CP visited the practice a total of 26 times. She was seen by a GP on 20 of those appointments, and had a nurse consultation on the other 6 occasions. CP did not disclose any concerns regarding her domestic situation at any of the consultations.
4.1.2; File notes indicate that CP had been a victim of domestic abuse in 2003 and had been in a refuge prior to re-registering at the practice in 2004.
4.1.3; In reviewing the notes for the IMR it was identified that there were no safeguarding issues flagged for Children B and C, and the one entry regarding Child D was in relation to an enquiry from the Child and Court Advisory Service (CAFCAS). There was no social care involvement or follow up action taken following the CAFCAS enquiry.
4.1.4; The majority of CP's appointments were for clinical matters, and involved routine follow ups. There were 2 non attendances recorded during the time period but there was no explanation offered. The practice does not routinely follow up non attendances unless the patient misses 3 appointments.
4.1.5; In November 2010 CP's patient notes record that she attended an appointment with "her husband".
4.1.6; The 6 appointments with the practice nurse were for contraceptive services, and routine questions were asked in relation to CP's partner. The IMR author states that these appointments and the associated questioning gives women the opportunity to discuss any concerns, but no disclosures were made and no concerns were raised.
4.1.7; There were 2 occasions when CP attended the practice with injuries to her toe. One was in 2009, around the time she commenced her relationship with MG, the other was in April 2012. Both explanations were recorded as an accidental injury, and no other person was stated as being involved.

4.2; Analysis of internal procedures and good practice
4.2.1; The practice has named GPs for both children and adult's safeguarding.

4.2.2; The SET (Southend, Essex and Thurrock) safeguarding procedures for children are available to all clinicians via an uploaded version into their personal desktop computer. However the adult safeguarding information was not as accessible.
4.2.3; All of the GPs and the nurses who had contact with CP were trained to level 3 in children's safeguarding, but had only completed the basic level for adult safeguarding.
4.2.4; Specific adult safeguarding training had been undertaken during a half day clinical shut down session, and domestic abuse training had been one component of that half day. 18 members of the practice had attended.
4.2.5; All clinicians have access to the West Essex Safeguarding Contact list and are aware of how to contact the key personnel for guidance. The lists are available in every consulting room.
4.2.6; Patient information leaflets are available in the practice reception and information is clearly displayed in waiting areas. This includes information from Safer Places (domestic abuse support services) and "Ask Sal", the adult safeguarding advice line.

4.3; Issues for further consideration;
4.3.1; There is a disparity in the time and training given to safeguarding children, and safeguarding adults. Whilst the training for children is mandatory, adult safeguarding is not and has a reduced priority as a consequence.
4.3.2; The Lister practice and primary care in general are not involved in the MARAC process, and therefore have little understanding of the role that they can play in the information sharing process, and the contribution they could make as custodians of much of the health data. Other health professionals are involved but this information is not cascaded through to primary care as a matter of routine.
4.3.3; Where children have different parentage and/or are known by different names, there is no systematic approach made to link siblings together, or as a whole family unit. This is a crucial aspect of seeing the bigger picture and enabling practitioners to identify previous incidents of domestic abuse and to assess risk appropriately and consistently.

5; The Elsenham Practice-Primary care GP practice;
This section of the report relates to MG only. MG was a patient at the practice from August 2006 till May 2012. Neither CP nor any of her children were registered at the Elsenham Practice.

5.1; Agency involvement relating to MG;
5.1.1 Records show that during the period covered by the review MG was seen at the surgery on 17 occasions, of these appointments 15 were with a GP and 2 were with a nurse or healthcare assistant. There are 4 GP partners within the surgery and MP was seen by each of them in the course of his health care.
5.1.2; In addition the practice records show that an attempt was made to contact MG on 5 separate occasions, when he had failed to attend his regular medication reviews, or when he had failed to attend a GP appointment.
5.1.3; In January 2009 the practice received a letter from MG's psychiatrist regarding his ongoing depressive episodes. However during March of the same year the practice

was informed that MG had failed to attend appointments with his psychiatrist on 2 separate occasions. He also failed to attend the next appointment made with his GP.
5.1.4; In June 2009 MG visited the GP and requested another appointment with the psychiatrist. The notes state that he was taking medication for depression, and had failed to attend the last 2 pre-booked meetings with the psychiatrist as he “could not get up in the mornings”. It was also noted at this time that MG had not worked for some time. A referral into Mental Health Services was subsequently made, but there is no note made as to the urgency of the requested appointment.
5.1.5; In early September 2009 the practice were informed that MG had not attended the appointment with the psychiatrist, but the next day received a confirmation letter that an assessment of MG had been carried out by the Crisis Resolution at Home Team. This psychiatric review identified “pre-occupying thoughts” and “a voice in my head”. This was diagnosed as depression with psychosis, which was classed as a new onset to the depression.
5.1.6; There is a note made of a visit to the local Walk in Centre in November 2009 with 2 injured fingers but with no explanation as to how the injury occurred.
5.1.7; In the same month the practice identified that MG needed to make an appointment with the GP for a medication review, and a telephone message was left, and after failing to attend the booked appointment, MG contacted the surgery and re-booked an appointment with the practice nurse.
5.1.8; MG attended the surgery after Christmas in 2009 and the notes indicate that “his partner” was present. It is assumed by the date that this was CP. MG stated that he had collapsed on Christmas day, and that he attended the hospital where they wanted to admit him, but he had discharged himself. The GP recommended that MG should return to the hospital immediately and offered to call an ambulance to the surgery, but MG insisted that he would get a lift there.
5.1.9; At a GP review in January 2010, MG completed a depression self assessment tool, and scored himself 17 out of 27. MG disclosed that he had not attended the last appointment with the psychiatrist, but following the GP review, MG was assessed as being compliant with the prescribed medication. Another referral to the psychiatrist was made, but MG failed to attend this appointment. CP’s parents have challenged MG’s stated compliance with his prescribed medication and further stated that he boasted of never having taken a pill in his life.
5.1.10; The practice received an update from the psychiatrist at the end of March 2010, which stated that MG was suffering from “terrible mood swings”. The report also recorded that MG was hearing 2 or 3 voices which were telling him that what CP said was “false”. The psychiatrist requested further tests relating to MG’s heart functionality before he could be started on additional medication for the new symptoms.
5.1.11; The following month MG attended the surgery again and was diagnosed with hypertension. Notes record that MG was seriously “distressed”.
5.1.12; Notes record a visit at the end of September 2010, when MG reported that he was still in a “low mood” but added that he has a supportive partner who he can talk to. Due to an increase and change of medication MG reported that he was feeling much better with “less voices in his head”.

5.1.13; In January 2011 there was a report from the (NEPFT) Derwent Centre, the local psychiatric unit, which stated that MG had insecurities about his relationship with CP, which exacerbated his feelings of distress.
5.1.14; An appointment in July 2011 notes that MG was accompanied by his partner (CP). He was feeling “down” and requested an early appointment with the psychiatrist. CP reported that MG is ”open” with her, and she feels that she can help with his anxieties and can calm him down.
5.1.15; There was a further depressive episode recorded in September 2011, and a subsequent visit to the GP noted that MG had been prescribed further anti psychotic medication. There was another report from the Derwent Centre which included an updated care plan and a note stating that there was a follow up appointment booked for MG in a further 3 months.
5.1.16; At the end of January 2012 there was another update from the Derwent Centre to the GP, which stated that MG was “heavily dependent” on his partner (CP), and psychologically resistant to other treatments. There is no explanation as to what heavily dependent means or what the effects of the identified dependency could be.
5.1.17; A further letter to the GP recorded that MG’s medication had been increased once again.
5.1.18; At the end of May 2012 MG visited the GP to inform him that he was moving in with his partner (CP) and he was looking forward to the move. The GP questioned MG’s dependency on CP but MG said that she was providing daily challenges to him and to his anxieties. It was noted that MG had a further appointment with the psychiatrist in July. The GP increased MG’s blood pressure medication at the same appointment, as his blood pressure was high and had been raised over the last 2 checks. Further blood tests were ordered and MG’s summary notes were handed over to him in order for him to transfer to a new GP surgery nearer to CP’s home.

5.2; Analysis of internal procedures and good practice;
5.2.1; The IMR author states that the practice has a named lead for children’s and adult’s safeguarding. Though it is noted that the current lead is about to retire, and therefore this role would need to be transferred to another partner within the practice.
5.2.2; It has been stated that there is a robust protocol for dealing with domestic violence alerts and for cascading that information throughout the practice, though there are no specific details as to how the protocol works in practice.
5.2.3; Some staff are recorded as attending a half day adult safeguarding training session via a practice shut down event. This included a domestic abuse component.
5.2.4; The practice had recorded an incident of domestic abuse between MG and Adult E in 2007, but had not transferred any concerns to his relationship with CP.

5.3; Issues for further consideration;
5.3.1; Safeguarding adults training should be delivered across the whole practice immediately. This training should incorporate domestic abuse as a separate aspect of the adult safeguarding procedure, and further ensure that the information given allows staff at all levels to understand their role, and where to take or raise concerns and information relating to domestic abuse disclosures or concerns.

5.3.2; There is no evidence of a clear separation between children's and adult's safeguarding, or how the standard safeguarding procedures e.g. SET, form part of an on-going training programme for all staff.
5.3.3; General practice is currently outside the MARAC process and there needs to be consideration given as to how important information can be shared with GP practices and cascaded to all internal practice staff.

6; NEPFT (North Essex Partnership NHS Foundation Trust)

This section of the report relates to MG only, and the report submitted has followed the format of a serious incident review, rather than an IMR. The background information relating to internal policy and procedure has been covered within an additional DHR which was running concurrently to this DHR. As the required information was contained within the body of the report, it was not deemed necessary to ask for a re-draft and re-submission. The panel decided to accept the report as it was submitted three and a half months after the deadline for completion due to internal staffing issues and changes with local personnel. A representative from NEPFT was in attendance at all the panel meetings and was open to questioning, discussion and further investigative enquiry.
The report also covers some additional background information relating to MG's upbringing and his family circumstances. This noted that he was brought up by his mother who suffered mental ill health and was well known to mental health and social care services in the area where she lived. She consistently presented with a complex set of mental health issues and housing needs.
MG went to live with his maternal grandmother at the age of 15 and after a brief spell in the army worked in security jobs until 2004 when an arm injury allegedly curtailed this work.

6.1; Agency involvement relating to MG;

6.1.1; MG was referred to psychiatric services in March 2004 and was seen as an outpatient until July 2004. MG reported that he had been diagnosed with schizophrenia. However as there are no notes available covering this period there is no information to substantiate this claim. It should be noted that none of the clinicians who have assessed him since have supported this diagnosis.
6.1.2; MG's GP referred him to psychiatric services again in January 2007. He was said to be suffering from "marked depression" due to experiencing consistent pain in his left arm following an operation. It was noted that the injury was caused during an assault whilst MG was employed as a doorman in Harlow. He stated that he had been unable to work since this incident and was waiting for a referral to the pain clinic. MG had a thorough assessment over the course of 2 appointments, and was diagnosed as having a "depressive disorder precipitated by physical ill health and subsequent loss of job". MG was offered various treatment options which included occupational therapy and supported employment through a local charity, but he was reluctant to follow up any of the pathways on offer, as he stated that he found it difficult to mix with others. His preferred option was to continue to attend outpatients appointments with a psychiatric doctor.

6.1.3; There were bi- monthly psychiatric outpatient appointments until July 2007, when MG disclosed that he had had an argument with his (then) wife which had resulted in him holding her up against a wall. The police were called and he was held in custody for 12 hours, but released following a decision by his wife not to support any charge being made against MG and further stated that she would not testify if the police pursued this route. MG's wife (Adult E) subsequently left the family home and left him to care for his 2 sons then aged 16 and 18 (Children E and F).
6.1.4; MG's medication was changed at this point and he was referred to the local CMHT (Community Mental Health Team) as it was felt that his symptoms had become worse and he needed additional support. It was agreed to offer a carer's assessment to MG's wife if she returned to the marital home. He was allocated a social worker at this point in order to address his anxieties and to further monitor his mental state. Notes also indicated that he was receiving support from a local church.
6.1.5; The allocated social worker worked with MG until Dec 2007, and the focus of the interventions was to help MG to come to terms with the end of his marriage. MG initially blamed his wife for the break up, but as time progressed he acknowledged that he had a part to play in the demise of his marriage. He had become dependent on his wife who had to "be strong" in recent years. He also described himself as "like 2 different people". One the world sees as looking "strong and intimidating" and the other being the vulnerable less self-assured person. This contradiction is noted throughout MG's care records. He described himself as disabled due to the pain in his arm and with a diagnosed heart complaint, but kept himself fit by cycling and running. He also described himself as passive whilst "wanting to destroy".
6.1.6; CMHT discharged MG in Dec 2007 as he had embarked on a new relationship and was receiving help and support from his local church.
6.1.7; Within weeks it was recorded that MG had returned to his GP expressing concern that his next psychiatric outpatient appointment was not till the middle of February 2008. MG stated that his wife wanted to return to the marital home, but as he had embarked on a new relationship he felt "torn". Records noted that although he was distressed there was no evidence of any suicidal or homicidal thoughts. It was further assessed that he was becoming dependent on services.
6.1.8; MG continued to be seen as an outpatient during 2008 and seemed to become more stable as the year progressed, stating that his new partner was "understanding" and "helped him with issues". However this relationship ended in January 2009 and he was recorded at that time as being in a "low mood and tearful".
6.1.9; MG was discharged from the outpatient's clinic in May 2009 as he had failed to attend his appointments on a number of occasions, but his GP re-referred him in June 2009. He was seen in September 2009 and was referred on to the CRHT (Crisis Resolution Home Team) as it was stated that his mood had deteriorated and there was an apparent onset of new psychotic symptoms. He disclosed that he had punched himself in the head and stomach, and four weeks previously had stepped onto the train tracks with a view to ending his life. He stated that this was following contact with his wife. MG stated that he was hearing voices in his head but was unsure whether this was actually a voice or his conscience. The CRHT assessment stated that MG had a "depressive disorder, precipitated by a relationship breakdown, loneliness, loss of job

and physical ill health" He was referred back to the care of the CMHT and encouraged to attend his outpatient appointments.
6.1.10; At the end of this episode it was noted that MG was now in a relationship with CP and was "happy in her company", but for the remainder of 2009 he still failed to attend his pre-booked outpatient appointments.
6.1.11; Again it was left to his GP to request another appointment with psychiatric services in January 2010, and this took place in March 2010. MG attended this appointment with CP. He stated that he was living in her house with her 3 children but was maintaining his own accommodation. He described "terrible mood swings" and voices in his head telling him to be suspicious of CP. At the same appointment he stated that CP "knows him inside out" and was immediately able to recognise his distress and helped him to cope better. He reported feelings of anxiety when he was out in public and only left the house to walk the dogs or to collect CP's children from school. He denied any suicidal or homicidal intent, and stated that although the voices were still there, the intensity had reduced and he felt able to control them. At this appointment MG's psychiatrist started MG on additional anti-psychotic medication, which appeared to give MG symptomatic relief.
6.1.12; The doctor at this appointment noted that he specifically asked CP whether she had any concerns regarding MG's behaviours or whether he had displayed any aggression towards her or the children. She stated that she had no concerns and that she was always around to keep an eye on him.
6.1.13; Records state that MG's mental health remained relatively stable during the rest of 2010, and it was noted that his occasional tendency to be suspicious about CP was as a result of low self-esteem rather than delusional thoughts.
6.1.14; In May 2011 the diagnosis of MG's mental ill health was recorded as "Recurrent Depressive Disorder". The GP made a request for a more urgent appointment noting also that MG had come to rely on the hour long appointments.
6.1.15; MG was seen by the senior trainee to MG's usual psychiatrist in August 2011. The new doctor recorded that MG was highly dependent on his partner (CP) as well as other health professionals, in order to contain his anxieties. He noted that there was no evidence of depressive illness, but as MG was experiencing an increase in his symptoms of anxiety, he made the suggestion to increase the dose of the anti-psychotic medication.
6.1.16; A review of MG's diagnosis was conducted by the same senior trainee in November 2011. He was aware that there had been a mention of schizophrenia in the past, but there was nothing mentioned in the clinical notes. The doctor discussed the possibility of a "borderline personality disorder" with MG as his depressive episodes were brief but recurrent. It was further assessed that the "auditory hallucinations" appeared to be situational, and would therefore not be helped by MG's anti-psychotic medication. The doctor noted that MG was reliant on the sedative properties of the medication he was taking, and made a note stating again that MG was also dependent on his partner and health professionals.
6.1.17; MG continued to be seen by the same doctor at out-patient appointments, and notes record that he was always accompanied by CP. MG stated that he would not be able to cope without CP and that she needed to go everywhere with him as he could not tolerate being out on his own. He felt people were talking about him. The doctor

recorded that MG would be better off with psychological therapies rather than medication but as MG was heavily dependent on the prescribed medication, he would be resistant to the suggestion of any alternative approach.
6.1.18; Outpatient appointments continued at regular intervals and MG always presented the same as within previous consultations. His final appointment before his arrest was on 10 July 2012. At this consultation MG reported that he was attempting to stretch himself by going out and exposing himself to challenging situations, but he felt that people were looking at him “the wrong way” and talking about him “with contempt”. This prompted inner feelings of hatred towards unfamiliar people. Notes state that MG’s mental state was very much as usual and recorded no biological symptoms of depression and no evidence of psychotic behaviours. At this appointment MG gave his address as that of CP. This appointment concluded with another review being booked for 3 months later, i.e. October 2012.
6.1.19; Following his arrest, MG was seen by a senior practitioner within the Criminal Justice Mental Health Team. They found no evidence of any significant mental disorder.
6.1.20; MG was remanded to the custody of HMP Chelmsford, and was seen immediately by the Mental Health Team there, and remained under regular review. The Consultant Prison Psychiatrist determined that MG suffers from a personality disorder, but did not think the symptoms reported were related to a functional psychotic illness. MG is on an ordinary prison wing and is compliant with his prescribed medications, though it is not recorded how the compliance was assessed.

6.2; Analysis of internal procedures and good practice;
6.2.1; As this was not a full IMR the information relating to internal policy and procedure regarding adult safeguarding or specifically domestic abuse training was taken from an IMR which was submitted for another local DHR which was running concurrently. This was further questioned at panel meetings and confirmed orally.
6.2.2; From the concurrent DHR report and from subsequent panel discussions and questioning, it was confirmed that;
The domestic abuse policy is contained within the adult safeguarding policy, and that all front line staff members have undertaken DASH (domestic, sexual and honour based abuse) training. Basic safeguarding training at levels one and two are delivered as one off training and levels three and four are reviewed every two to three years.

6.3; Issues for further consideration;
6.3.1; There is disconnect within the referral and appointment follow up processes regarding potentially high risk service users. Whilst it has been stated that there is an existing protocol regarding clients who do not attend appointments, particularly those who have had an urgent referral into NEPFT, there was no evidence as to how this is implemented or how it works in practice. Further enquiries did not offer any better insight other than follow ups are undertaken and the GP is informed.
6.3.2; It is accepted that general practice is the main point of contact for all health services and therefore there is an urgent need to maintain an up to date holistic record of what is happening within each patient’s care pathway. Closer engagement and communication with GPs and with primary care in general, is an essential aspect of managing the overall health and risk of each patient.

6.3.3; There was no assessment offered or made to CP or to the wider family. It is imperative that the carer's perspective and experience is taken into account. This is a valuable contribution to the overall assessment of health management and risk, to themselves and to the family in general.
6.3.4; Following his arrest at the home he shared with CP and following her death, Police found a substantial quantity of prescription medication, which had been prescribed to MG. Given that he had been described on more than one occasion as being compliant with his medication, it is unclear how this assessment could be based on clinical evidence rather than just a verbal assurance from MG. As previously stated and is covered within the interview with CP's parents this compliance is strongly challenged.

7.1; Stewards Academy;

7.1.1; Whilst an IMR was requested from Stewards Academy, what was received initially amounted to an informal note, stating that Child B had been offered internal support at the school since the death of his mother.
7.1.2; After a specific request for more and better information, there was a revised statement from the school which gave more detail about the level of involvement with the family and the problems that Child B had since going into secondary education.
7.1.3; The statement recorded that Child B had joined Stewards Academy in September 2010. He joined together with a group of other children who he knew well from his previous junior school.
7.1.4; CP had attended a transition meeting prior to the transfer of Child B, and had attended the meeting with MG. There were notes made of the meeting which record that MG was CP's "partner" but not Child Bs' father. However the couple seemed very comfortable with one another and were very tactile.
7.1.5; After a time at the school, it was noted that Child B had issues with anger management. He was closely monitored and supported by a Pastoral Support Manager (PSM) within the school. CP came into school to discuss Child B's problems and stated that Child B had the same issues at home. CP excused the behaviour by saying that he was provoked by his younger siblings. CP also stated that Child B clashed with his "stepfather" MG. It became evident through further conversations between the PSM and Child Bs' newly appointed Learning Mentor, that Child B was missing his real father, who at that time was having very little contact with him.
7.1.6; In Feb 2012 CP went into the school with MG to discuss the on-going issues with Child B. There were no particular concerns raised by CP and they were recorded as being very supportive of the work the school was undertaking with Child B.
7.1.7; A further note records that the PSM was in regular contact with Child B's "stepfather" (MG).
7.1.8; On the school sports day, 13-07-12, Child B injured his ankle, but informed staff that it was an on-going problem. The school medical officer examined him and contacted CP to advise that he should go to casualty. Later on the same day Child B returned to school stating that "casualty had been too busy for him to wait" so he had returned to school.

7.1.9; The school added a footnote to state that Stewards Academy have taken a pro-active role to support Child B since his mother's death, and that he is receiving counselling from an organisation called "Trauma Assist", and that this had been arranged through Victim Support.

7.2; Analysis of internal procedures and good practice;
7.2.1; The statement does not go into any detail about the internal policies and procedures relating to safeguarding, though it would be mandatory for the school to have a named lead for children's safeguarding, and to work within the Southend, Essex and Thurrock (SET) procedures.
7.2.2; The statement concludes by saying that there was never any cause to involve social care (CSC) with the family, and that there was never any information or suspicion with regard to domestic abuse. However with the on-going behaviour issues with Child B and the knowledge that this was a "reconstituted" family, it is surprising that this avenue was not explored further.

7.3; Issues for further consideration;
7.3.1; Whilst it is not mandatory for schools to take part in the DHR process, it can only improve the overall shared learning and awareness of domestic abuse if they do. Whilst there is a shared commitment to ensure that any practice or policy failures are not repeated, the DHR process is not about apportioning blame or finding scapegoats.

8; Additional Information, requested from SEPT (South Essex Partnership NHS Foundation Trust);
8.1.1; Given the scant information supplied by Stewards Academy, a request for additional information was submitted to SEPT at a fairly late stage. This was to try and ascertain whether there was any further information available, relating to Children B, C and D's interactions with school nursing staff, or health visitors.
8.1.2; SEPT have provided a mini "chronology" which covered all appointments since the birth of each of the children listed in 8.1.1. The majority of the notes relate to routine development checks, health examinations and minor accidents.
8.1.3; As a further fact to note, there is a police incident record on the file relating to a domestic abuse incident when Child B was a little over 8 months. The date logged for this incident is 27-01-2000.
8.1.4; In October 2000 Child A was taken to Accident and Emergency (A&E) with a head injury after "falling on a radiator".
8.1.5; A record made by the Health Visitor in March 2003, notes that the family are fleeing domestic abuse perpetrated by Child B's father (Adult B). At this time it appears that CP was trying to secure alternative housing in Southend. However a further note gives a different address in Harlow one day later than the note about the desired move. Following this, a Southend address was actually recorded in July 2003.
8.1.6; There is a record of another address back in Harlow by November of the same year, (which is logged as temporary accommodation). It also states that Child A was unable to access a school place, suggesting that CP and her family had moved back permanently into the Harlow area.

8.1.7; Child C was born at the beginning of December 2003 and there is home visit recorded by a health visitor in Jan 2004 stating that there were no concerns. A further home visit some 10 days late, records that “mother (CP) having difficulties coping”. Child A also had a bruise on her eye from a “bump on chair”.
8.1.8; A routine visit by the Heath Visitor in May 2005 noted that Child C had bruising round the eye, but there was no explanation logged and no action taken.
8.1.9; Police notified the Health Visitor that Child A was involved in a domestic incident at another address, though it was recorded that CP was unaware of this. The Health Visitor discussed housing tensions and the safety of the children’s play with CP.
8.1.10; A further visit to A&E is recorded involving Child C with scalds to his face, chest and arm from a cup of tea.
8.1.11; There are a number of recorded discussions about behaviour concerns relating to Child B and Child C, and 2 further head injuries treated at A&E and the Walk in Centre, in relation to Child C during 2005 and 2006.
8.1.12; Child C was seen a further 2 times at A&E during 2007 for a foot and an eye injury, but during routine Health Visitor visits no concerns were recorded.
8.1.13; During 2009 Child C was referred to the Child Development Centre for behavioural problems. He did not attend the first appointment and it was re-booked, but as he did not attend the second appointment the case was closed.

8.2; Analysis of internal procedures and good practice;
8.2.1; As this was supplementary to the DHR process, there is no information provided as to internal policies and procedures relating to safeguarding or specifically to domestic abuse.

8.3; Issues for further consideration;
8.3.1; There is no detail provided, but once domestic abuse has been identified within a family, particularly where there are children present, there should be a protocol that flags up unexplained injuries to the children, and an automatic trigger alert made to CSC.
8.3.2; Further noted comments summarising “no concerns” should also be qualified where there has been domestic abuse within the family, and where there are persistent behaviour problems being displayed by one or more children.

9; Summary of responses to the specific Terms of Reference for the DHR;

9.1; Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
9.1.1; All agencies responded to the question by stating that they felt they had been sensitive to the needs of both CP and MG.
9.1.2; All had knowledge of domestic abuse indicators and policies to support referral routes which enable victims or potential victims to be able to access help and support.

However it was noted throughout all the IMRs that there were no disclosures made by CP and therefore nothing to respond to.
9.1.3; As previously stated there is a real disparity in the level of training within adult safeguarding, when compared to children's safeguarding. All agencies whilst confidently stating their high standard of children's safeguarding seem to take a less pro-active approach to training which is not mandatory, but equally valid.

9.2; Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/ perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim, or perpetrator, subject to a MARAC?
9.2.1; As above all agencies had safeguarding policies and procedures though some were more explicit than others, but as both CP and MG were not identified as a victim or perpetrator of domestic abuse, there were no risk assessments undertaken. Concerns regarding the children were overlooked or ignored as the links to previous domestic abuse were not made.
9.2.2; MG was not subject to a MARAC, and was therefore never managed under the process.

9.3; Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?
9.3.1; As there was no domestic abuse identified within the relationship between CP and MG, inter agency information sharing was not relevant to this review, but barriers to information sharing still continue to challenge the ability for any one agency to have sight of the bigger picture.

9.4; What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?
9.4.1; There are a number of missed opportunities which have been identified as a result of the IMR process and as a consequence of this review. These are covered within the summary and recommendations section of this report.

9.5; Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered, or provided, or relevant enquiries made in the light of the assessments, given what was known or should have been known at the time?
9.5.1; Again as there was no domestic abuse identified within the CP/MG relationship, there were no direct risk assessments undertaken.
9.5.2; However, given that MG had been diagnosed with a mental health condition, and had developed issues around a dependency on CP and on health services in general, there should have been a risk assessment undertaken immediately, when MG disclosed that he was moving in with CP and her children.

9.6; When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of the options/choices to make informed decisions? Were they signposted to other agencies?

9.6.1; As stated within each of the IMRs, CP did not make any disclosures relating to domestic abuse during her relationship with MG. According to the NEPFT report she was given a direct opportunity to make a disclosure during one of MG's assessments but she said that she had no concerns for herself or for the children. There were therefore no opportunities to direct CP to any support agencies, or to discuss other options.

9.7; Was anything known about the perpetrator? For example, were they being managed under MAPPA (Multi Agency Public Protection Agency)?

9.7.1; MG was never discussed at MARAC or managed under MAPPA.

9.8; Had the victim disclosed to anyone and if so, was the response appropriate?

9.8.1; Given that there were a number of occasions where CP had the opportunity to make a disclosure and said nothing, agencies were unaware of the domestic abuse within the household. CP not only denied that domestic violence was present within her relationship with MG she went further to pretend that all was well and they were a very "together" couple. This was verified within the meetings and later interviews with CP's parents.

9.8.2; The police IMR states that CP had injuries relating to a domestic assault by MG but had told a family member she had fallen over. This was not known to police until after her death.

9.9; Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

9.9.1; All of the IMRs considered issues relating to equality and diversity. There were no issues raised within these headings regarding CP, MG and the wider family.

9.9.2; Whilst it was stated that MG considered himself to be disabled due to the injury in his arm, there is no indication that this was an issue in itself. It was noted within MG's psychiatric notes that the "disability" prevented MG from working which in turn exacerbated his depression.

9.10; Were senior managers or other agencies and professionals involved at the appropriate points?

9.10.1; As there was nothing highlighted within individual agencies, there was no reason to escalate to more senior managers for review or further consideration.

9.10.2; There was a lack of consistency and follow up within CSC, but this related to CP and previous partners, not specifically whilst she was with MG.

9.11; Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

9.11.1; There are questions relating to the internal linkages made between what has been termed as “reconstituted” families within primary care and other statutory agencies.
9.11.2; This is the 2nd domestic homicide within the Harlow district during the past 18 months. There was a previous case which was “downgraded” to a Domestic Death Review following a decision by the CPS (Crown Prosecution Service) not to proceed with formal charges.
9.11.3; During the course of the review there were questions raised as to the status of MG’s SIA (Security Industry Authority) license, and whether this had been reviewed or revoked when his mental health problems were identified. Enquiries were made to HDC (Harlow District Council) as the licensing authority. The response explained that when the council licenses premises, part of the conditions of the license is that there must be an appropriate number of door staff, and that these individuals are in turn licensed by the Security Industry Authority (SIA). The council subsequently does random checks to ensure that the licensed premises are complying with the conditions of their particular license.
Regarding applicants with mental health issues, the SIA (Home office website www.sia.homeoffice.gov.uk) states:

“We will take into account any recent mental health problems where you have had to be detained or been subject to other compulsory measures in the five years prior to your application. We will not seek out information about any mental health problems which have not been subject to compulsory measures or resulted in detention.”

MG was never detained under the Mental Health Act, and therefore be assumed his license was never reviewed in this capacity.
Upon further enquiries it has been confirmed that MG’s license was allowed to expire on 4 July 2011 and there was no application to renew.
9.11.4; Questions were also raised as to the status of CP’s housing tenancy with HDC (Harlow District Council) when MG moved in as a co-habitor. The HDC Housing dept replied to confirm that the tenancy of 55 Copshall Close (CP’s home address) commenced on 2nd April 2007 as joint tenancy in the names of Mr and Mrs J (CP and Adult D). On 15th January 2010 an intention to quit was received from Mr J (Adult D) and the tenancy was transferred into the sole name of Mrs J (CP) on 22nd February 2010. Since February 2010 there has been no further contact or involvement between CP and the housing dept.
With regard to MG there are no housing records held locally relating to him individually or within his relationship with CP.

9.12; Are there ways of working effectively that could be passed on to other organisations or individuals?
9.12.1; In terms of effective working, there is the very real challenge of inter-agency communication and information share. This will be covered within the recommendations.

9.13; Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

9.13.1; Lessons to be learned from the review will be covered within the recommendations.

9.14; How accessible were the services for the victim and perpetrator?

9.14.1; Both CP and MG appeared to know their way round the respective systems. GPs accommodated MG when he stated that he was unable to attend early appointments as he could not get up in the mornings due to the effects of his prescribed medication. He was offered later appointments as a result of this request.

9.15; To what degree could the homicide have been accurately predicted and prevented?

9.15.1; CP had a number of abusive relationships in the past, which had involved the police, court services, and CSC at various times within these relationships. It therefore has to be assumed that she knew what to do in order to report domestic abuse and to involve the relevant support and care services regarding her own and her children's welfare and protection.

9.15.2; Whilst CP had gone from one abusive relationship to another, other injuries with previous partners had never been so severe as to have been life threatening and there was no indication during her relationship with MG that he could or would display that level of violence towards CP.

9.15.3; Looking at the whole picture as is created by the overview report, it is feasible to believe that whilst CP did not make any disclosures regarding domestic abuse, and stated that things were OK with the relationship with MG, it is very apparent that things were not as they should have been within the wider family.

9.15.4; MG was being treated and managed within mental health services who continued to see him at regular interviews, often with no urgency associated to a situation that was potentially chronic or volatile.

9.15.5; Given that no agency had a complete overview, or access to other pieces of the jigsaw it is tragic to conclude that this homicide could not have been predicted nor prevented.

10; Final Summary;

10.1; CP, and in later years her children, were known to CSC, and to Essex Police for a number of years prior to her relationship with MG. There were a number of domestic abuse incidents reported with previous partners, and this in turn created police alerts and subsequent referrals to CSC.

10.2; It should be noted that none of the police reports resulted in further action. This is because CP did not want any of the allegations of violence to be taken any further

within the criminal justice system. It is therefore difficult to understand how the police could have done anything differently with regard to CP's previous partners.
10.3; However once CSC were involved and the presence of domestic abuse was identified within the family, (prior to MG), it appears that the referral, assessment and follow up process was abandoned far too early to protect the children directly, and indirectly CP.
10.4; Whilst the earlier referrals would not have protected CP against MG, it could have flagged the exposure of the children to a domestic abuse situation, and subsequently concentrated on their on-going safety.
10.5; Where children are present within a family where domestic abuse has taken place, it is imperative that they are involved in any subsequent referral or investigation process, and that their voices are heard. Where health visitors are the main link with the family, there should be clearly stated escalation processes for referral into CSC. Closing a case before a thorough investigation has taken place enables perpetrators to move from relationship to relationship, and increases the risk to partners and their children.

11; Recommendations;

11.1; Essex County Council (ECC), Children's Social Care;

11.1.1; In line with policy, procedure and good practice, practitioners need to ensure that children's voices are heard. They need to be seen and interviewed in order for practitioners to gain a better understanding of what's going on within the whole family and within that child's world.
11.1.2; There needs to be a better link between the IRT (Initial Response Team) and their CSC colleagues after the initial referral and recommendations. This is particularly important in a situation where children have been involved in a domestic abuse situation.
11.1.3; There must be a system whereby children, step children, half brothers and sisters, can be linked to each other's records within CSC. There also needs to be a family chronology linked to the records of individual children if CSC is to be able to work out the relationships within "reconstituted families".
11.1.4; DASH training should be undertaken by all practitioners but particularly those practitioners involved in the IRT, who should complete this training immediately.
11.1.5; There should be a more timely use of a Family Group Conference (FGC) especially where there has been a domestic abuse incident. This will alert practitioners to the whole picture in relation to the entire family, and would provide better safeguards and monitoring arrangements in order to secure the welfare of the children.

11.2; Princess Alexandra Hospital (PAH);

11.2.1; The adult safeguarding policy should be signed off and implemented with immediate effect, as this has been waiting for ratification for some time.
11.2.2; All members of the safeguarding team should have specialist training in domestic abuse and all staff should have a basic level of adult safeguarding training which includes domestic abuse as a specific topic within the training.

11.3; Essex Police;
As there was no involvement between the police and CP or MG, there are no recommendations relating to this IMR or the DH review in general.

11.4; Lister Medical Centre;
11.4.1; SET procedures for adult safeguarding should be as accessible as the children's SET procedures and be uploaded onto desktop for immediate access by all GPs.
11.4.2; Systems must be updated in order to be able to make links between parents and siblings, step children, and half brothers and sisters. A note on parental responsibility should also be added to each child's records where there is a reconstituted family.
11.4.3; A training programme, which covers domestic abuse as a separate item to adult safeguarding, should be delivered to all staff including front line administrative staff.
11.4.4; GPs should have a simple toolkit of "routine" questions for each person to flag up indicators of domestic abuse.
11.4.5; Primary care should be included in the MARAC process.
11.4.6; Domestic abuse incidents (via police alerts-DV/1) should be discussed at practice meetings in order to share information, highlight good practice, and to develop better response options, as well as raising a greater awareness of domestic abuse.

11.5; The Elsenham Practice;
See references to the recommendations within the Lister Practice which are also applicable to the Elsenham Practice, specifically;
11.4.1
11.4.3
11.4.4
11.4.5
11.4.6

11.6; West Essex CCG-in their capacity as a lead safeguarding agency
11.6.1; WECCG should consider the appointment of a domestic abuse lead, which could operate within the whole adult safeguarding agenda. The post could lead on the roll out of specialist training and act as an information and "expert" resource to primary care.

11.7; NEPFT;
11.7.1; When cases are on-going, i.e. over one year, and patients are accessing services via a number of providers, there should be a multi-agency review to ensure that all of the supporting agencies are working towards the same goals for the patient, and coordinating that care for the best outcomes.
11.7.2; There is no evidence of risk assessments being reviewed or shared with other agencies, including primary care. The policy around risk assessments and who they are shared with should be reviewed to ensure that there are regular reviews particularly when there is a change of medication and/or the emergence of new symptoms.
11.7.3; There was no carers assessment completed with regard to CP, even though MG reported that she was his main carer and she agreed that she was "looking after him". NEPFT states that it has a policy with regard to this and it is mandatory for any carer to

have an assessment. NEPFT therefore need to review how this policy is being implemented and adhered to, if situations such as MGs were allowed to slip through the process.
11.7.4; Compliance with prescribed medication must be based on clinical evidence rather than verbal reassurances, particularly where appointment attendance and other aspects of case management have been uncooperative or resistant.

11.8; Stewards Academy;
As there was very little detail given within the Stewards Academy IMR, it would be difficult to assess any recommendations for better practice.
However given the horrific nature of this incident, whilst it is not mandatory for any education establishment to take part in the DHR process, or to submit an IMR, it is hoped that in the spirit of inter-agency cooperation and prevention, that they would come into the arena as willing contributors and not have to be coerced into providing relevant and timely information.

11.9; SEPT;
This was not a formal IMR submission and was presented at very short notice to supplement the lack of information from Stewards Academy.
The DHR review panel are grateful for the information provided and the additional insight given by being able to see the various interactions between the children and health services, specifically school nursing and health visiting.
As the information provided was just a copy of notes relating to each of CP's children, it would not be appropriate to make any assumptions regarding best practice or perceived short falls within the services mentioned.

11.10; All Agencies;
11.10.1; Should raise the value and importance of adult safeguarding training and awareness to that of children's safeguarding, and to ensure that domestic abuse features appropriately within that training.
11.10.2; Must develop appropriate information sharing protocols that can override the barriers caused by separate IT systems, and the laws regarding data protection.
11.10.3; All agencies should familiarise themselves with the "7 golden rules of information sharing" as published by HM Government.
11.10.4; Clinical Commissioning Groups (CCGs) in their safeguarding role, should develop a simple to use toolkit which will enable clinicians and practice staff to ask four or five pertinent questions regarding domestic abuse, and be confident about the pathway for referral if there are concerns.
11.10.5; Within a domestic abuse situation it is of concern that referrals and/or the escalation of any identified issues , only make reference to physical or violent abuse, whereas it is well referenced that controlling and coercive behaviour as well as emotional abuse, are often part of the pattern of perpetrator behaviours. Agencies need to factor in ALL aspects of potential risk and acknowledge that domestic abuse covers a wider spectrum of perpetrator behaviours.

12; Conclusion

12.1; Crime statistics from 2009/2010 show that domestic abuse accounted for 14% of all reported violent incidents, and that women were the victims in 77% of all cases. It is also recorded that domestic abuse has the highest rate of repeat victimisation of any serious crime with 47% experiencing more than one incident, and 30% more than three.

12.2; This review has examined the history of CP and her previously abusive relationships. It has also reviewed information held by the various agencies with regard to Children A, B, C and D, in order to ascertain whether there was any indication from the children's perspective as to what was happening in the family home. There were no disclosures by CP to any agency and no disclosures from any of the children with regard to how the relationship between CP and MG had deteriorated to an abusive one. The family of CP all confirmed that they were completely unaware of what was happening within the relationship.

12.3; With regard to MG, whilst there is a history of violence in relation to a number of recorded assaults, police information implies that this was as a result of his work as a bar or nightclub doorman.

12.4; There was the one incident of domestic abuse recorded for MG which involved his ex-wife, but there were no other explicit indications that his relationship with CP had also become an abusive one. However there were clear indications that his over reliance on CP could also be regarded as controlling and coercive behaviour

12.5; There are clear references to the fact that MG was 2 different people during his periods of care within psychiatric services, and by his own admission, he was both intimidating, which he enjoyed, but also fearful and insecure. Though in the latter months before CP's death his statements become more emphatic about people "looking at him the wrong way" and that he wanted to "hurt them".

12.6; There is no clear evidence from MG's regular medical practitioners, that they were concerned about his psychiatric problems, even when his symptoms changed. Medical records do not support MG's own disclosure that he was schizophrenic. Following on from this, the medication he received after a number of different assessments was tailored to the symptoms that had been medically diagnosed. On a number of visits MG stated that the medication was helping and that the voices, he had previously been experiencing within his head, had either subsided or were not as aggressive in their nature.

12.7; Reports do not make reference to any possible consequences with regard to MG's "dependency" within the medical diagnosis he was given for his mental health issues. Whilst it is understandable that someone who is particularly depressed and insecure, can become dependent on prescribed medication and support services over time. However, there is no indication as to what could happen when one person becomes totally dependent on another. Especially, as whilst the dependency was increasing towards CP, MG was experiencing delusional thoughts about CP and whether what she said was "true".

12.8; Given all of the above, there was still no firm evidence from any agency who had dealings with ANY family member that CP and MG were in an abusive relationship. Essex Police also had no previous knowledge prior to being called to the fatal incident. In all instances the expected level of service was provided, and the correct procedure followed. Whilst there were occasions where opportunities were missed, given that

there were no concerns raised, it is tragic to conclude that there was no way of predicting or preventing this horrendously violent act, which was perpetuated in front of CP's children. Whilst CP is the victim within this domestic homicide review, the fact that 3 children were present when the incident happened should never be ignored within the overall process.

12.9; Raising awareness of Domestic Abuse is and will remain an on-going issue both locally and nationally, and the Harlow Domestic Abuse Forum needs to continue with this as a major focus of its work, and also to establish a collective community understanding and responsibility.

APPENDIX 1

GLOSSARY OF ABBREVIATIONS

ABE	Achieving Best Evidence
ADAS	Alcohol & Drugs Advisory Service
ANK	Address Not Known
BESD	Behavioural, Emotional and Social Difficulties
BOP	Breach of Peace
CAFCASS	Children & Family Court Advisory & Support Service
CAIT	Child Abuse Investigation Team
CAIU	Child Abuse Investigation Unit
CCG	Clinical Commissioning Group
CDAT	Community Drug & Alcohol Team
CDC	Child Development Centre
CIN	Child In Need
CMHT	Community Mental Health Team
CPt	Child Protection
CPA	Child Protection Act
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution Home Team
CSC	Children's Social Care
CSF	Children, Schools & Families
DAAT	Drug & Alcohol Action Team
DASH	Domestic Abuse, Stalking & Honour Based Violence
DNA	Did Not Attend
ECC	Essex County Council
EPDS	Edinburgh Postnatal Depression Scale
EWO	Education Welfare Officer
FGC	Family Group Conference
GBH	Grievous Bodily Harm
HDC	Harlow District Council
HV	Home Visit
IRT	Initial Response Team
LLP	Limited Liability Partnership
MARAC	Multi Agency Risk Assessment Conference
MDT	Multidisciplinary Team
NEPFT	North Essex Partnership NHS Foundation Trust
NFA	No Further Action
PACE	Police & Criminal Evidence Act
PAH	Princess Alexandra Hospital
PNB	Pocket Note Book
PNC	Police National Computer
PSM	Pastoral Support Manager
SCF	Schools, Children & Families
SEPT	South Essex Partnership University NHS Foundation Trust

SET	Southend, Essex & Thurrock
SI	Serious Incident
SIA	Security Industry Authority
SSD	Social Services Department
WECCG	West Essex Clinical Commissioning Group
WIC	Walk In Centre

APPENDIX 2

TERMS OF REFERENCE, MARCH 2012

INTRODUCTION – decision to hold a review and timescales

This Domestic Homicide Review (DHR) is initiated by the Safer Harlow Partnership (the Community Safety Partnership for Harlow), in response to the death of CP on 15 July 2012, and is being undertaken in accordance with the requirements of the Domestic Violence, Crime and Victims Act (2004).

The Review will be undertaken following the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Review issued by the Home Office in March 2011.

On 17 July 2012 Essex Police notified the Chair of the Partnership Performance Executive of the Safer Harlow Partnership of the death of CP. The circumstances of the death fit the Home Office criteria for the establishment of a DHR.

The Home Office was informed of the decision to conduct a DHR on 27 July 2012 and the Domestic Homicide Review Panel ('the Panel') has six months from that date in which to complete the Review.

THE PURPOSE OF THE REVIEW

DHRs are not inquiries into how the victim died or into who is culpable. These are matters for Coroners and criminal courts to determine. Nor are DHRs specifically part of any disciplinary enquiry or process.

The purpose of the review is to:

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

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

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

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

THE SCOPE OF THE REVIEW

The following issues will be considered by each agency's Individual Management Review (IMR) and the Overview Report:

- Were practitioners sensitive to the needs of the victim and the perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

- Did the agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/ perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim, or perpetrator, subject to a MARAC?

- Did the agency comply with domestic abuse protocols agreed with other agencies, including any information-sharing protocols?

- What were the key points or opportunities for assessment and decision-making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered, or provided, or relevant enquiries made in the light of the assessments, given what was known or should have been known at the time?

- When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of the options/choices to make informed decisions? Were they signposted to other agencies?

- Was anything known about the perpetrator? For example, were they being managed under MAPPA?

- Had the victim disclosed to anyone and if so, was the response appropriate?

- Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

- Were senior managers or other agencies and professionals involved at the appropriate points?

- Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

- Are there ways of working effectively that could be passed on to other organisations or individuals?

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

- How accessible were the services for the victim and perpetrator?

- To what degree could the homicide have been accurately predicted and prevented?

EXPERT OPINION

- Mental health

TIME PERIOD OVER WHICH EVENTS SHOULD BE REVIEWED

Agencies are to supply all information related to any contact with the victim or alleged perpetrator where the IMR author feels that the information could relate to the identification of vulnerability issues; and to provide detailed information and analysis about all contacts that took place since January 2009.

Agencies should also include details and analysis of any relevant significant events or incidents which occurred outside of the time period, but which are, or may be, relevant to the case.

ORGANISATIONS INVOLVED

Following the scoping of the Review, the following agencies will be invited to have representation on the Panel and will also be required to submit an Individual Management Review:

- Essex County Council (Schools, Children & Families)
- Essex Police
- Princess Alexandra Hospital NHS Trust
- North Essex Partnership NHS Foundation Trust

The following agencies will also be required to submit an Individual Management Review but are not invited to have representation on the Panel:

- Stewards Academy
- Kingsmoor Primary School
- Lister Medical Centre
- Elsenham Surgery

The following agencies/individuals will also have a place on the Panel, either to provide expert opinion, or because they were not involved in the case and can therefore offer independent scrutiny to the Panel:

- Essex County Fire & Rescue Service
- Essex Probation
- Essex Safeguarding Adults Board
- Harlow District Council
- NHS North Essex
- Safer Places

INVOLVEMENT OF FAMILY MEMBERS

Consideration will be given to engagement of family members, if they can be identified.

PARALLEL REVIEWS

There are no parallel reviews being conducted in respect of this DHR.

Criminal investigation

The Panel will liaise with the Senior Investigating Officer in relation to the criminal investigation.

Essex Police are members of the DHR Panel, and any information shared as part of the Review may be referred to the Disclosure Officer by the Police representative as potential third party evidence, if they feel it may have an impact on the case.

Coroner's Inquiry

The Review will be completed and Overview Report written, but both will not be published or publicised until the completion of the criminal investigation.

MEDIA COVERAGE AND ENQUIRIES

The Review plans to bring together the relevant organisations' media teams to prepare a joint reactive media statement, once the Overview Report and Executive Summary have been finalised and approved by the Home Office for publication. Any media statement will be released only on the completion of the criminal investigation and publication of the review.

LEGAL ADVICE

The Panel and Chair do not anticipate requiring legal advice. If legal advice is required this will be sought from partner agency legal teams.

INDEPENDENT CHAIR AND OVERVIEW REPORT WRITER

Jackie Sully has been appointed the Independent Chair and Report Writer for this Review. Jackie has experience of Serious Case Reviews and is independent of the organisations involved in this DHR. She is the Chairperson of the Harlow Local Strategic Partnership and also Chairperson of the Harlow Voluntary Sector Forum.

LIAISON WITH THE HOME OFFICE

Liaison with the Home Office will be managed by Malcolm Morley, Chairperson of the Safer Harlow Partnership, or Lynn Seward, Chairperson of the Safer Harlow Partnership Performance Executive.

PROCESS

The Panel will review the DHR process on an ongoing basis and make recommendations to the Safer Harlow Partnership where developments to the process are identified.

Lynn Seward, Chairperson of the Safer Harlow Partnership Performance Executive will facilitate communication between the Panel and the Safer Harlow Partnership regarding the DHR.

APPENDIX 3

INTERVIEW WITH THE FAMILY OF CP

As part of the review process and after the trial of MG had been concluded, the panel Chair had the opportunity to meet and interview CP's mother and father, Mr and Mrs P, and to discuss any issues or concerns regarding their involvement with the investigation and various other processes to date. There was also the opportunity to discuss CP as a daughter and as a mother, and to ascertain their thoughts on how support systems and processes could be improved for women experiencing domestic abuse.

Both Mr and Mrs P were full of praise for the involvement and on-going support from the whole police team who were part of the case, and particularly for the officers who have acted as family support and liaison officers, who continue to offer a very well valued presence in their on-going challenge to get to grips with the untimely death of their daughter.

The following summarises the questions which formed the basis of the discussion:

1. **Tell me about CP**

CP was a fun loving bubbly person who enjoyed going out, and her family life. Having a number of siblings she was part of a tight knit family unit, where she supported and was supported by her parents, brother and sisters. CP's parents did not notice any difference in her behaviours or personality when she got together with MG, though she did not attend as many family events, and when she did he was constantly at her side. The family did not think anything of this and just accepted that this was "normal" within a new or relatively new relationship.

2. **What would you like us to know about CP's life?**

CP had known MG for a while before she went out with him. CP's parents said she knew him from his job as a doorman or "bouncer" in the clubs round the town, and used to chat to him when they saw one another. CP had been in a previous abusive relationship while she was married to Child B's father, and her parents had intervened once they found out that Adult B had been violent to CP.

3. **What would you like us to know about the relationship between CP and the perpetrator?**

The relationship between CP and MG appeared to be mutually supportive and caring. MG referred to CP's parents as "mum and dad", which other family members did not like. They observed that he always sat next to CP and placed his hand on her leg, which they took as a normal sign of affection, particularly within a new relationship. He accompanied CP during her numerous hospital and doctor's appointments, transporting her to and from surgeries and staying with her, which again was interpreted as caring rather than controlling.

They said that MG was obsessed with his looks and was always “working out”. They had no idea that he had classed himself as disabled and observed that the disability was part of a scam in order to avoid regular work and thus enabling him to claim unemployment and disability benefits, whilst receiving cash in hand on the doors of clubs etc.

They had been surprised to hear about MG’s mental health problems during the trial as MG apparently boasted that he never took pills, and this claim was further supported when the police discovered a vast amount of prescription medication in CP’s home after MG had been arrested. From other IMR reports it was recorded that MG had been described on numerous occasions by mental health services as being compliant with his prescribed medication. Mr and Mrs P did not recognise the person described as “depressive” and with a personality disorder. They described his behaviour as bullying and controlling rather than as a direct result of a mental illness.

In the latter stages of CP and MG’s relationship MG is alleged to have had other men sub-contracted to work for him so that he didn’t have to work himself (noting here that his own SIA license expired in 2011). They observed that MG was earning money indirectly via his supply of security staff.

NB This information was provided by CP’s parents, but was not corroborated. Mr and Mrs P observed that MG had a very difficult relationship with his own family which at one stage appeared to have broken down completely, and he appeared to have no contact with his immediate relatives.

Whilst they were not unduly concerned about MG’s relationship with CP there were times when things did not add up. With hindsight for example there was the occasion when MG collapsed on Christmas Day and was taken to the local hospital, but discharged himself later on the same day, as he wasn’t prepared to hang around for blood tests etc. At the time they accepted this reasoning but as time wore on they wondered why someone who had just had what appeared to be a heart attack would take off from hospital and self-discharge.

Since the trial they have received information that whilst MG was with CP he was having a parallel relationship with a woman who claims to have a 14 year old son by him. This fact was not known to the police and is something they have stated they will be looking into further.

4. **Were there any good times in the relationship?**

CP’s parents and extended family were completely taken in by what appeared to be a decent and caring relationship. CP did not disclose to anyone within the family, or as we now know, to any other agency that she was suffering domestic abuse in her relationship with MG.

5. **Do you know who CP turned to for help, if anyone, when she had suffered abuse?**

It appears that CP did not disclose the domestic abuse to anyone or give the slightest hint that the relationship was abusive.

6. Did CP try to talk to you or anyone else about the abuse she suffered?

See above.

7. Were you aware of the abuse? When/how did you become aware?

The true details of the relationship and domestic abuse did not come to light until after CP's death and at the trial of MG.

8. What kind of support might have been helpful to CP in order to stay safe?

It is very hard to identify what would have helped CP in this particular situation as there was no clue as to the domestic abuse within her relationship with MG, and never any indication given to family members or health professionals, even when it would seem that there could have been opportunities.

9. Is there anything else you would like us to know about CP's life?

It has been documented within the Essex Police IMR, that Mrs P visited CP after a family BBQ on the day that she died, and there was an assumption made that this was because there had been an argument between CP and MG during the course of the afternoon. Mrs P explained that she went to CP's house after the family event as CP had disagreed with her sister over a family matter and she had gone to make peace. She saw CP at the door and did not go right into the house. She did not see MG and assumed he was in the bedroom putting the youngest child (Child D) to bed. There was a good relationship with the youngest child but a more strained one with the 2 older boys (Child B and C) but this was assumed to be because being older the 2 boys were at an "awkward" age.

Neither Mr nor Mrs P had any idea that the handle had been removed from Child B and Child C's bedroom door, and locks fitted to the outside. The bedrooms were in another direction in the layout of the house, and they only ever went into the living areas. There has not been any explanation given by MG as to why the 2 boys (Child B and Child C) were locked in their bedrooms each night.

10. What message would you give to other families who are experiencing violence?

Victims must find a way to tell someone. However that is easier said than done, as it has to be acknowledged how clever and calculating perpetrators can be, and how easily controlling and bullying behaviour can be masked by pretence of caring and affection, especially within a new or fairly new relationship.

11. How would you like CP to be remembered?

The whole P family wish for CP to be remembered as the happy, lively and bubbly person she was. They also want her to be remembered as a good and loving mother who was devoted to her children.

Sadly the family now have the prospect of an appeal being lodged against the verdict and subsequent sentence of MG, which if accepted will mean that they have to go through the whole court process again.

On a more positive note it was reported that CP's children are doing well and Child C and Child D are living with Child A, who now has her own family. Child B is living with his father out of the area, but may return to Harlow and the rest of his siblings at some point in the future.

Mr and Mrs P would be willing to speak up and help any future campaign to highlight the issues of domestic abuse and to try and prevent any other family having to experience what they have had to live through. They have a very close family who are supporting one another through this terrible tragedy.

APPENDIX 4

ACTION PLAN

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
1. To ensure all NEPHT Care Coordinators, including medical staff, are aware of the need to provide carer's assessments and the relevant policy.		Completed	NEPHT	All Carers are offered CPA Carers Assessments in accordance with NEP Polices. Achieved.
2. In cases where only one NEPHT professional is involved in review and monitoring without any input from other professionals/team for more than a year, a MDT /peer review to be considered.		Completed	NEPHT	Achieved under CPA.
3. NEPHT care coordination role and responsibilities to be clarified and reiterated with regard to service users who attend only Outpatient Clinics, especially Trainee Doctor run clinics.			NEPHT	In progress.
4. If a service user has been attending a NEPHT trainee run review clinic for more than a year seeing multiple trainees, consideration to be given to moving that service user to consultant clinic and vice versa annually.			NEPHT	In progress, Junior doctors also have supervision to discuss cases with the consultant.

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
5. NEPHT risk assessments and management plans to be documented in Patient Records chronologically in an agreed manner.	Risk assessments and management plans will be easily accessible to all professionals involved.	Completed	NEPHT	Achieved. Remedy has resolved this issue.
6. Even in cases where only one professional is involved, a NEPHT team debrief to be organised following serious incidents to support the clinician and the team.		Completed	NEPHT	Achieved. It's part of making experiences count.
7. West Essex CCG to meet with Essex Police to discuss how primary health can fit into MARAC procedures.		20.08.2014	West Essex CCG Essex Police	WECCG is working closely with Safer Places on the Daisy GP Project. Part of the project involves supporting the practice to become involved in the MARAC process. The CCG will support the Daisy project worker to encourage Primary Care to engage with the MARAC process.
8. West Essex CCG to contact Social Care to discuss the possibility of named contact/ team for children's social care.	GPs will have better and more effective communication with the Social Care Departments.	Completed	West Essex CCG Social Care	GPs are able to contact social care for advice/referral through central Essex number-0845 603 7627. The number would support a call being transferred to locality of a named social worker.
9. West Essex CCG to contact Specialist Nurse, Domestic Abuse to arrange training programme.	A programme of further training regarding domestic abuse will be developed and agreed for all staff in GPs.	Completed	West Essex CCG	As of 01.04.2013 Primary Care contracts are managed by NHS England. GP practices are independent contractors and therefore accessing training via

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
			SEPT	the CCG is not mandatory. However, WECCG still has a responsibility to improve quality within Primary Care. Accordingly WECCG has set up a GP training calendar offering Safeguarding Adult and Children training (including Domestic Abuse). In addition to the above the CCG has delivered training to administrative and reception staff from practices in Harlow and Epping. A future date is planned for Uttlesford practices. More specialist training around Domestic Abuse is available through the Essex Safeguarding Adults Board.
10. West Essex CCG to obtain advice from Specialist Nurse, Domestic Abuse on a domestic abuse policy for general practice.	A written policy for Domestic Abuse for general practice.	Completed	West Essex CCG SEPT	ESAB Domestic Abuse Policy framework and cover letter sent out to all GP practices by WECCG on 03.04.2013.
11. West Essex CCG to develop (with GPs) an "in house" protocol for recording parental responsibility, a note where children have parents with different names, and a further note to ensure that siblings are linked on their health records.	Where children have different parents, GPs will add father's/mother's name to the child's records, ascertain who has parental responsibility for the child and link all siblings.	Ongoing	West Essex CCG GPs	An under18s registration form has been developed by named GPs. Following discussions with the Designated Nurse for Safeguarding Children and GPs it has been identified that this form is not being routinely used in all practices. Further consultation and work is required to ensure all practices

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				are using this new form and that relationships have been created in SystmOne.
12. SET Safeguarding Adults Guidelines to be added to all desktops in GPs, where necessary.	GPs will add the SET Safeguarding Adults Guidelines to all desktops for immediate availability as is the SET Safeguarding Children's Guidelines.	Completed	West Essex CCG GPs	SET Safeguarding Adults Guidelines emailed out to all GP Practices by WECCG. In addition, all relevant guidance and policies are available to all GP Practices via the West Essex CCG intranet.
13. GPs to have a simple toolkit of routine questions for each person to flag up indicators of domestic abuse.		Ongoing	West Essex CCG GPs	WECCG is working closely with Safer Places on the Daisy GP Project. Part of the project involves coaching clinicians and practice staff to ask pertinent questions and to refer cases on to the Daisy Project worker.
14. Domestic abuse incidents should be discussed at GP practice meetings in order to share information, highlight good practice and to develop better response options, as well as raising a greater awareness of domestic abuse.		Ongoing	West Essex CCG GPs	This best practice is encouraged by the CCG and reinforced by the Daisy Project.
15. WECCG should consider the appointment of a domestic abuse lead, which could operate within the whole adult safeguarding agenda. The post could lead on the		Completed	West Essex CCG	The lead for Domestic Abuse currently sits with the Safeguarding Adults Nurse Specialist at the CCG. Close working with the Designated Nurse for Safeguarding Children

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
roll out of specialist training and act as an information and expert resource to primary care.				occurs in cases involving children.
16. PAH domestic abuse policy to be ratified.	Domestic abuse policy at PAH will be ratified.	Completed	Princess Alexandra Hospital	Policy ratified 28.01.13.
17. Domestic abuse training programme to continue in PAH.	PAH staff to receive training in domestic abuse.	Completed and reviewed quarterly	Princess Alexandra Hospital	Since Jan 2012 -175 Staff have undertaken specific domestic abuse training. This includes training as part of the DAISY project for midwives, which is due to be rolled out to Accident and Emergency staff as another branch to this project.3/4/2014 - To date 215 staff have been trained within midwifery. The A/E project is underway and training has commenced with 31 staff having attended training since the project started in November 2013. ELearning is available and face to face training will recommence early June. All staff have domestic abuse awareness on induction and yearly updates as part of their safeguarding training.
18. Compliance by the Assessment & Intervention Teams where there is a recommendation from IRT for further action and	IRT have a number of tools to assist them in their risk assessment and decision making, therefore, Assessment & Intervention colleagues need		Children's Social Care	In the light of the findings from a Serious Case Review and from previous DHRs, together with an overall acknowledgement that multi-agency practice in this

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
intervention in cases where there has been domestic violence/abuse (as IRT have no further involvement after referral and no way of knowing whether the referral has been addressed as recommended).	to trust the judgements of their IRT colleagues and progress the recommendations made or there needs to be a reassessment of decision-making which involves the relevant team managers.			area needed to change, a decision was made in 2013 to set up a multi-agency Domestic Abuse team. Since September 2013, a Joint Domestic Abuse Triage Team (JDATT) has been established. The focus of this team is to provide a multi-agency response to all DV1s (domestic violence notifications), thereby managing risk more effectively and ensuring a more rapid and robust response to those DV incidents considered to be most serious. The JDATT team considers each notification within the context of relevant information held by Police, Social Care and other agencies. This includes analysing the history and patterns of previous referrals, and analysing and assessing the levels of risk involved. In relation to this specific recommendation, this is no longer considered to be an appropriate recommendation. The Assessment and Intervention teams will take very seriously the recommendations for action from the specialist JDATT team. The Assessment and Intervention teams must however have the right to

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				change the direction of a case or the interventions needed as they consider additional information and/or changes in circumstances. Within the new structure, the information that A and I teams now receive from JDATT should ensure that there is clear evidence of the need for further assessment.
19. Children's Social Care practitioners to ensure children are always seen and their views obtained. Practitioners need to ensure they are familiar with tools available to enable them to engage with children of different ages and understanding.	Practitioners will be able to gain a better insight and understanding of family circumstances and effects on the children's development when they have an understanding of the child's world.		Children's Social Care	This is now embedded as an essential component of the work with Children and families – in all situations. The expectation is that social workers will see and listen to children and young people to ascertain their views and feelings, with the emphasis on seeing the child/young person on their own wherever possible and appropriate. There are a range of tools available (and emphasised through Social Care training) to engage with children of different ages and understanding.
20. Initiatives devised by the Assessment & Intervention Teams in the North Quadrant to be rolled out.			Children's Social Care	These initiatives were piloted in one of the Quadrants in 2012 in respect of sharing information about a new partner's domestic abuse history; these initiatives

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				have however not been proceeded with as it was considered that in certain situations this may actually have been increasing the risks for potential victims of domestic abuse.
21. The Child Protection Co-ordinators in Children's Social Care to lead on a series of targeted practice workshops for social work practitioners	Practitioners will have better skills to assist them in their use of strengths based assessments.		Children's Social Care	This has been completed.
22. Children's Social Care practitioners to ensure: • That the detail of children of reconstituted families, step and half children and surnames of siblings are linked to each other's records. • Previous records held on SWIFT and paper case files should be added to children's current file. • Family history to be included on records of all individual children. • Information is uploaded onto Protocol in a timely manner to ensure information is readily			Children's Social Care	This recommendation is about improving the overall quality of recording practices, and co-ordinating effectively the details of family members with different surnames, addresses, especially in relation to re-constituted families. There has been a lot of work within Social Care over the past two years to ensure that all relevant information - names, relationships significant others, addresses etc. is always added to the electronic record. This is emphasised in the training of staff around recording, the use of paper files etc. and it is intended that the training will further emphasise this following on from this DHR.

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
available • Case records are linked to forms in a uniformed way – there must be clear reference in case notes to related forms.				
23. Implement a range of learning methods and measures throughout the operational services of Children's Social Care.	Reflective thinking will be encouraged.		Children's Social Care	This has been a priority within Social Care since 2011/12, in ensuring that workers are using a range of appropriate interventions according to the assessed needs of children and their families, and that the overall culture of the organisation has become one of continual learning and development.
24. DASH training to be made available to all Children's Social Care practitioners but essentially to those involved in the initial assessment and intervention process.	Practitioners will be able to develop a keen eye in assessing risk and develop their practice where there is domestic violence/abuse.		Children's Social Care	This was piloted in one of the Quadrants. The critical issue with DASH was considered to be that it only focused on certain elements in respect of Domestic abuse incidents, and that it was not holistic enough. The Police do complete a DASH at the incident, although understandably the quality of these has been rather variable. It is felt that certain elements of the DASH are useful in respect of assessing risk, but the DASH can be limiting of the whole

Targets	Outputs / Outcomes	Date for Completion	Delivery Partners	Progress as at 30.06.14
				picture.
25. Where there is a Court request for CSC to provide reports in relation to matters in private proceedings, Children's Social Care managers to ensure that all relevant statements have been obtained prior to completion of the report.	This will enable CSC to make a sound assessment and judgement about family functioning and whether there is a need for CSC to become involved with the family.		Children's Social Care	This is recognised and recommended as essential basic practice, and social workers are reminded of the importance of all statements being received prior to completion of the report.
26. Better use of and early referral for a Family Group Conference (FGC) by Children's Social Care.	Relatives will have a better understanding of members of their family, and will therefore be better placed and can be more instrumental in providing relevant safeguards and monitoring the welfare of the child.		Children's Social Care	There are clear guidelines in place in respect of referrals for Family Group Conferences – when these should be considered, the specific circumstances, the timeliness, and the processes involved.

APPENDIX 5

LETTER FROM HOME OFFICE QUALITY ASSURANCE PANEL

Safeguarding & Vulnerable People Unit
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Mr Malcolm Morley
Chair of the Safer Harlow Partnership
C/o Marina Sherriff
Harlow Council
Civic Centre
The Water Gardens
Harlow
CM20 1WG

21 May 2014

Dear Mr Morley,

Thank you for submitting the revised Domestic Homicide Review (DHR) report from Harlow to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel. I apologise for the delay in getting back to you.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear a lot of effort has gone into revising this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The revised document provides clarification and amendments regarding the points we raised in our previous correspondence to you. Ahead of publication of the report we would ask you to consider whether the continued absence of an IMR from the North Essex Partnership Trust particular to this case, leaves a gap in the evidence for this DHR

I have also noted at page 96 a reference to the prospect of an appeal being made by the perpetrator against the verdict. Appropriate advice should be taken regarding the timing of publication in the event that the appeal is successful, in order not to prejudice the appeal process.

Please also ensure the report is anonymised before publication, as all identifiable references, should be removed from all the documents, in order to protect identities and comply with the Data Protection Act 1998, in accordance with paragraph 73 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews

We do not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding and Vulnerable People Unit