Domestic Homicide Review

The London Borough of Croydon

Case of Janice

Chair Anthony Wills and Victoria Hill
November 2014

Contents

Introduction

Details of the incident

1.1 Janice (victim) had been out with her friends and she returned to a friend's address in the early hours of the morning to collect her car and then left. At 04.43hrs, Police were called to an argument outside Jacob's (perpetrator) address. Jacob had been in a long-term and intimate relationship with Janice but they were separated at this time, and they had a son together (Ethan). The Police attended and spoke with Janice and Jacob. The Police advised Jacob to go home (as they were in the street), which he did, and the officers offered Janice a lift but she refused this. She stated she was going to her friend's and then left the area.

1.2 Janice failed to collect her sons from a friend on the following morning at 08:00hrs as previously arranged. As this was out of character for Janice, and after attempts to contact her, the friend contacted the Police and reported her missing.

1.3 As part of the Police missing person enquiries, Jacob was interviewed by the Police two days later. Janice's body was located in the boot of Jacob's car the following day. He was subsequently arrested for Janice's murder. He was later charged with the murder of Janice. When cautioned, he replied, "I didn't murder her".

1.4 Jacob has been sentenced to eight years custody. The judge stated in his sentencing comments that this was not domestic abuse and therefore did not increase the sentence which that criteria, if present, would attract. The panel strongly believe that the judge's views show a lack of understanding of domestic violence and the nature of abusive relationships. The panel are clear that this is a domestic homicide and this review has proceeded on that basis.

1.5 Following his conviction, Jacob was written to seek his consent to engage in the review. He declined to participate in the review.

The review

1.6 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Community Safety Partnership (CSP) in the London Borough of Croydon. The initial meeting was held in early 2013 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death.

1.7 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.8 The purpose of these reviews is to:

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

1.8.2 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.

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

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

1.9 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

Terms of Reference for the DHR

1.10 The full terms of reference are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

DHR methodology

1.11 Pseudonyms have been used in this report for all individuals mentioned in the review.

1.12 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Janice, Jacob or the children. IMRs included chronologies for contact in the period agreed by the panel for the terms of reference for the review.

1.13 The time period subject to the review was January 2005 to the date of Jacobs charge for Janice's murder. It was also considered helpful to involve those agencies that could have had

a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

1.14 Croydon Safeguarding Children's Board did not undertake a serious case review and no other parallel reviews were conducted.

1.15 Once the IMRs and chronologies had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

Composition of the DHR panel

1.16 Agencies and services represented:

- Metropolitan Police – Croydon Borough and Critical Incident Advisory Team
- Croydon Council – Public Realm and Safety
- Croydon Council – Social Care and Family Support
- Croydon Council – Public Health
- Croydon Council – Adult Social Services and Housing[1]
- Croydon Council – Safeguarding and Looked After Children Service
- NHS England (Croydon Clinical Commissioning Group)
- Croydon Health Services NHS Trust
- London Probation Trust
- South London & Maudsley NHS Foundation Trust
- Croydon Council Family Justice Centre
- Standing Together Against Domestic Violence (chair).

(A full list of panel members is contained in Appendix 2.)

1.17 Throughout the review and until November 2013, the independent chair of the DHR was Anthony Wills. Anthony Wills was an ex-Borough Commander in the Metropolitan Police, and was previously the Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing effective, coordinated responses to domestic violence. Anthony Wills retired from Standing Together in November 2013 and also from his position as independent chair of this review.

[1] Croydon Landlord Services provided an IMR and a Chronology for the Review.

1.18 Anthony Wills was supported in this review by Victoria Hill, an associate consultant for Standing Together. Victoria Hill has fifteen years' experience of working in the domestic violence sector and she supported Anthony Wills in his role of chair throughout this review, drafting the overview report and has attended the panel meetings.

1.19 Following Anthony Wills retirement, Victoria Hill has taken on the role of the independent chair for this review. Both Anthony Wills and Victoria Hill have no connection to the London Borough of Croydon or with any agency involved in this case.

Overview of health services in the London Borough of Croydon

1.20 Due to the complexities of the different health services whom individuals involved in this review have had contact with; a brief overview of each organisation is provided for the reader below:

Croydon Health Service NHS Trust

1.21 Croydon Primary Care Trust was established as a provider and commissioner of services in 2002. Croydon Primary Care Trust (PCT) became the commissioning PCT in August 2009. Croydon PCT then became NHS South West London. In 2011 the Croydon Borough Team were responsible for commissioning services.

1.22 Croydon Community Health Service was the provider arm of Croydon PCT until the 01/08/2010 when it amalgamated with the Croydon University Hospital (CUH) and became Croydon Health Service NHS Trust. As of 2012, Croydon Health Service is now divided into four clinical directorates[2]:

- Adult Care Pathways
- Surgery
- Cancer and Core Functions
- Family Services.

[2] www.croydonhealthservices.nhs.uk/Downloads/Corporate_Information/Clinical%20Directorate%20Chart.pdf

NHS England

1.23 NHS England is an executive non-departmental public body. It works under its mandate from the government to improve the quality of NHS care and health outcomes, reduce health inequalities, empower patients and the public and promote innovation. Its key responsibilities include:

- Authorisation and oversight of CGGs and support for their on-going development
- Direct commissioning of primary care
- Specialised health services, prison healthcare and some public health services (including, for a transitional period, health visiting and family nurse partnerships)
- Developing and sustaining effective partnerships across the health and care system.

South London & Maudsley NHS Foundation Trust (SLaM)

1.24 SLaM provides a full range of mental health services: for people of all ages, from over one hundred community sites in south London, three psychiatric hospitals and specialist units based at other hospitals. It provides mental health and social care services in partnership with local authorities. Every year, the Trust provides about 5,000 people with hospital treatment and supports about 30,000 people through its community services.

Summary of contact with health services

1.25 The Croydon Health Service's Records (formally Mayday Healthcare Hospital and Croydon Community Health Services) show that Janice had ten Accident and Emergency (A&E) attendances during the period of the review. Janice and her two children had several interventions and consultations with the Children's Universal Services, to receive development, behavioural, maternal health and safeguarding advice. Janice and Aiden (Janice's eldest son with her previous partner David) had other meetings with the Consultant Child Psychiatrist for cognitive assessment of Aiden and they also attended the Family Support Centre five times. Aiden had one attendance to A&E in July 2007. Ethan (Janice's youngest son with Jacob being the father) had one attendance at A&E. Jacob attended A&E four times during the period of this review.

The Facts

Janice's death

2.1 Janice had been out with her friends in the evening and she returned to a friend's address in the early hours of the morning (at around 04:00hrs) to collect her car and then left. She was due to collect her children (from a friend who was looking after them) to take them to nursery at approximately 08:00hrs later that morning. A short while later, the Police were called by Jacob's current partner, to an argument at the address of Jacob's address who stated that Janice was knocking on the door.

2.2 Police attended and spoke with Janice and Jacob. They were having a verbal argument and no criminal allegations were made to the Police. Janice told the officers she went to his address to speak to him as he had been ignoring her and had not seen their child (Ethan) for five months since he had started a new relationship.

2.3 The Police advised Jacob to back to his home (as they were out in the street). He returned home and following an argument with his current girlfriend, she then left his address. The officers at the scene offered Janice a lift, which she refused. She stated she was going to her friend's and then left the area. The officers remained at the scene for about ten minutes whilst they completed their paperwork before leaving.

2.4 Janice failed to collect her sons from a friend at 08:00hrs later that same morning as previously arranged. This was out of character for her, so after several attempts to contact her, the friend contacted the Police and reported her missing. As part of the missing person enquiries Jacob was spoken to as a witness on the following day.

2.5 As concerns about Janice's whereabouts increased, Jacob was interviewed as a potential suspect by the Police. This led to his arrest and further interview.

2.6 Jacob made admissions in a Police interview to killing Janice. He stated that she picked up a claw hammer from the kitchen worktop and hit him, causing two minor abrasions on his forearm. A struggle ensued resulting in him pushing her backwards away from him using open palms. He stated that she hit her head when she fell to the ground. She was unconscious but breathing. He tried to rouse her but she stopped breathing. He stated it was an accident. He placed Janice's body in a bag, wrapped it in a sheet and placed it in the boot of his car, where it remained until he declared its location in Police interview.

2.7 He was subsequently arrested for Janice's murder. When cautioned, he replied "I didn't murder her". As a result of disclosures made in interview, his car was located, and Janice's body was discovered by Police officers in the boot of his vehicle. Janice's life was pronounced extinct by the London Ambulance Service at 14.52hrs.

The relationship between Janice and Jacob

2.8 The couple had been separated for a year following a long term relationship. Janice and Jacob had one child together (Ethan). Janice had another child from a previous relationship, (Aiden) with David. At the time of Janice's death, Jacob was in a new relationship (no domestic violence has been disclosed or reported in this relationship).

2.9 A family genogram is included as Appendix 3 to assist the reader.

The perpetrator – Jacob

2.10 Jacob is of Black British Caribbean origin. There was limited involvement with his GP from first registering as a child. He had an early history of road traffic accidents and alleged confrontation with the Police as a teenager. There are three contacts with Health Services which may be relevant to the issues being considered by the review:

2.10.1 In early 2000, Jacob attended his GP regarding swelling to his left hand allegedly having assaulted a policeman (outside the terms of reference of the review).

2.10.2 In the Summer of 2005, Jacob was seen with a fracture to his right hand, but there is no record of how this injury was caused.

2.10.3 Late in 2011, Jacob attended A&E accompanied by Police, after he had sustained a laceration near his left eye caused by a fight with another driver.

2.11 It is noted that Jacob had a different GP than Janice. He was known to the probation service.

Contact with agencies and services

Metropolitan Police

3.1 Janice had previous contact with the Police in relation to domestic violence with her ex-partner (David) in 2005 and 2006 (in 2004 there is also a domestic violence incident with a different partner – not David or Jacob where no further action was taken). The domestic violence incident in 2006 with David was a cross allegation. Both parties were arrested[3]. This was not progressed following advice from the Crown Prosecution Service.

3.2 The Police attended a domestic incident between Janice and Jacob on the night before Janice's death (see paragraphs 2.1 and 2.2 for details). Prior to this there was one domestic incident reported to the Police in September 2011.

3.3 The domestic violence incident between Janice and Jacob in September 2011 was following their recent separation. Janice had discovered that Jacob had apparently been unfaithful to her. Their child Ethan was staying with Jacob. Janice had been out and attended Jacob's address to confront him about the affair. Jacob refused to let her take her son and she then called the Police. The Police were unable to contact her and the Police operator tried several times to return the call. The operator finally spoke to Janice and she said that Police were not required. She then did not answer the phone.

3.4 The Police attended her address but the flat was in darkness. They spoke to neighbours who believed that Janice was not at the address and they did not raise any concerns. The officers re-attended the address the following morning. Janice was reluctant to speak to Police and stated that she felt embarrassed that she had called for Police as she was drunk and apologised. She told Police there had never been any violence or threats of violence from Jacob.

3.5 A Book 124D was completed and a SPECCS+ risk assessment was completed assessing the risk as a 'standard' risk. Background intelligence checks were conducted on both parties as a couple and correctly identified that there was no previous history. The officer created a Police Merlin report which was shared with children's social care a day after the incident in September 2011. Janice made no allegations and wanted no further involvement from the Police Community Safety Unit (CSU).

[3] Metropolitan Police practice has changed since this time and both parties are no longer arrested in situations of cross/counter allegations. Now when the Police investigate a counter-allegation, they evaluate each party's complaint separately to determine whether there was a primary aggressor. Officers avoid making dual arrests.

3.6 In November 2011, Jacob was involved in a collision with another vehicle. The other driver called the Police and stated that Jacob punched him in the head. Jacob denied driving and refused to provide a breath test. He was eventually cautioned for common assault and charged with driving offences. He was sentenced to ten weeks imprisonment.

3.7 On the night of the homicide, the Police were called to a domestic incident at Jacob's address by his current girlfriend at 04.43hrs. Janice had attended the address and was knocking on the front door and shouting. Janice went downstairs and a verbal argument ensued between them.

3.8 Officers found Janice and Jacob arguing in the street. No offences were disclosed to the officers. Both Janice and Jacob provided their details but refused to answer questions relating to a risk assessment. Jacob was advised to return to his home address. Officers offered Janice a lift somewhere, but she declined. She informed the officers that she was going to a friend's house but would not provide details of the address. She was last seen by Police walking towards a block of flats via an alleyway. Officers remained at the location for ten minutes whilst they completed their paperwork to provide a presence and to check that she did not decide to return.

3.9 A risk assessment was completed using DASH and this was graded as 'standard' based on the information available at that time. Background intelligence checks correctly identified one previous incident between them (although relevant, the history between Janice and her previous partners would not have been contained within a 'five year' intelligence check and so officers did not include this information).

3.10 This was the last time Police saw her alive.

NHS England (Croydon Clinical Commissioning Group)

3.11 Janice had a pregnancy confirmed at the end of 2004, and gave birth to Aiden in the Summer of 2005. No concerns were evidenced. Domestic violence is mentioned in her patient notes in May 2006 where she first showed signs of depression, and at the confirmation of her second pregnancy where she disclosed domestic violence with her ex- partner, David.

3.12 In August 2005, Jacob was seen at Croydon University Hospital (CUH) with a fracture to the right hand. There is no evidence of how this fracture was caused or discussion with the patient in regard to unexplained injuries and his previous history of accidents /injuries. There appears to be no consideration, as to whether there were any underlying issues which could

have been explored when seen at his GP surgery a few days later.

3.13 From May 2006, Janice saw her GP for a variety of health issues. She disclosed poor sleep, feeling low and tearful for no reason, and problems coping with child care. She was described as not suicidal and prescribed Temazepam.

3.14 In 2007, Janice attended Accident and Emergency (A&E) Croydon University Hospital (CUH) with a laceration to mouth, lip and jaw. There was no reason noted for this injury or any follow-up arranged; although she continued to be seen from July 2007 until November 2007 for treatment for eczema by her GP.

3.15 From March 2008, Janice started to raise concerns regarding Aiden's behaviour within the home and at school, which eventually resulted in the first Children Adolescent Mental Health Services (CAMHS) referral in November 2010.

3.16 In February 2009, Janice was seen by a GP in relation to stress at work and stress avoidance advice was given. In August 2009, the pregnancy with Ethan was confirmed and Jacob was noted as the father. She was seen regularly by the midwife and GP regarding antenatal care and was screened for depression on every occasion she was seen. She was seen in A&E regarding vaginal bleeding. Early signs of possible depression were identified in the last month of the pregnancy although no action was noted.

3.17 During 2011, Aiden was seen by a number of specialists within SLaM and a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) was confirmed by the end of 2011. During this time, Janice reported Aiden was becoming more violent and aggressive and in January 2012 she wrote to the GP requesting help with seeking larger accommodation. There is no evident documentation of a response from the GP Practice to this letter.

3.18 In November 2011, Jacob attended CUH A&E after a 999 call at 09.30hrs having sustained a laceration to the left side of his face. This was following the "road rage" incident where the Police were involved. There is no evidence in the patient's notes of any explanation for the injury nor any follow-up or concerns raised regarding his previously mentioned wife (Janice) and children in relation to safeguarding issues.

3.19 The youngest child, Ethan, was seen on two occasions in A&E at CUH:

- December 2011 at 11.13hrs for a head injury
- March 2011 at 09.23hrs after perfume was sprayed in his eyes

3.20 There were no further actions for these two attendances.

3.21 From February 2012, Janice's patient notes detail that she was finding it difficult to cope with the children. She sought advice from her GP in relation to headaches and a recent family bereavement. Struggling with the children is a consistent theme throughout 2012. It is not until September 2012 that it is recommended by the GP that Janice should seek advice from the Health Visitor. The way it is recorded suggests that Janice was responsible for organising this help herself rather than a referral made for her by the GP.

3.22 During mid-May 2012, Janice contacted the surgery complaining of headaches and low mood. She was tearful and concerned about her older son and stated that her relationship with her partner had ended. Janice was screened for depression with a score of 23/27, which is considered high. Her presentation was noted as being low in mood. She expressed that she wished 'she was dead' and had tried taking tablets with alcohol, though her friends found her. She said that this had scared her, but she would not harm her children and was not considered suicidal or psychotic at that point.

3.23 There was no documentation of discussion of a Mental Health referral or concerns regarding any risk to the children. Antidepressants were prescribed and reviews of her depression continued on a monthly basis until October 2012, with continuation of antidepressant medication throughout. There is no evidence of depression screening being conducted during that period or documentation of discussion of any Mental Health referral or concerns regarding any potential risk to the children. Janice was receiving treatment for hair loss which could have been considered a result of the stress she was experiencing. There was no record of her medication being reviewed at any of these consultations.

3.24 From June 2012, it is noted that Aiden required 1:1 teaching support and a specialist curriculum to meet his needs. Janice requested a referral in September from the GP practice to CAMHS. It is noted that Janice reported that Aiden was becoming more challenging at school, that she had financial problems and was on antidepressants.

3.25 In July 2012, Aiden attended the Minor Injuries Unit in Weymouth Dorset having fallen over in a caravan park. There was no further action and a letter was sent to the GP to follow-up. A letter was sent to Janice to follow-up with an appointment for the head injury, but there is no record of such an appointment for this event with the GP practice.

3.26 In September 2012, Janice requested a referral for her older son to CAMHS. She stated that She felt 'lost' in the system and a referral was then made to CAMHS and she was advised

to contact her Health Visitor for support.

3.27 Aiden was last seen by the GP Practice in October 2012 due to an injury at school having been pushed over by another child.

3.28 CAMHS tried to contact Janice by phone also by letter in October and December with no response and the case was closed.

3.29 In October 2012, Janice saw her GP and reported continued depression and on-going issues with her children and was observed to be very low with the current situation. She requested time off work to deal with documentation regarding her older son's educational needs and stated she had approached Children's Social Care for help and support at home. Her last consultation with her GP was in early November 2012 and had no reference to previous concerns. Janice's last contact with the GP surgery was at the end of December 2012 for a repeat prescription for hair loss treatment.

Croydon Council – Family Justice Centre

3.30 There was only one contact recorded in September 2011. This was following a non-crime domestic incident following an argument with Jacob. The FJC were unable to confirm the source of this signposting contact but from cross referencing the IMRs it is thought to have been Croydon Landlord Services who signposted Janice to the FJC. No details of the children were given. The FJC left two messages on Janice's phone in September 2011 and there was no response recorded or any direct contact with her.

Croydon Council – Adult Social Services and Housing

3.31 Information from Croydon Landlord Services highlighted that Janice had experienced domestic violence from her previous partner (David). It also stated that she was evicted from her YMCA hostel because she was pregnant in 2002. There is no evidence of what additional support she was offered in relation to the domestic violence and being a pregnant teenager and a young mother.

3.32 Between August 2005 and March 2006, Janice was housed temporarily in council accommodation. Following an assault by David she was given a sponsored tenancy. In May 2009, Janice was offered a secure tenancy and then there was no further contact until 2011.

3.33 In September 2011, Janice was interviewed by a duty officer. In this interview she disclosed the previous assault (in 2006) by David and talked about her fear as she had recently seen

him again in the local area where they had an argument. She also disclosed her current partner (at the time) Jacob had assaulted her. Janice was signposted to the Family Justice Centre, but there is no information on what follow-up action was taken and if she attended.

3.34 In October 2012 Janice made a complaint regarding youths congregating in her housing block. There was an incident when she approached them with a hammer, but no apparent assault took place. The Police were called but they received no information about a hammer or any details regarding suspects and no further action was taken. There is no further information available about this incident.

Croydon Council – Children's Services

3.35 There were four contacts between late 2005 and 2006 (of approximately a year in length). These were a result of notifications from the Police Merlin system, for issues of domestic violence (due to non-retention of records no further information was available to the review). There were six contacts in total in respect to Janice and her children (the first was December 2005, and the last contact was in September 2012). The last two are described below.

3.36 In July 2011, Janice made direct contact herself with Children's Social Care regarding a request for respite care for Aidan. This information was recorded on the system but no action was taken. There was no evidence of discussions with other agencies about her approach for help or why no action was taken.

3.37 Janice contacted Children's Services in September 2012 stating that she was struggling to cope with the children. This was progressed to an initial assessment undertaken by the Children With Disability Team. Aiden did not meet the criteria for services, and the assessment stated; *"it remains clear that Janice needs additional support and is near breaking point".* Janice disclosed her concerns about his behaviour and stated that Aiden's father's input and support was ad hoc. Apart from a resource pack, there is no evidence of what further enquiries were made to in order to support Janice and Aiden.

3.38 In October 2012, the Education, Placement and Provision Panel agreed to increase Aiden's teaching assistance to 32.5 hours, mainly as a result of Janice's persistence in seeking this support.

Croydon Health Services NHS Trust

3.39 During the time period covered by this review, Janice attended A&E on ten occasions. Two of

the ten could be deemed to be for domestic violence related injuries (September 2006 and March 2011). There were a possible three other injuries that could have been domestic violence related injuries, but insufficient information was recorded to confirm this. Janice, Jacob and Ethan had contact with Children's Universal Services for development, behavioural, maternal health and safeguarding advice. There is no evidence of any domestic violence enquiry being conducted.

3.40 Prior to the time period subject to this review, Janice came to the attention of Croydon Health Services when she was pregnant. Janice was a teenager (17 years) and there is no evidence whether domestic violence was considered or discussed during her antenatal care.

3.41 In May 2005, Aiden was born and the records state that there were no disclosures of domestic violence in her maternity records. It is unconfirmed but there is no evidence that Janice was ever asked about domestic violence.

3.42 In September 2006, Janice attended A&E with an injury to her arm. Janice disclosed domestic violence with her partner at the time (David - father of Aiden). There is no record of what advice or support was offered to her following this disclosure. There is also no record of what safeguarding action was taken regarding Aiden being exposed to domestic violence.

3.43 In July 2007, Janice attended A&E with an injury to her inner lip. There was no information of how this injury was sustained.

3.44 During her pregnancy with Ethan, Janice disclosed past domestic violence with her previous partner (David) to health professionals. The records do not mention any issues or concerns about her current relationship or what advice was given.

3.45 Domestic violence was also not apparently considered when pregnant and when she attended A&E with vaginal bleeding (on two separate occasions in January 2005 and September 2009).

3.46 In December 2010, Ethan was seen at A&E after he sustained a head injury when a TV unit and a DVD player fell on his head. During the consultation she disclosed that her partner was at work, that they were not separated but did not live together. There were no further explorations of the family dynamic. This incident was subsequently assessed by Health Visitor Liaison.

3.47 In March 2011, Janice attended A&E with an injury to her right hand, stating that her partner had squeezed her hand. There is no record of what advice was given regarding domestic violence. No safeguarding children referral was made.

3.48 In December 2011, the records note that Aiden and Janice were seen by the Consultant Paediatric Psychiatrist from SLaM to complete a cognitive assessment. During this consultation, Janice spoke about her past experiences of domestic violence and emphasised that Aiden had not witnessed the violence. There is no mention of Jacob and any relevant concerns.

3.49 In June 2012, Aiden was discharged from the Enuresis Clinic, for bedwetting (having never attended the clinic) due to unsuccessful attempts to contact Janice.

3.50 In October 2012, the Education, Placement and Provision Panel agreed to increase Aiden's Teaching Assistance to 32.5 hours.

London Probation Trust

3.51 Jacob was known to probation. He carried out two Community Orders for unpaid work. These orders have no statutory requirement to undertake supervision. A full risk assessment was not required. He completed both orders. He also went to prison for driving whilst disqualified which originated as an arrest for common assault.

3.52 The first order was made in 2007 for eighty hours unpaid work, which he completed without any issues in three months. The second order was made in 2011 for one hundred fifty hours unpaid work and was completed in twelve months. He had twenty-four acceptable absences, the majority being in relation to child care issues.

3.53 All of the information regarding the assault in 2011 against another driver was not available to Probation. That information would have led to a full risk of harm assessment being conducted. The information available to probation showed that he did not have a history of violent or aggressive behaviour. The available information showed his offending history to be all driving related.

3.54 Janice was not known to probation.

South London & Maudsley NHS Foundation Trust (SLaM)

3.55 SLaM had no treatment contact with Janice.

3.56 SLaM had contact with Aiden (Janice's son) concerning his assessment and diagnosis. It was recorded in his history that Janice had experienced postnatal depression in relation to domestic violence, but there were no concerns noted regarding domestic violence at the time of Aiden's assessments.

3.57 Aiden was referred CAMHS in the September 2010 for an assessment following concerns raised about his behaviour by his GP. This referral was supported by an educational psychologist who noted an assessment for possible ADHD and ASD. Aiden was placed on a waiting list and his first appointment was in the Spring of 2011. Janice was provided with information about respite care.

3.58 The next recorded assessment was much later in November 2011. Janice was not present at the assessment. Feedback was given, and it was noted that Janice was fearful that Children's Social Care would remove him due to his problematic behaviour as she feared she would be blamed for this. Following the assessment there were several telephone calls to Janice in December 2011 and early 2012. Contact was not established until the Spring of 2012. Further appointments were made but Janice cancelled these.

3.59 Further contacts were made and messages left for Janice from April to September 2012, but it was considered that she had withdrawn from the service because she did not attend arranged appointments. In January 2012, Aiden was discharged from CAMHS because of non-engagement. A letter was sent to both Janice and the GP informing them of this decision, which also offered Janice the opportunity to re-engage with the service.

Contact with family, friends and other people who knew Janice and Jacob

3.60 Family members of Janice have been approached about contributing to the review. Friends did express an interest in involvement but despite several attempts and conversations this has not taken place as they have not responded to invitations to meet. Similarly Janice's father was contacted by Anthony Wills, but has not subsequently responded to requests for further involvement.

3.61 Janice's mother contributed significantly to the review. Her concerns centre on two areas. First she believes that the action of the Police when called to the incident on the night Janice disappeared should have been more effective. This is discussed further in the analysis section. Secondly, she feels that all the agencies that had contact with Janice should have recognised her needs and responded more effectively, both individually and together. If she had been provided with the support she needed her situation may have been more

manageable and reduced the possibility of the outcome in this case. This accords with the findings of this review.

Analysis

4.1 The review of Janice's contact with services shows a resourceful woman who accessed general practice, emergency services and requested help via the educational system, CAMHS and Children's Services. It is noted that although she was resourceful and proactively asked for help, services did not respond to her appropriately and she did not receive the information and help she needed.

4.2 It is recognised that victims can often fall through gaps in services, and this appears to be what happened to Janice. Despite her proactively seeking help, a sense of her feeling lost in the system emerges from the IMRs. She was attempting to access services but there was no lead agency who took responsibility for her needs and coordinating support for her and the children. This is recognised as being a symptom of poor inter and multi-agency work and it is widely agreed that a coordinated community response to domestic violence can help address the issue of a victim being isolated in the community.

4.3 Throughout the medical records it is evident there were increasingly concerning issues with regards to her health and wellbeing and that of the children. There is no evidence of any safeguarding issues discussed, referred or documented in the medical records (other than allegations of assaults from 1996 – not domestic violence related).

4.4 She attended health services frequently (for her children and herself) for on-going medical and social issues with evidence of stress related issues. Janice was open to disclosing her problems and concerns with professionals. A systematic approach to follow-up her concerns (about her depression and stress) was lacking.

4.5 Janice appeared to be isolated and vulnerable. She contacted Children's Services directly herself on two occasions specifically requesting support. These concerns were not addressed. Given her fears of involvement by Children's Social Care, it is significant that she decided to approach them herself as she was seemingly struggling to cope with her young children and was desperate for help. The panel felt that Janice was perhaps becoming overwhelmed by her situation and was under great stress, (as evidenced by her request for support from Children's Services, and the incident in 2012, when she approached youths by her home with a hammer (unconfirmed). The response to Janice should have been more positive. Early help and support should have been put in place.

4.6 Around mid-June 2012 there is evidence of Janice's increased frequency of consultation with the GP regarding her ability to cope with the children, working and her increasing stress and depression, as well as her other physical health problems.

4.7 In the last months of 2012, it is evident that Janice was seeking support from health and Children's Social Care agencies to support and help her with both children. The GP records show no documentation regarding her support networks other than not seeing her friends often and there is no mention of family support. There is also no evidence of referral or discussion in relation to the risk assessment of the family unit by Children's Social Care, in particular the children's needs in terms of parenting and the impact of the older son's diagnosis and behaviour towards his younger brother.

4.8 It is recognised that Aiden's formal diagnosis of ADHD would have been a time of considerable stress for Janice. She relied on Jacob for child-care and support (also his mother who would often have the children over-night). It is unclear what other support she had available. The Police account of the incident on the night before Janice's death was described as an argument between her and Jacob. It appears that she had become increasingly frustrated about the lack of consistent support with the children from Jacob since he had started a new relationship. Janice was left alone to manage and parent the children.

4.9 At Janice's first contact with Croydon Health Services in December 2004, she was a pregnant teenager. The social information was left blank; although, she had previously been evicted from a YMCA hostel and this information did not lead to further exploration of her circumstances. During this pregnancy, there is no evidence that she was asked about domestic violence (in 2004 routine enquiry for domestic violence during pregnancy became national policy). In addition, the vulnerability of being a teenage mother does not appear to have been considered. The high risk of experiencing domestic violence as a pregnant teenager was also not recognised[4].

4.10 The 2006 domestic incident (with Janice's previous partner) was not progressed as the Crown Prosecution Service decided that there should be no further action. After long discussion, the panel felt that this case highlighted inconsistencies that still existed in charging discussions with the Crown Prosecution Service. Work is now happening regionally across south west London Boroughs between the Police and the Crown Prosecution Service to improve prosecution practices for domestic violence cases. The panel have welcomed this work.

[4] Harrykissoon S, Rickert V, Wiemannet C (2002) Prevalence and patterns of intimate partner violence among adolescent mothers during the postpartum period. *Archives of Paediatrics and Adolescent Medicine* 156(4): 325-330

4.11 Despite Janice's and Jacob's refusal to answer questions relating to the DASH risk assessment, (at the incident in January 2013), the reporting officer still completed the Book 124D and conducted a risk assessment on the information available to him. The 'standard' risk assessment was appropriate in these circumstances. There were limited options available for the police officers dealing with Janice as they had no powers to detain her. They considered taking her away from the area to another address, but Janice refused. The police officers waited at the scene whilst they completed their paperwork to see if Janice returned after she declined a lift from them. This is standard Police practice to provide a presence at the scene.

4.12 Janice's mother believes that this could be considered differently. Whilst she accepts that the officers remained at the scene, she believes that Janice was so vulnerable that they should have taken other action. She feels that their positioning did not prevent Janice from finding a different route back to Jacob's property. Apparently Janice also had no coat and no shoes and was evidently (from CCTV pictures) very cold. This was the depths of winter and in the early hours of the morning. Her actual words were that they (the Police) "failed to protect the vulnerable". She accepts that Janice may have been emotional at this time, but she felt that her needs and their skills should have led to a more pro-active approach. Her belief is that the Police should be better trained in circumstances such as these and be more empathetic.

4.13 Of course much Police action is based on their lawful powers. There is no evidence of any crime (and there was no evidence of drunkenness) so arrest was impossible. Whilst Janice was undoubtedly vulnerable in the sense that she was wearing little clothing on a cold night, this in itself is insufficient to take any action under other powers such as the Mental Health Act. Janice was very clear that she believed the Police had no power to detain her.

4.14 Janice had a history of domestic violence within her previous relationship (David), which she disclosed to health professionals. The response from services (and her experience of services as a teenager) may have impacted on her willingness to report any future domestic violence incidents and having faith in getting the support she needed.

4.15 There was no evidence that she was ever directly asked about her relationship with Jacob. It is possible that her help seeking in relation to domestic violence may have been limited by her own fears that she voiced to CAMHS about being blamed for Aiden's behaviour as a result of him being exposed to domestic violence in her relationship with David. This may have been a factor in deciding not to engage with services because of her fear of him being removed by Children's Social Care.

4.16 The information contained in the Police IMR, which details Jacob's offending history, gives a very different view of the individual than is reflected by the assessments and the account of the Probation Service. The incident of "road rage" would have perhaps altered their risk assessment in terms of the risk of harm he posed to others.

4.17 The limited information shared with Probation on his previous convictions supports the argument that the questions asked by the Probation Service as part of their intelligence checks need to be improved and more specific. Access arrangements to the Police National Computer may need to be improved so that Probation can have direct access to a person's up-to-date offending history so that their work is better informed and based on all information held on the individual. The Police should help support this process by sharing all relevant details on offenders as part of these intelligence checks.

4.18 It was confirmed that Janice and the children were held as part of a corporate caseload within Croydon Health Visiting Service. This meant she did not have a named Health Visitor, despite the issues and concerns identified by different agencies, such as:

- Aiden's problematic behaviour.
- Aiden's diagnosis of ADHD.
- Janice's approaches to Children's Social Care for additional support with the children.
- Janice's disclosure to CAMHS that she was struggling to cope with the children.
- Janice's later disengagement with CAMHS.
- Janice's previous history of domestic violence.
- Documented issues of Janice's isolation and lack of support.
- Janice's experience of postnatal depression in the context of domestic violence experienced with her previous partner David, (and that she had been a teenage parent).
- Janice's high score of stress and depression.

4.19 Croydon Health Services has confirmed that the caseload estimate is 540 children per Health Visitor (this calculation is based on current establishment of fifty-four whole time equivalent Health Visitors and mid 2011 Croydon population estimates for children of 0-4 years). This is significantly above the Laming Report (2009) recommendation of a maximum of 400 children and the Community Practitioner Health Visitor Associate who recommend 250 children per case load if complex/vulnerable. The panel felt that high caseloads were a concern. The Health Visiting Services were simply not aware of all the issues Janice was confronting. It is agreed within the panel that had the GP referred Janice then a named Health Visitor could

have been nominated and they could have been a lead agency for providing and coordinating support through the Common Assessment Framework (CAF) system to provide early help to Janice.

4.20 Being held as a corporate caseload in the Health Visiting Service would have no doubt lessened opportunities for Janice to have been asked about her relationship and how the family was coping. High caseloads with the Health Visiting Service would have meant it was difficult for staff to identify concerns and to address these issues.

4.21 Since 2008, Croydon Health Services have used the local Safeguarding Children's Board Domestic Violence Policy. They do not have a specific policy of routine enquiry for domestic violence by Health Visitors. The local Safeguarding Children's Board Domestic Violence Policy requires an update. Midwives and Health Visitors should ask about relationships and the possibility of domestic violence. These professionals often experience difficulties in conducting enquiry as the woman is accompanied to appointments by their partner and other family members, or they are present at home during the new birth visit. Organisational policies are needed to help support midwives and Health Visitors conduct enquiry in a safe, appropriate and confidential way. Although Janice disclosed past domestic violence (with her previous partner), records do not confirm if she was ever asked during her antenatal care when she was pregnant with Ethan.

4.22 The situation of Jacob being registered with a different GP practice may have reduced the consideration by the GP of the "Think Family" safeguarding approach, in relation to possible risks to his ex-partner and children and their safeguarding obligations.

4.23 Jacob's previous convictions for driving offences could suggest there was an element of recklessness in his thinking and behaviour. His caution for common assault confirms his recklessness and disregard for personal safety and the safety of others. On review of his probation records, he had a significant number of authorised absences from his unpaid work to cover child-care. These absences and the child-care arrangements were not explored by his supervising officer, which had they have been, may have given an indication of the dynamics of the relationship with Janice and how the family was functioning.

4.24 Information on his caution for common assault was not supplied to Probation. The Probation Service relies on checks on past offending to be conducted and shared with them by the Police. It was thought that the caution may have overlapped the time period when the check was conducted and when Jacob's list of convictions was updated, which may account for it being missed.

4.25 Despite attempts made by SLaM, Janice did not engage with CAMHS, which led to them eventually formally discharging the case. It is accepted that their primary focus was responding to the needs of the child, yet this case has highlighted a conflict between attempts to engage with the parent and providing treatment to the child. The parent has a right to disengage and decline the offer of service, which should be a concern when there may be safeguarding children issues. It is concerning that there was no liaison between CAMHS, the GP and Croydon Children's Services about the disengagement or any follow-up of the concerns raised in the assessment by Janice about struggling to cope and a child who was in real need of help. That should have taken place.

4.26 The GP was an important conduit of information between the family and other services. Information sharing was limited between agencies which the GP could have been better placed to facilitate and support. There was no follow-up of contacts and each consultation was viewed in isolation.

4.27 The response of A&E to the family was isolated and operated without any effective connection to the multi-agency response to domestic violence (and the safeguarding of children). Attendances were viewed in isolation not as a pattern of need.

4.28 Janice disclosed to maternity services her previous history of domestic violence with David. The relationship with Jacob was never explored. It is important that every opportunity (particularly during ante and postnatal care) is utilised to provide messages around domestic violence and the support services that are available. This is relevant and essential as research shows that pregnancy is a heightened risk factor for domestic violence[5].

Themes identified in this review

4.29 **Information Sharing**

4.29.1 There was very little sharing of information about the family's issues between Health Services (particularly the GP and CAMHS). The contacts with Children's Social Care were not shared with Health Visiting Services which could have prompted a CAF and an offer of early help to the family being made.

4.30 **Role of universal services**

4.30.1 Janice had regular and ongoing contact with her GP. Despite the

[5] Lewis, Gwynneth, and Drife, James (2005) Why Mothers Die 2000-2002 - Report on confidential enquiries into maternal deaths in the United Kingdom (CEMACH). *For more research on domestic violence and pregnancy visit http://www.womensaid.org.uk/page.asp?section=000100010010000400020003#7*

issues the family were experiencing, she remained as a corporate caseload within the Health Visiting Service. A named Health Visitor whom she may have been able to develop a relationship with and to whom she could disclose concerns would have been beneficial.

4.31 **Early intervention and family support**

4.31.1 Exploration of a CAF and "a team around the family", (with one lead professional to coordinate support for the family) would have been appropriate, considering Janice's request for respite care, her disclosure to Children's Services about struggling to cope and her the approach to CAMHS (and subsequent disengagement from the service). More is needs to be done should t engage positively with who approach Children's Services for help, especially when they do not meet the threshold for statutory intervention.

4.32 **Risk Assessment**

4.32.1 A&E did not consider risk assessment in their contact with Janice. Identification of risk and safeguarding concerns were not explored, which was highlighted by the A&E safeguarding prompts not being utilised. Despite disclosures of past domestic violence to clinicians (both maternity and at CAMHS), issues in relation to the relationship with Janice's current partner (Jacob) were not considered.

4.33 **Understanding and awareness of the dynamics of DV and its impact**

4.33.1 The review of the IMRs document several disclosures by Janice of domestic violence in her previous relationship with David. There was no evidence that she was ever asked about her relationship with Jacob despite her stating that they had separated. The issue of domestic violence was not explored by the clinicians Janice came into contact with even though she shared her concerns about the impact on Aiden of him previously witnessing domestic violence. When Janice was pregnant with Aiden (when she was a teenager) the reality of domestic violence was not considered.

4.34 **Role and function of the Family Justice Centre**

4.34.1 The IMR process highlighted issues with record keeping and follow-up systems within the FJC. In September 2011, Janice was referred to the FJC by Housing but there was little detail in either of the IMR about this. The one occasion of signposting Janice to the FJC was not followed up by the originating agency. The

difference between signposting to a service and a proactive referral needs to be agreed at a Borough level so that staff understand their responsibilities and act to follow-up these.

4.35 **Mental Health**

4.35.1 Janice was routinely screened for depression as part of her antenatal care. Early signs of depression were noted but there was no follow-up. Janice later had a high score for depression (23/27) but was never referred to a specialist service. It has not been possible to establish why this did not happen given that Croydon has an established Peri-Natal Mental Health Service. Janice's Health Visiting records had no evidence of her depression.

4.36 **Role of health services**

4.36.1 Janice and her two children had regular contact with the GP and also contact with CAMHS. The issues Janice was openly raising to her GP were not progressed and the disengagement from CAMHS was not followed-up. It appears that the GP could have been a more effective conduit for a system of coordinated support for the family.

4.37 **Disengagement with services**

4.37.1 The IMRs suggest that Janice was struggling with a number of difficulties. She had considerable contact with services (Health) but there was disengagement with CAMHS and she became isolated with little support.

4.37.2 The treatment offered by CAMHS did not meet the needs of Janice nor was it appropriate. Given the concerns Janice raised about her child's behaviour, a group treatment environment something she had already stated she was struggling with. This may have been too difficult for her to engage with. She stated she was isolated and struggling with all the demands on her. She approached her GP for support as she was balancing a lot of competing demands on her time.

4.37.3 Janice was referred to and from agencies. No one agency or professional took responsibility for following actions up. The panel can only offer suggestions as to the reasons why Janice did not engage with CAMHS, but the on-going pattern of being passed around services must have caused her frustration and influenced her decision to discontinue contact. All services must examine the reasons why some clients disengage, and use this information to help shape their services and systems to be

more client-centred and accessible. Professionals need to be equipped to understand the parental right to refuse or disengage with a service, against the dynamics of safeguarding responsibilities and supporting vulnerable families.

4.38 **Culture of questioning**

4.38.1 There was a general failure to ask appropriate and sensitive questions about the circumstances Janice's social life. A&E clinicians need support and training so that they are able to conduct clinical enquiry for domestic violence. Consistently, there was missing information following contact with A&E. The quality of general clinical enquiry for treating presenting injuries appeared to be at a minimum. Basic factors relating to causes of injuries are not explored or recorded, along with a lack of detail on what the clinician asked as part of their investigations and what response was given by the patient.

4.39 **The role of fathers**

4.39.1 Jacob's role as a father was apparent in the Probation account, but other than that, he is invisible in other agency accounts (in contact with his child and with Janice). Despite the number of absences recorded on his unpaid work order with The Probation Service (due to child care issues), there was no exploration of his family dynamics or his relationship.

4.39.2 Following the separation Janice may have been viewed as a lone parent. There was no evidence that this issue was considered.

4.40 **The "Think Family" approach to safeguarding**

4.40.1 Health Services, particularly the GP, appear to have struggled to see the connection of the various issues facing the family. There was a lack of understanding of the family history. Incidents, presentations and consultations were viewed in isolation.

4.40.2 GP's need to consider all aspects of the family to improve their risk assessment and safeguarding responses. They should consider both children and adults in the family concerned to make an informed holistic assessment. This would help to improve referral practices and identifying early safeguarding concerns (the past history of unexplained injuries resulting in A&E admissions emphasises this point).

4.40.3 Janice's stress and depression was not seen as ongoing (since 2006), and the risks of self-harm were not viewed in the context of safeguarding the children or responding to a vulnerable adult. There must be an improvement in how the patient's social history is explored, including consideration of the responsibility for children in the patients care, any relationship issues with a partner, and the underlying reasons for unexplained injuries.

4.41 Policies and processes

4.41.1 The stated local priority of domestic violence, is not helping to drive an effective response. The panel has identified that there is a gap between strategy and operational delivery.

4.41.2 The Borough has a Domestic Violence Strategy but there is little evidence of how this translates into operational practice. There is no Borough Domestic Violence Referral Pathway in place, which leaves practitioners struggling to know who to refer to and what their role and responsibilities are.

4.41.3 The A&E safeguarding prompts were a local process designed in response to recommendations from a Serious Case Review in 2011. The prompts ask staff to consider if patients who arrived in the department have a dependent child and the age of the child. It also asks about any evidence of domestic violence. There is evidence that these prompts are not being used. The use of the prompts is not embedded into practice and this should be urgently reviewed by the Hospital Trust in light of the SCR recommendations and findings from this review.

4.42 Signposting and referral practices

4.42.1 Referral and signposting practices have been discussed in detail by the panel. The FJC created and supported a signposting culture which had the unintended practical outcome of absolving statutory services of their responsibilities to take adequate safeguarding action. It appears (as in Janice's experience) victims were "sent" to the Family Justice Centre rather than professionals taking responsibility for making and following up referrals.

4.42.2 The lack of a local domestic violence referral pathway has compounded this situation, as front line practitioners are daunted and working under operational pressures to navigate the different services. Professionals need to understand their responsibilities, know how (and whom) to make referrals to and be clear on the

follow-up action they have to take. Systems and procedures should be in place to support and empower professionals respond appropriately to issues and concerns of domestic violence.

Conclusions

Preventability

5.1 The panel have not identified a single event or point of contact that could have prevented Janice's death. There is no "chain of causation" which would indicate agencies could have prevented her death.

5.2 Although it is agreed that Janice's death could not have been foreseen or prevented, Janice had little support networks to utilise. A coordinated offer of early help by statutory services would have been helpful to Janice and her children. Had early help been put in place, the issues about domestic violence may have been identified and could have been appropriately responded to.

5.3 There is little evidence of reported domestic violence between Janice and Jacob. Police officers at the scene on the domestic incident (prior to Janice's death) spoke with Janice and encouraged her to accept a lift home. This point of contact has been discussed in detail with the Police representatives of the panel, to fully explore the limitations they faced in compelling Janice to leave the scene and the appropriateness of their response. The panel does not seek to place responsibility on Janice for her decision to remain at the scene and understands the position the Police faced that they were powerless to remove her.

5.4 The lack of a recorded history of domestic violence may be due to an absence of domestic violence enquiry and assessment by agencies to which she turned for support. The panel agreed that statutory services should have responded better to Janice's (and her children's) needs. The panel felt that Janice was under increasing pressure and was actively seeking help and support but this was not identified or responded to.

5.5 Croydon has been recognised as an area of innovative practice on the issue of domestic violence. The Integrated Court and the FJC were two key projects the Council developed to revolutionise the response to domestic violence. Whilst this innovative practice should be celebrated, the high profile nature of these initiatives meant that little critical examination and review of the quality of the services was conducted. It is acknowledged that there is a significant change now underway to the response to domestic violence in Croydon.

Diversity

5.6 The protected characteristics as outlined in the Equality Act 2010 have been considered in relation to this case:

5.6.1 **Age:** Janice was a teenage parent who had been evicted from a YMCA hostel due to becoming pregnant. There appears to have been little consideration of the specific support she needed at this time and her emotional resilience. Her transition into adulthood was accompanied by experiences of domestic violence with David and services had little understanding of the issue of relationship violence in adolescent relationships. The panel agreed that it is a positive development that the government definition of domestic violence has been changed to include sixteen and seventeen year olds.

5.6.2 **Disability:** Aiden's diagnosis of ADHD and ASD is relevant, given the support Janice was seeking from services regarding her children and coping with their behaviour.

5.6.3 **Gender reassignment:** Not applicable.

5.6.4 **Marriage and civil partnership:** Janice and Jacob had separated. There is no evidence of this being considered by agencies.

5.6.5 **Pregnancy and maternity:** Janice was a teenage parent, and research indicates the high risk of domestic violence experienced by teenage mothers (see footnote 4).

5.6.6 **Race:** Both Janice and Jacob were of Black British Caribbean ethnic origin. The review did not uncover any indirect or direct evidence of racism.

5.6.7 **Religion or belief:** Not applicable.

5.6.8 **Sex:** Not applicable.

5.6.9 **Sexual orientation:** The couple were heterosexual (no relevant issues identified).

General

5.7 Improvements to the local coordinated community response to domestic violence need to be strengthened by policies, procedures, staff training and a referral pathway to support professionals respond effectively to concerns and disclosures of domestic violence. In order to

reduce the likelihood of future domestic homicides, these improvements should be mediated and driven through the local partnership with the engagement and commitment of all agencies.

5.8 Developments in the response to domestic violence in Croydon

5.8.1 Since October 2012, there has been a programme of positive and innovative developments in Croydon's coordinated response to domestic violence. The FJC, which is seen as the lead organisation supporting victims and survivors, has seen footfall increased by 300% and is now seeing on average twelve clients per day.

5.8.2 The developments and the work completed on this are listed below:

a. The FJC has had significant financial investment and it has transferred directorates from Community Safety to the Children, Families and Learners. There is a new Governance Structure and the Anti-Violence Group and Domestic Abuse and Sexual Violence Group have been merged. The new group will be chaired by the Chief Executive of Croydon Council to provide leadership to the issue and reflect the local priority of domestic and sexual violence.

b. A DV declaration has been written for all Directors and Chief Executives of partnership agencies to sign-up to.

c. There is now a coordinated action plan in place to prevent and tackle domestic and sexual violence and services and tackling perpetrators which is broader than simply signposting victims to the FJC.

d. The domestic abuse and sexual violence strategy has been re-written (as well as the MARAC protocols), which has secured senior management engagement in the MARAC. Multi-agency MARAC training has been developed. The performance of the MARAC has improved with better attendance and increased referral rates by 400% (sustained over six months and increasing, averaging twenty cases per fortnight).

e. The partnership with Victim Support to manage the CRIS list has been reviewed and is now working effectively.

f. A multi-agency approach has been developed at the FJC, which includes representation from probation and Mental Health Services.

g. The number of IDVAs has been increased (by two) and there is a plan in place to train all remaining FJC staff.

h. Secured agreement for a joint strategic needs assessment on domestic violence.

i. Agreed a single assessment process with housing for individuals presenting as homeless due to domestic violence.

j. A domestic violence data and information sharing protocol is now in place.

k. Co-wrote the tender with Supporting People for the three local refuges and for the floating support service.

l. Developed surgeries for practitioners to help support their understanding of domestic and sexual violence and improve practice.

m. Agreed referral routes and pathways, protocol now written.

n. Commissioned prevention work in a cluster of schools.

o. The Police (CSU) will be based in the FJC one day per week and an IDVA will be based at the Police station one day per week.

p. Legal remedies will be shared with Police to look at civil protection action taken to help consider all options not just criminal justice responses to domestic violence.

5.8.3 Despite Janice suffering domestic violence over a long period of time with three different partners, she had little contact with the Police. Her contact with Health Services was particularly significant in this case.

5.8.4 The events she experienced as a young woman (which pre-date the time period subject to this review and so have not been included in detail in the report), bear some relevance in looking at her perception and experience of contact with services. Had those experiences been addressed more satisfactorily (when she was a young

woman), she may have had a more positive early adulthood and may have avoided the on-going victimisation she experienced.

5.8.5 It would seem that Jacob was her entire support network for the children (with his mother often looking after the children overnight). Janice's attendance at Jacob's address on the night before her death may indicate the stress she was under at the time, and her frustration at his lack of help with the children. It is clear that the behaviour of her son was challenging and that was deeply difficult for her. Janice did well to seek help and the review considers that statutory services should have done more to support her.

5.8.6 Many services had a number of opportunities to support Janice and her children. Health Services should have done more to help her about her frustration, stress and depression.

5.8.7 It is noted that the Borough does have a domestic violence strategy, yet there appears to be a disconnect between this vision and what happens in operational practice. In light of what we have discovered regarding the use of the A&E prompts, (introduced as a result of an earlier serious case review and not being used), it will be extremely important that the partnership response to this review is able to engage and influence Health Services, including A&E.

5.8.8 There was evidence that the engagement of the Health Service in the local partnership, particularly the community safety arena has been limited. The scale of Janice's contact with Health Services shows how important it is that health are engaging and fully committed to supporting the domestic violence agenda.

5.8.9 This case has highlighted a lack of professional responsibility to follow-up actions and necessary referrals. A borough wide domestic violence protocol or care pathway is required where staff are trained so that they are able to understand and respond appropriately, according to their role and responsibilities.

Recommendations

6.1 The recommendations in this report reflect the missed opportunities that existed to support Janice in her parenting role and to allow for safe and appropriate enquiry regarding domestic violence. This case has shown that the offer of early help to families in need in Croydon must be improved. It is hoped that the introduction of a multi-agency safeguarding hub in Croydon will help enhance the sharing of information and ensuring that targeted and timely support is offered to families who come to the attention of services. The “team around the family” and CAF needs to be used by professionals and practitioners across the entire multi-agency partnership. Clinicians within community health services need to be supported so that when it is appropriate, they are able to lead the CAF process.

6.2 The panel were also concerned that the Croydon Multi Agency Safeguarding Hub (MASH), as currently configured, will not necessarily help victims of domestic violence who do not have children. The recommendations of this review include consideration of the need to have policies and practice that supports all victims, regardless of their family composition.

6.3 The recommendations of this review are specific and detailed to support the Croydon Community Safety Partnership and individual agencies understand the issues identified by this review and highlight where improvement is needed. The recommendations will also help the partnership hold agencies accountable for the action they now need to take. The recommendations are wide ranging and attempt to address direct themes identified in the review, as well as associated issues that have an impact on the response to domestic violence by statutory services.

6.4 The review identified that engagement with health partners in the Community Safety Partnership has been limited. If the recommendations of this review are to be implemented, Public Health and the Clinical Commissioning Group must engage fully with the coordinated community response to domestic violence.

6.5 Internal actions for agencies have been identified in their respective IMRs and have already been promulgated to allow learning to occur alongside swift change to organisational activity. These completed actions are shown below.

Agency actions and early learning

6.6 **Croydon Children's Services**:

6.6.1 **Agency action and early learning 1**

The evidence clearly suggests that Aiden was a child in need and services should have been offered regardless of any other criteria that existed. The CWD team now has permanent managers appointed, has consultants working with the team who look at the clinical decisions being made by the team, and has undergone an audit of all open cases to ensure that all children referred to it receive an appropriate standard of service and are safe.

6.6.2 **Agency action and early learning 2**

Allegations of Domestic Violence involving children are assessed according to the age of the child/children involved and the level of risk identified within the information presented. If a child younger than twelve months old is involved then a Section 47 (Child Protection) Investigation takes place.

6.6.3 **Agency action and early learning 3**

Croydon Children's Services are planning to use Independent Review Officers (IROs) to review all new Child in Need cases. This will ensure clear planning for children, an independent view of risk and threshold for services.

6.7 **Family Justice Centre**

6.7.1 **Agency action and early learning 4**

The referral pathways agreement for housing and social care and other partners, including the requirement to records action and outcomes, are being re-written.

Panel recommendations

6.8 All recommendations will be overseen by the Croydon Community Safety Partnership, and will be delivered by the Croydon Domestic Violence Strategic Group. The recommendations also have been translated into an action plan (Appendix 4) which is included at the end of this report.

6.9 Croydon Community Safety Partnership

6.9.1 Recommendation 1

Conduct a rigorous borough wide review of the response to domestic violence. This review must address the gap between the strategy and delivery of the strategic aims in operational practice of partner agencies.

6.9.2 Recommendation 2

In conjunction with other strategic boards, produce a domestic violence protocol, policy and care pathway, across the partnership and for each organisation. This should include domestic violence enquiry and provision for safeguarding children and vulnerable young people.

6.9.3 Recommendation 3

Disseminate learning from the two Croydon Domestic Homicide Reviews widely across the partnership. This should be in the form of a written briefing to all staff and dissemination sessions and incorporating findings into any domestic violence training that is commissioned and delivered locally.

6.9.4 Recommendation 4

Commission a borough multi-agency domestic violence training programme. This should be done with support of other strategic boards and take up of training should be audited and monitored per agency by the Croydon Domestic Violence Strategy Group. It is recommended that the training covers awareness and dynamics of domestic violence, specific skills training on enquiry and completion of MARAC risk assessment, safeguarding responsibilities and referrals pathways.

6.9.5 Recommendation 5

Develop an early intervention approach to domestic violence through local schools (that ties in with the existing programme on gangs and sexual exploitation) and is age appropriate.

6.10 Metropolitan Police:

6.10.1 Recommendation 6

Review the policy of restricting intelligence checks to five years.

6.10.2 **Recommendation 7**

Use this case as a briefing aid and learning tool for Croydon Police to support an enhanced response to potential victims of domestic violence.

6.11 **London Probation Trust:**

6.11.1 **Recommendation 8**

Ensure specific and open questions are asked to the Police as part of intelligence checks so that more accurate information is obtained to inform risk assessments.

6.11.2 **Recommendation 9**

When subject to an order, when there are a sustained number of absences in relation to children of the offender (e.g. child care) a risk assessment should be completed, supported by a line manager.

6.12 **Metropolitan Police and London Probation Trust:**

6.12.1 **Recommendation 10**

Ensure that probation officers have quick access to the Police national computer to inform their reports and risk assessments.

6.13 **SLaM:**

6.13.1 **Recommendation 11**

Complete an audit on Did Not Attend (DNAs) who were discharged from CAMHS to check that risk assessments have been or are now completed before decision to discharge as outlined in the policy and provide a new offer of support (where appropriate).

6.13.2 **Recommendation 12**

Provide those referring to SLaM Child ADHD Services information to help them signpost families to other support networks at the time of the referral as it is recognised that there are at times delays from date of referral to date of first appointment, and the family may require more speedy support.

6.14 **Croydon Safeguarding Children's Board:**

6.14.1 **Recommendation 13**

Review its prioritisation of and response to the issue of domestic violence. This should include recognition of the possibility of domestic violence within each referral

and policies which address routine and/or selective enquiry about the existence of domestic violence.

6.14.2 **Recommendation 14**

Review corporate policy for responding to families who fail to engage with services (and make amendments) in light of the findings of this review.

6.14.3 **Recommendation 15**

Audit safeguarding children's training (and take up across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.

6.15.4 **Recommendation 16**

Highlight and explain the think family approach, so that practitioners, professionals and clinicians understand the concept and their roles and responsibilities regarding safeguarding children.

6.15.5 **Recommendation 17**

Review the process of the early offer of help to examine its effectiveness with particular reference to CAF implementation within health services and how domestic violence is included in this assessment.

6.15.6 **Recommendation 18**

Review and update the local Safeguarding Children's Board Domestic Violence Policy and ensure it is widely circulated to all relevant professionals.

6.16 **Croydon Council Family Justice Centre:**

6.16.1 **Recommendation 19**

Rewrite the Multi-Agency Borough referral pathway agreement which should include action taken by agencies and the outcomes of referral.

6.17 **Croydon Council Public Health:**

6.17.1 **Recommendation 20**

The Joint Strategic Needs Assessment on domestic violence should reference the findings of the two Croydon Domestic Homicide Reviews.

6.18 **NHS England (Croydon Clinical Commissioning Group) and Croydon Council Public Health:**

6.18.1 **Recommendation 21**

Look to pilot and/or commission a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.

6.19 **Croydon Clinical Commissioning Group:**

6.19.1 **Recommendation 22**

Ensure engagement in Croydon's coordinated community response to domestic violence through regular and appropriately senior representation at the Croydon Domestic Violence and Sexual Violence Strategy Board.

6.20 **Croydon Children's Services:**

6.20.1 **Recommendation 23**

Develop a system where independent approaches to Children's Social Care from individuals and families requesting help and support which then do not meet the threshold for statutory intervention are reviewed and shared with universal family support services.

6.21 **NHS England:**

6.21.1 **Recommendation 24**

As NHS England have provided funding within GP budgets to deliver safeguarding training (adults and children), a local review of this training should be instituted to ensure domestic violence is included in this training and to an appropriate level.

6.21.2 **Recommendation 25**

Ensure, when appointed, that the Lead GP for safeguarding has domestic violence included in their job description.

6.21.3 **Recommendation 26**

Develop a depression screening and care pathway for GP's, and review the tools that are used to include psychological/social aspects on the dynamic of mental health and domestic violence.

6.21.4 **Recommendation 27**

Safeguarding adult training to be implemented to raise awareness of the issues identified.

6.21.5 **Recommendation 28**

Include learning points in the Croydon CCG Newsletter.

6.21.6 **Recommendation 29**

Include these learning points in case reflection session with GP Practices once organised.

6.21.7 **Recommendation 30**

Data relating to family members and dependents should be gathered at the time of registration and/or the initial health check.

6.21.8 **Recommendation 31**

Consideration should be given to flagging cases where there is high-risk or potentially high-risk.

6.21.9 **Recommendation 32**

Consideration needs to be given as to how information can be shared with other practices if parents have re-registered at separate practices.

6.21.10 **Recommendation 33**

Meet with staff to provide a briefing on the initial review findings to enable opportunities to learn from them and develop their confidence and competence re managing such cases.

6.21.11 **Recommendation 34**

Support staff through case reflection as needed.

6.22 **Croydon Health Services NHS Trust:**

6.22.1 **Recommendation 35**

Create, disseminate and then regularly review an organisational domestic violence policy and care pathway. This should include:

a. Specific reference to the use of the A&E prompts for the emergency department.

b. Inclusion of routine enquiry within the service specification of any new commissioning processes, particularly for health visiting and school nurses.

c. An organisational stance on providing “private time” at the antenatal booking appointment, and then throughout all antenatal care appointments to enable midwives to ask about sensitive issues such as domestic violence.

6.22.2 **Recommendation 36**

Work with the Community Safety Partnership to ensure a workforce training programme on domestic violence is delivered (this may be part of the training led by the CSP or separately commissioned).

6.22.3 **Recommendation 37**

Develop and distribute a universal resource on help and support available for all new parents, to support routine enquiry for domestic violence during ante natal and post natal care.

6.22.4 **Recommendation 38**

Conduct a systematic review of the processes within A&E so that staff are aware of their role and responsibilities in relation to responding to domestic violence and any safeguarding concerns. This should include a mandatory training programme for all A&E staff and provision of information on local domestic violence support services and how to refer to them.

6.22.5 **Recommendation 39**

Embed the use of the A&E safeguarding prompts in practice, and seek to include the key questions in the prompts in the new electronic record keeping system (Cerner) to be used by services within CUH from 30 September 2013 onwards.

6.22.6 **Recommendation 40**

Review and improve systems of sharing safeguarding concerns between the emergency department and other departments with CUH (including the ward staff).

6.22.7 **Recommendation 41**

Reconfirm domestic violence enquiry practices within maternity services and ensure that staff are appropriately trained to ask about domestic violence and respond to a concern or a disclosure from a pregnant woman. This should include approaches for enquiry of pregnant teenagers and also for women who have suffered a miscarriage.

National recommendation – (included for information only and not for Croydon Community Safety Partnership to progress).

6.23 **Recommendation 42**

Implement a new specific separate category of domestic violence on the Children Social Care System for registration within child protection plans for cases where domestic violence is the reason for registration[6].

[6] This was recognised as a gap within Croydon but categorisation is determined by "Working Together" and this problem appears to be one for all children's services. The panel felt it vital that the extent and scale of domestic violence is accurately recorded rather than potentially hidden within emotional or physical categories on the current system.

KEY

Aiden	Son of Janice and previous partner David
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
CAMHS	Child Adolescent Mental Health service
CSC	Children Social Care
CSP	Community Safety Partnership
CSU	Community Safety Unit (Police)
CUH	Croydon University Hospital (formally Mayday Healthcare)
CWD Team	Children With Disability Team
David	Janice's previous partner and Aiden's father
DHR	Domestic Homicide Review
DV/A	Domestic violence and abuse
Ethan	Son of Janice and Jacob (perpetrator)
GPs	General Practitioners
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety (GP practice scheme)
Jacob	Perpetrator
Janice	Victim
MARAC	Multi Agency Risk Assessment Conference
MPS	Metropolitan Police Service
MASH	Multi Agency Safeguarding Hub
PCT	Primary Care Trust
SLaM	South London & Maudsley NHS Foundation Trust

Appendix 1

Domestic Homicide Review Terms of Reference for Janice

This Domestic Homicide Review is being completed to consider agency involvement with Janice, and her partner, Jacob, following her murder on January 2nd 2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

The Review will work to the following Terms of Reference:

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information is shared in the final report when published.

2. To explore the potential learning from this murder and not to seek to apportion blame to individuals or agencies.

3. To review the involvement of each individual agency, statutory and non- statutory, with Janice and Jacob during the relevant period of time: **January 1st 2005 – January 6th 2013.**

4. To summarise agency involvement prior to **January 6th 2013.**

5. The contributing agencies to be as follows:
   a. Metropolitan Police
   b. Croydon Council
   c. London Probation
   d. Croydon Health Services NHS Trust
   e. Croydon Clinical Commissioning Group
   f. South London & Maudsley NHS Foundation Trust

6. For each contributing agency to provide a chronology of their involvement with the Janice and Jacob during the relevant time period.

7. For each contributing agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

8. For each contributing agency to provide an Individual Management Review:
   a. identifying the facts of their involvement with Janice and/or Jacob, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.
   b. To consider issues of activity in other boroughs and review impact in this specific case.

9. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a. Analyse the communication, procedures and discussions, which took place between agencies.
    b. Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
    c. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d. Analyse agency responses to any identification of domestic abuse issues.
    e. Analyse organisations access to specialist domestic abuse agencies.
    f. Analyse the training available to the agencies involved on domestic abuse issues.

    And therefore:

    g. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
    h. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
    i. To improve inter-agency working and better safeguard adults experiencing domestic abuse.

10. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Janice or Jacob in contact with their agency.

11. To sensitively involve the family of Janice in the review, if it is appropriate to do so in the context of ongoing criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process.

12. To coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

13. To commission a suitably experienced and independent person to chair the Domestic Homicide Review Panel, co-ordinating the process, quality assuring the approach and challenging agencies where necessary; and to subsequently produce the Overview Report critically analysing the agency involvement in the context of the established terms of reference.

14. To establish a clear action plan for individual agency implementation as a consequence of any recommendations. The action plan should meet SMART criteria.

15. To establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

16. To provide an executive summary.

17. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Safer Croydon Partnership Board.

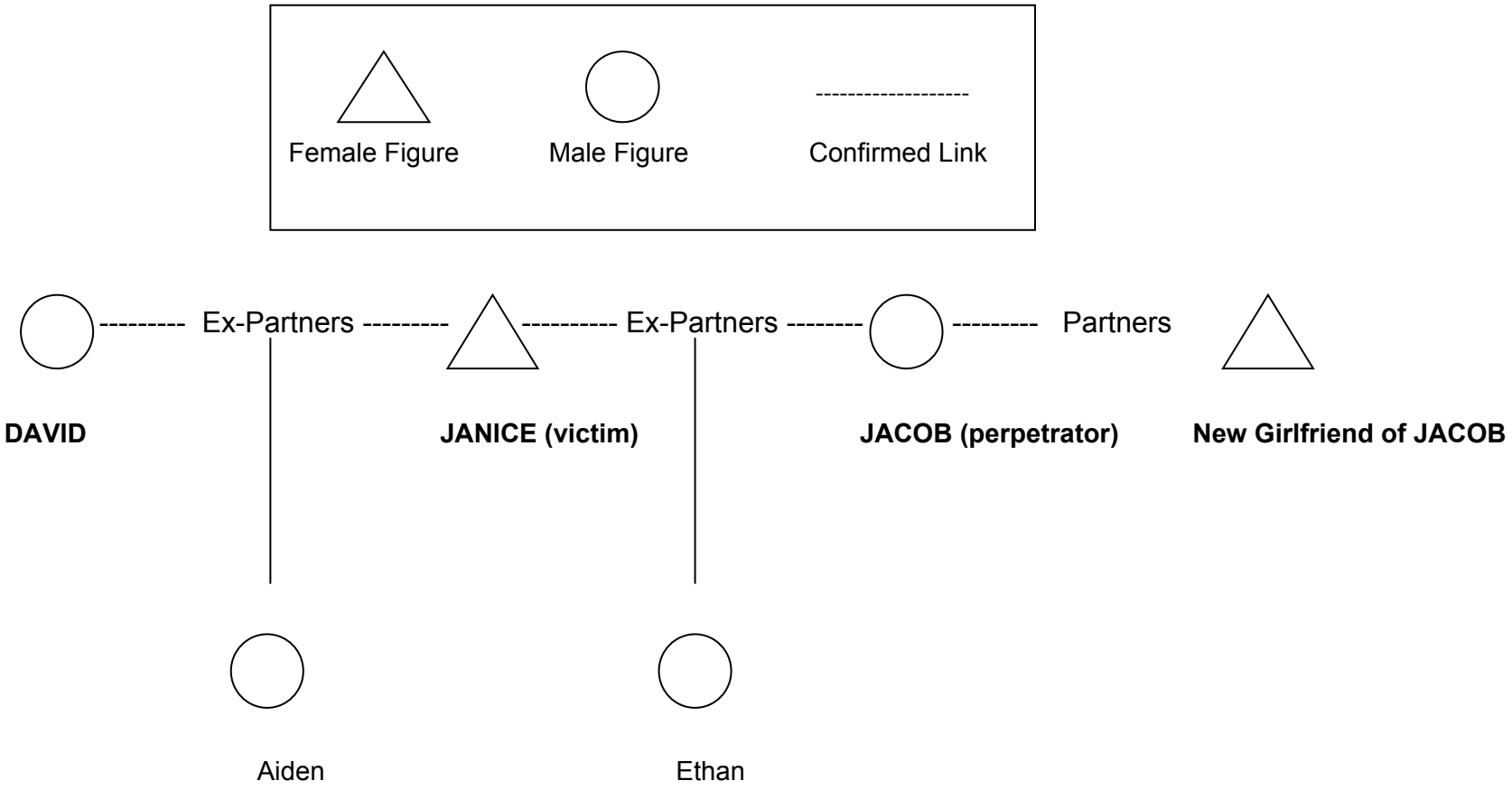
Appendix 2

Panel members and agencies represented

Agency	Panel Member
Anthony Wills	Standing Together
Victoria Hill	Standing Together
Carl Parker	Croydon Council
Simon Messinger	Metropolitan Police Service
Helen Flanagan	Metropolitan Police Service
Paul Gardner	Metropolitan Police Service
Andy Opie	Croydon Council
Rachel Blaney	NHS
Patricia Leigh	NHS
Wanda Palmer	NHS
Edwina Morris	NHS
John Scott	Croydon Council
Elaine Trainor	Croydon Council
Dr. Jane Fryer	NHS

Appendix 3

Janice's Family Tree



Appendix 4

All recommendations will be overseen by the Croydon Community Safety Partnership

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Croydon Community Safety Partnership					
Conduct a rigorous borough wide review of the response to domestic violence. This review must address the gap between the strategy and delivery of the strategic aims in operational practice of partner agencies.	Review responses to DV by all partners, identify and map gaps	Domestic Violence Strategy Group.	Mapping exercise on current resources and responses.	Q3 2014/15	Prevention work informed by mapping exercise
In conjunction with other strategic boards, produce a domestic violence protocol, policy and care pathway, across the partnership and for each organisation. This should include domestic violence enquiry and provision for safeguarding children and vulnerable young people.	Develop DV protocol, policy and care pathway across the partnership and for each organisation including enquiry and provision for safeguarding children and vulnerable young people.	Domestic Violence Strategy Group.	Mapping exercise on current resources and responses. Agreement by Partners on DV protocol. Implementation of DV protocol;	Q4 2014/15	Better understanding of victims' experiences and issues.

Disseminate learning from the two current domestic homicide reviews widely across the partnership. This should be in the form of a written briefing to all staff and dissemination sessions and incorporating findings into any domestic violence training that is commissioned and delivered locally.	Ensure all partners have received copies of DHRs and are signed up to the action plan	Domestic Violence Strategy Group.	Sign off of both DHRs by the Home Office	September 2014	Partnership Action Plan and Joint Strategic Needs Assessment reflect findings from the domestic homicide reviews for AB and HG.
Commission a borough multi agency domestic violence training programme. This should be done with support of other strategic boards and take up of training should be audited and monitored per agency by the Croydon Domestic Violence Strategy Group. It is recommended that the training covers awareness and dynamics of domestic violence, specific skills training on enquiry and completion of MARAC risk assessment, safeguarding responsibilities and referrals pathways.	A range of training programmes will be implemented to cover the problem areas identified where DV arises.	Domestic Violence Strategy Group.	First cohort of trainees graduate from each training programme. Second cohorts engage in training.	Training programmes will be a continuous process	Earlier identification resulting in more MARAC referrals & more early help. Information on the toxic trio embedded within training across adults and children's services. Drug services to explore the dynamic of domestic violence when working with individuals with substance misuse issues. People who misuse drugs or alcohol, have mental health problems and are affected by DASV are referred to relevant health, social care and specialist DASV services.
Develop an early intervention approach to domestic violence through local schools (that ties in with the existing programme on gangs and sexual exploitation) and is age	Use Roots of Empathy Evidenced based Programme and	Children, Families & Learners Service	First courses to start in March 2015.	First programme to complete June 2015	Children aware of ways to report DV and recognise signs in friends families.

appropriate.	develop Values Versus Violence to be launched in March				
Metropolitan Police					
Review the policy of restricting intelligence checks to five years.	In all DV investigations intelligence checks to be extended to be commensurate with ages of victim and perpetrator.	Metropolitan Police	First extended checks are carried out.	Immediately	Risks that may not be flagged up under shorter period can now be recognised.
Use this case as a briefing aid and learning tool for Croydon police to support an enhanced response to potential victims of domestic violence.	Lessons learned from this case used as exemplar for police in-house training	Metropolitan Police		September 2014	Officers have improved awareness of DV risks
London Probation Trust					
Ensure specific and open questions are asked to the police as part of intelligence checks so that more accurate information is obtained to inform risk assessments.	POs are more rigorous when discussing clients with the police	Probation Service		September 2014	Risks that would have remained hidden are exposed and appropriate action taken.
When subject to an order, when there are a sustained number of absences in relation to children of the offender (e.g. child care) a risk assessment should be completed, supported by a line manager.	POs are more rigorous in questioning clients about missed appointments	Probation Service		September 2014	Support tailored to meet client's needs.

Metropolitan Police and London Probation Trust					
Ensure that probation officers have quick access to the police national computer to inform their reports and risk assessments	Better access allowed to PNC	Metropolitan Police / Probation Service	Formal notice issued allowing POs to have fuller PNC access.	December 2014	POs better informed about client's past misdemeanours.
SLaM					
Complete an audit on Did Not Attend (DNAs) who were discharged from CAMHS to check that risk assessments have been or are now completed before decision to discharge as outlined in the policy and provide a new offer of support (where appropriate).	Audit on past practice with respect to DNAs and risks they present	SLaM	Audit commences	Q4 2014/15	Accurate assessment made on risk assessments made and those missed and lessons that can be learned from why they were missed.
Provide those referring to SLaM child ADHD services information to help them signpost families to other support networks at the time of the referral as it is recognised that there are at times delays from date of referral to date of first appointment, and the family may require more speedy support.	Education programme to be implement and handbook or other information produced to ensure successful direction	SLaM	Information sharing commences	Q4 2014/15	Families at risk receive the service they should and are not left in a position of uncertainty.
Croydon Safeguarding Children's Board					
Review its prioritisation of and response to the issue of domestic violence. This should include recognition of the possibility of domestic violence within each referral and policies which address routine and/or selective enquiry about the existence of domestic violence.	Instigate review and follow up with education on lessons learned	Adult Safeguarding Service Children's Safeguarding Service	Review process commences Educational process commences	Q4 2014/15	Staff recognise indicators of DASV and how it affects children and young people Interventions put in place that aim to strengthen the relationship between the child and their non-abusive parent or carer.
Review corporate policy for responding to families who fail to engage with services	Initiate review of policy where there	Adult Safeguarding	Policy review commences	Q4 2014/15	Amendments to corporate policy in light of findings of

(and make amendments) in light of the findings of this review.	is non-engagement	Service Children's Safeguarding Service	Code of Practice issued		the DHR for AB. Policies monitored with regard to children's and young people's needs.
Audit safeguarding children's training (and take up across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.	Thoroughly examine training, possibly through external consultant, to ensure DV issues are understood.	Children's Safeguarding Service	Set up audit group. Carry out audit Issue report	Q4 2014/15	Increase in the number of children identified as being at risk and increase in appropriate measures taken to safeguard them.
Highlight and explain the Think Family approach, so that practitioners, professionals and clinicians understand the concept and their roles and responsibilities regarding safeguarding children	Training implemented to ensure Think Family is understood and how to respond to risks	Domestic Violence Strategy Group.	Programme of Think Family seminars set up for partners. Seminars held	Q4 2014/15	Practitioners, professionals and clinicians understand the Think Family Approach and their responsibilities regarding safeguarding children. This to be evidenced through commissioned and non-commissioned services.
Review the process of the early offer of help to examine its effectiveness with particular reference to CAF implementation within health services and how domestic violence is included in this assessment.	Review board set up, review held, report produced, suggested actions implemented.	Adult Safeguarding Service Children's Safeguarding Service	Review process implemented Report made Report recommendations implemented	Q4 2014/15	Early intervention measures targeting children, young people and families implemented. Early Help pathways fully established, facilitating support to access services Early Help guidance fully

					embedded within universal and targeted services
Review and update the local safeguarding children's board domestic violence policy and ensure it is widely circulated to all relevant professionals.	Review board set up, review held, report produced, suggested actions implemented.	Adult Safeguarding Service Children's Safeguarding Service	Review board set up. Report and policy produced Policy circulated to relevant professionals. Training on revised policy carried out.		Staff know how to refer children and young people to child protection services and how to contact safeguarding leads to discuss whether a referral is appropriate.
Croydon Council Family Justice Centre					
Rewrite the multi-agency borough referral pathway agreement which should include action taken by agencies and the outcomes of referral.	Toolkit rewritten. Toolkit to be distributed.	FJC	Final version to be circulated.	March 2014 – phase 1	First draft of toolkit written after consultation locally and in line with national practice. Final version to be made available in Summer 2014

Croydon Council Public Health					
The Joint Strategic Needs Assessment on domestic violence should reference the findings of the two Croydon domestic homicide reviews.	DHR findings to be incorporated into JSNA.	Croydon Public Health	Revised JSNA to be circulated to partner agencies.	December 2014	Partnership Action Plan and Joint Strategic Needs Assessment reflect findings from the domestic homicide reviews for AB and HG.
NHS England (Croydon Clinical Commissioning Group) and Croydon Council Public Health					
Look to pilot and/or commission a borough wide system to improve the response of primary care to patients who are experiencing domestic violence, such as Project IRIS.	New system piloted for responding to DV victims	NHS England	Pilot system implemented	Q4 2014/15	Victims of DV enjoy better understanding and appropriate care within NHS

Croydon Clinical Commissioning Group					
Ensure engagement in Croydon's coordinated community response to domestic violence through regular and appropriately senior representation at the Croydon Domestic Violence and Sexual Violence Strategy Board.	CCG actively engage in DASV Board	Croydon CCG	Senior officers participate in a local strategic multi-agency partnership to prevent DASV.	Q4 2014/15	Senior officers participate in a local strategic multi-agency partnership to prevent DASV along with representatives of front line practitioners and service users or their representatives.
Croydon Children's Services					
Develop a system where independent approaches to Children's Social Care from individuals and families requesting help and support which then do not meet the threshold for statutory intervention are reviewed and shared with universal family support services.	New system developed to ensure families at risk are not placed in jeopardy.	Children, Families and Learners	Families not meeting threshold have DV risk recognised and intervention provided.	Q4 2014/15	Clear referral pathways to local services that can support children and young people affected by DASV set up.
NHS England					
As NHS England have provided funding within GP budgets to deliver safeguarding training (adults and children) a local review of this training should be instituted to ensure domestic violence is included in this training and to an appropriate level.	Ensure appropriate training implemented	NHS England	GPS receive safeguarding training	Q1 2015/16	Staff know or have access to information about services, policies and procedures of all relevant local agencies for people who experience or perpetrate DV
Ensure when appointed that the Lead GP for safeguarding has domestic violence included in their job description.	JD appropriately revised	NHS England	Lead GP is fully aware of DV responsibilities.	Q4 2014/15	Lead GP encourages development of DV awareness among other

					GPs
Develop a depression screening and care pathway for GP's, and review the tools that are used to include psychological/social aspects on the dynamic of mental health and domestic violence.	Depression screening developed	NHS England	GPs trained in revised screening and use of new tools to identify depression		GPs know about services and procedures
Croydon Health Services NHS Trust					
Create, disseminate and then regularly review an organisational domestic violence policy and care pathway. This should include: - Specific reference to the use of the A&E prompts for the emergency department - Inclusion of routine enquiry within the service specification of any new commissioning processes, particularly for health visiting and school nurses - An organisational stance on providing "private time" at the ante natal booking appointment, and then throughout all ante natal care appointments to enable midwives to ask about sensitive issues such as domestic violence.	New practice and procedure developed and implemented.	Croydon Health Services (CHS) and South London and Maudsley NHS Trust (SLAM)	Better outcomes from A&E admissions		1. The lessons to be learnt from the 2 Domestic Homicide reviews completed by CHS has been incorporated into Level 3 safeguarding children training. 2. All associated tools, guidelines, procedures and contact details (in relation to identifying, exploring and responding to DASV) have been loaded onto the CHS intranet in a policies and procedures folder called "Domestic Violence". 3. During all levels of

					training all staff are directed to the safeguarding children policies and procedures folder on CHS intranet. 4. Domestic violence, the definition and where to access information and advice is included in all levels of safeguarding children training. 5. Included in the electronic packs sent to staff prior to training is the handout on Domestic Violence, CAADA questionnaire, FJC and MARAC. 6. All staff providing ad hoc safeguarding advice to staff within CHS are aware of the need to advocate the use of the CAADA questionnaire, when exploring /

					responding to DASV. 7. The use of the CAADA questionnaire and referrals to MARAC is a significant section of our domestic violence safeguarding children training for level 3 staff. 8. Case studies included in all levels of training include at least 50% of cases where domestic violence is prevalent. This allows for practitioners to talk through how to identify, explore and respond to DASV. 9. A half day session on domestic violence is delivered to all level 3 staff, as part of their safeguarding children foundation training.

					10. All of our safeguarding children training (including the domestic violence presentation for level 3) is scrutinised annually by the CSCB sub group learning and development. 11. All of our presentations are reviewed a minimum of annually –to ensure data is accurate, references are updated and new resources are included. 12. As part of the recommendation from a recent DHR, the Named Nurses adult and children have drafted a CHS Domestic Violence Policy will continue to raise awareness of DASV.

Work with the Community Safety Partnership to ensure a workforce training programme on domestic violence is delivered (this may be part of the training led by the CSP or separately commissioned).	Develop and deliver workforce training centred on DV	Croydon Health Services Safer Croydon Partnership Board	Training to recognise evidence of DV is implemented to all appropriate staff	Q1 2014 / 15	Improved knowledge and skills among more varied staff brings about wider recognition of cases of DV
Develop and distribute a universal resource to on help and support available to new parents to support routine enquiry for domestic violence during ante natal and post natal care.	Provide an ante and post natal care service that is trained in recognising risks of DV	Croydon Health Services (Midwifery and Health visitors)	Midwives and Health Visitors receive DV risk recognition training	Q1 2014 / 15	1. All women offered the opportunity to discuss concerns with their Midwife and Health Visitor. 2. Domestic violence discussion is a routine part of the initial assessment undertaken by the HV service. 3. There is a clear guideline in place for all midwives; giving instruction about screening for domestic violence and where / how this is recorded on maternity records.

					4. The family health needs assessment tool used by the health visiting service has been recently updated to include the need to explore domestic violence.
Conduct a systematic review of the processes within A&E so that staff are aware of their role and responsibilities in relation to responding to domestic violence and any safeguarding concerns. This should include a mandatory training programme for all A&E staff and provision of information on local domestic violence support services and how to refer to them.	Processes reviewed. Shortcomings identified. Practice revised. Training in new practices.	Croydon CCG Croydon Health Services	Admissions to A&E where there are DCV risks are identified and appropriate action implemented, engaging partners from across Croydon.	Q1 2014 / 15	Improved systems of sharing safeguarding concerns between the emergency departments and other departments within CUH, including the ward staff An environment for disclosing DASV created. Trained staff ask people about DASV. Specialist advice, advocacy and support as part of comprehensive referral pathway.

Embed the use of the A&E safeguarding prompts in practice, and seek to include the key questions in the prompts in the new electronic record keeping system (Cerner) to be used by services within CUH from 30 September 2013 onwards.	Create script with series of prompts for staff to be trained to ask in A&E of suspected DV victims	Croydon Health Services	Named Nurses for Child Protection and Vulnerable Adults and the FJC to meet in order to discuss how this can be implemented.	Q1 2014 / 15	Less risk of DV victims coming into A&E having their risk overlooked.
Review and improve systems of sharing safeguarding concerns between the emergency department and other departments with CUH, (including the ward staff).	An environment for disclosing DASV created where trained staff ask people about DASV and specialist advice, advocacy and support provided as part of comprehensive referral pathway.	Croydon Health Services	Training on delivery of revised practice introduced	Q1 2014 / 15	Improved systems of sharing safeguarding concerns between the emergency departments and other departments within CUH, including the ward staff
Reconfirm domestic violence enquiry practices within maternity services and ensure that staff are appropriately trained to ask about domestic violence and respond to a concern or a disclosure from a pregnant woman. This should include approaches for enquiry of pregnant teenagers and also for women who have	Current practice to be reviewed to identify gaps and training put in place	Croydon Health Services	Current practice reviewed and training implemented	Q1 2014 / 15	1. All women offered the opportunity to discuss concerns with their Midwife and Health Visitor. 2. Domestic violence discussion is a routine

suffered a miscarriage.					part of the initial assessment undertaken by the HV service. 3. There is a clear guideline in place for all midwives; giving instruction about screening for domestic violence and where / how this is recorded on maternity records. 4. The family health needs assessment tool used by the health visiting service has been recently updated to include the need to explore domestic violence.