DHR OVERVIEW REPORT INTO THE MURDER OF CRYSTAL, DECEMBER 2011

Glossary

ABH: Actual Bodily Harm
CNWL: Central and North West London NHS Trust
CPS: Crown Prosecution Service
CRIS: Crime Recording Information System
CSC: Children's Social care
CSP: Community Safety Partnership
DHR: Domestic Homicide Review
EACH: Ethnic Alcohol Counselling Harrow
IDAP: Integrated Domestic Abuse Programme
IDVA: Independent Domestic Violence Adviser
IMR: Individual management Review
IPCC: Independent Police Complaints Commission
LB: London Borough
MARAC: Multi-Agency Risk Assessment Conference
NSPCC: National Society for the Prevention of Cruelty to Children
PND: Police Disposal Notice

Contents

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Preface

This Domestic Homicide Review (DHR) has been an emotionally affecting experience for all involved.

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Crystal, and thank them, together with the others who have contributed to the deliberations of the Review, for their time, patience and co-operation.

The Chair extends her thanks to all members of the Review Panel who took their role very seriously, and devoted many hours to analysing, discussing and extracting the lessons to be learned from this homicide. Even among the specialist domestic abuse workers who collectively have heard the stories of thousands upon thousands of abused women and children, this case has shocked and lingered on in our minds.

The care and thoughtfulness expressed in the process was very moving, not least because it seemed to be the most sustained attention ever given by professionals to the circumstances of Crystal's life. Fortunately, much of the poor practice uncovered in this review is historical. Events are included so as to present a complete picture of Crystal's life but do not necessarily result in recommendations due to policies and practices having changed well before the commencement of this DHR. Where issues have not been addressed, recommendations are, of course, included.

The Review Chair thanks the Panel for the professional manner in which they have conducted the Review and the Individual Management Review authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies. She is joined by the Review Panel, in thanking Sarah Kurylowicz and Mike Howes for the efficient administration of the DHR.

Thanks are also due to Karen Ingala-Smith for permission to use her words.

1. Introduction

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom she was related or with whom she was or had been in an intimate personal relationship or

(b) A member of the same household as herself;

with a view to identifying the lessons to be learnt from the death.

1.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013. This can be found in full at Appendix B.

1.2 The purpose of a DHR is to:

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

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

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.3. This Domestic Homicide Review (DHR) examines the circumstances leading up to the death of Crystal who was murdered in December 2011 by her partner, Rameez. The decision to undertake a DHR was made by Harrow CSP in consultation with local specialists. The Home Office was informed in line with statutory requirements. The Panel met for the first time in April 2012 where IMRs were commissioned and agencies advised to implement any early learning without delay. A decision was subsequently made, however, to suspend further meetings until the criminal trial and IPCC investigation had concluded. The first trial in October 2012, resulted in the jury being unable to reach a verdict so a retrial was set for March 2013. In the end, the Panel did not reconvene until September 2013, after which monthly meetings took place until February 2014. Efforts to secure the participation of the victim's family and the perpetrator further delayed the process for some months.

Following these events, the subsequent delay was entirely the responsibility of the chair and report author for which she expresses unreserved apologies.

2. Overview

Persons involved in this DHR[1]

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
Crystal	F	23	Victim	Dual Heritage: White and Asian British
Rose	F	6	Daughter	Asian British

[1] All names in the above table are pseudonyms

Rehan	M	2	Son	Asian British
Iqbaal	M	Five weeks and six days	Daughter	Asian British
Rameez	M	26	Perpetrator and father to Rehan and Iqbaal	Asian British
Nadira	F	50	Mother of victim	Asian British
Maryam	F	21	Sister of victim	Dual Heritage: White and Asian British

2.1. Summary of the case:

Crystal and Rameez met in 2004 but their relationship didn't begin until 2007. The relationship was characterised by multiple contacts with the police, almost all of which resulted in no further action due to Crystal being reluctant to substantiate initial reports and there being insufficient evidence to otherwise proceed. The relationship was volatile with multiple break-ups and reconciliations. Crystal and Rameez had two children together, both of whom were removed from their care due to a combination of neglect, parental drug use, involvement in prostitution and domestic violence.

Two weeks before the homicide, the relationship was off again with Rameez subject to bail conditions not to contact Crystal who moved in with her mother. Late in December 2011, Rameez collected Crystal from her mother's house and shortly afterwards, she sent a text message to a friend stating that she and Rameez were back together again and he was going to take her out for a meal. Crystal told the friend they would visit for a drink beforehand, but when the couple never arrived, the friend called Rameez. He claimed not to know of any plans and said he had not had any contact with Crystal since they had broken up.

In the early hours of the following day, neighbours of Rameez heard loud voices, including a woman saying 'no'. Three hours later they were woken by him entering the flat before leaving again in his car. Rameez was then caught on CCTV driving to the canal and then back on to the Uxbridge Road minutes later.

Crystal's body, wrapped in a black bin liner, was later found by a dog walker, floating in the canal. The post mortem revealed blunt instrument trauma to the head and compression to the neck.

Rameez was arrested and charged with her murder. In the first trial in October 2012, the jury were unable to reach a verdict so a retrial was set for March 2013. This resulted in a guilty verdict of murder and an automatic life sentence with a recommended minimum of 16 years, less time spent on remand.

3. Parallel reviews

In addition to the criminal trial, the IPCC also undertook their own investigation into the actions of the Metropolitan police in this case. Thanks are due to the IPCC for kindly providing a copy of their report post-trial.

A Serious Case Review was considered but felt to be unnecessary as no children were resident with Crystal at the time of the murder. However, safeguarding issues in relation to the children were thoroughly considered within the DHR terms of reference and subsequent agency reports.

Ealing Hospital also undertook a Serious Incident Review and the findings from this were incorporated into their IMR. Despite their relatively limited contact with Crystal, a Serious Incident Review was triggered by the death occurring so soon after Crystal had given birth.

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following agencies:

Advance (IDVA Service)
Brent and Harrow PCT
Central and North West London NHS Foundation Trust (Harrow Drug and Alcohol Service until January 2010)
Compass Harrow (integrated Drug and Alcohol Service from 2010 onwards)
Ealing Hospital NHS Trust
Harrow Adults and Housing Services
Harrow Children's Social Care
Harrow Council – Policy & Partnership
Harrow Domestic and Sexual Violence Forum
Harrow MARAC (information provided by Hestia Housing and Support)
London Probation Trust
Metropolitan Police
North West London Hospitals NHS Trust
Victim Support

5. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. Davina James-Hanman is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence.

All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

6. Terms of Reference and Scope

The full terms of reference can be found at appendix A. In summary, these were as follows:

1. Each agency's involvement with the subjects of the Review.

2. Whether an improvement in any of the following might have led to a different outcome for Crystal:

(a) Communication between services and, in particular, between services in different London Boroughs;
(b) Information sharing between services and, in particular, between services in different London Boroughs;
(c) Joint assessment, decision-making, intervention and monitoring.

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

(a) Professional standards;
(b) Domestic violence policy, procedures and protocols; and
(c) Whether these standards, policies, procedures and protocols are consistent with current best practice and what more could have be done to increase access and take up.

4. The response of the relevant agencies to any referrals relating to Crystal or Rameez, during the period covered by this Review concerning domestic violence or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact within the period covered by this review onwards.
(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
(c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made (d) The quality of the risk assessments undertaken by each agency in respect of Crystal and Rameez

5. The training provided to child focussed services to ensure that, when the focus is on meeting the needs of a child, the welfare of adults is also a significant consideration.

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

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of those involved and whether any special needs were explored, shared appropriately and recorded.

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

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

10. Whether there are lessons for the further development of the Multi Agency Safeguarding Hub (MASH) and information sharing with the diversity of service providers.

It was originally thought that Crystal and Rameez started their relationship 2008 but this was later revised as being 2007. Further information came to light that caused the Panel to revise the scope to 2003 when Crystal became pregnant with her first child. This then became the starting date for the scope until the time of Crystal's death in 2011.

7. Confidentiality and dissemination

7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication, by the Home Office Quality Assurance Panel.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

8. Methodology

Individual Management Reviews (IMR)

8.1. All of the agencies listed below submitted an IMR with the exception of Woman's Trust whose contact was minimal. The IPCC also provided a copy of their report (see parallel reviews).

8.2. Contributing agencies:

- Advance (IDVA service)
- Brent MARAC (information provided by Advance)
- Compass (Drug agency)
- Ealing Hospital Trust
- Each (Alcohol counselling service)
- Harrow Children's Social Care
- Harrow Drug and Alcohol Service (CNWL)
- Harrow MARAC (Hestia)
- Housing - Harrow
- London Probation Trust
- Metropolitan Police
- NHS Brent - GP
- North West London Hospitals NHS Trust
- Victim Support
- Woman's Trust

Agencies completing IMRs and Reports were asked to provide chronological accounts of their contact with Crystal and/or Rameez and their children prior to the homicide. Where there was no involvement or insignificant involvement, agencies advised accordingly. The DHR has focused on the contacts of agencies from 1st January 2003 to December 2011 but also includes relevant information prior to that period. The recommendations to address lessons learnt are listed in section 12 of this report and an action plan to implement those

recommendations are catalogued in Appendix D.

Each IMR was scrutinised by the Panel and in some instances the report was redrafted to take account of questions raised.

The Review Panel has checked that the key agencies taking part in this Review have domestic violence policies and is satisfied that where these exist, they are fit for purpose. For those agencies that did not have domestic violence policies in place, recommendations to address this have been made.

The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

18 agencies/multi-agency partnerships were contacted about this review. Four responded as having had no relevant or significant contact with either Crystal or Rameez.

This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMRs) of participating agencies
- The Police Senior Investigating Officer
- The criminal trial and associated press articles
- DHR Panel discussions
- The perpetrator
- The judge's summing up at trial

A brief conversation also took place with the solicitor who represented Crystal during the care proceedings for her children. Although declining to share details of the proceedings on confidentiality grounds, the solicitor did share her impressions of Crystal and Rameez.

At one Panel meeting, the issue of next steps was discussed. It was agreed that the following options should be considered:

- Holding a seminar – ensuring all professionals involved in the case are invited to a presentation on the findings
- A cross-borough event.
- Dissemination through bodies and various events such as the DSV Forum, LSCB, LSAB, SCR group, Safer Harrow.

It was also recorded that the Community Safety Partnership is responsible for monitoring the action plan of the final report.

8.4. Involvement of family and friends

Extensive efforts were made to involve family and friends. At the start of the process, the Chair made contact with Crystal's mother and sister to inform them of the DHR. At their request, due to the on-going criminal trial and IPCC investigation, contact was not resumed until these processes had concluded. Although initially expressing interest in contributing, with several meetings arranged and then postponed, both her mother and sister eventually stopped responding and a decision was made to conclude the DHR without their input. The Panel is aware that the murder has had a devastating impact on

them both and appreciates that they do not want to engage in a process that has the potential to cause still further distress.

After the trial, the perpetrator was also contacted and invited to participate. After lengthy negotiations, the Chair eventually met with the perpetrator in prison for several hours. This was both a sobering and enlightening experience and the Chair would like to record her thanks for his input and the support of London Probation in arranging this visit.

The Panel agreed that post publication, a full and un-redacted copy of this report would be placed on the files of Crystal's three children so that should they come seeking information later in life, it would be available to them. In the event of this occurring, the key message that Rameez wanted them to know was that Crystal loved them dearly and that the loss of them caused her more pain than she could bear.

Efforts were also made to contact friends of Crystal and Rameez but no responses were received.

9. Chronology

Agency contacts with Crystal, Rameez and their children numbered almost 800 over the nine years preceding the murder. Agency records prior to this date were also provided to the Panel and although encompassing a smaller number of agencies, also ran to several hundred contacts dating back to when Crystal was seven years old.

It is clear from agency records that Crystal's childhood and adulthood was often unstable and chaotic. Due to the issues involved, drug addiction and child protection in particular, agency involvement was on-going and extensive as was regular involvement of the police in their lives. It is likely that Crystal experienced extensive physical and sexual abuse as a child which did not abate as she reached adulthood. She gave birth to her first child at 15 and a second at 21. Both children were permanently removed from her care; the first step in this process began when her daughter was two and a half years old, becoming permanent almost two years later, in the same month that Crystal had a termination. Her son, born two years after this, was removed from her care at birth. Two years later, almost six weeks before Crystal was murdered, she gave birth to her third child which was, once again, removed from her care, also at birth. The Panel did not question the decisions made with regard to Crystal's children but noted these events to understand the circumstances which shaped her life and to note the impact of cumulative trauma. Searching questions were made of responses to her as a child when it was felt she was seriously failed. The Panel accepted that practice has changed beyond all recognition since that time and thus this report does not dwell on those years except to note its likely impact on Crystal's need to self-medicate, her involvement in prostitution and her trust in authority, all of which had consequences that likely further eroded her sense of self-worth.

The chronology of events is very long due to large amounts of agency contact. Despite the length, the number of agency contacts has been dramatically reduced by excluding, for example, routine medical appointments or agency records that merely reflect the sharing of the same information. Most of the routine referrals to Victim Support following police contact have also been omitted for brevity. In all cases this resulted in a single call from Victim Support and a declining of support by Crystal. Extensive information about other family members has also been omitted except where it provides context to the lives of Crystal or Rameez.

The scope of the Review focused on events from 2003 onwards when Crystal became pregnant with her first child. However, a summary of events prior to this date was also

provided by both the Metropolitan Police and Children's Social Care and is included here to give a complete overview of Crystal's life. The Panel believe that the failure to protect her as a child undoubtedly continued to resonate throughout the remainder of her life.

Except where otherwise noted, all incidents resulted in appropriate referrals and information sharing with other agencies although some interesting discrepancies were noted in what was recorded. For example, in one incident police records state that they attended a family argument and no further action was taken but Children's Social Care (CSC) record 'Mother drunk. Arrested for assault.'

Before 2003

Prior to 2003 there is information on files but it often lacked detail. As such, this DHR has had to rely on chronologies which do not always provide background details in respect of the incidents chronicled, including whether and how they were investigated.

However, for Crystal, the chronology prior to 2003 provides a set of family dynamics and behaviours which are repeated time and again, not only within the family, but with others outside of the family. Although it is not clear what had been substantiated or not, the concerns prior to 2003 include:

1) Sexual, physical and emotional abuse to Crystal, her sister and her mother
2) Sexualised behaviour and language by both Crystal and her sister
3) Violence between the adults, between the siblings, and between the adults and the children. It should be noted that all of these incidents were 'non-crimed' and involved various permutations in terms of who was the perpetrator and who was the victim with all parties occupying both positions at different times with no one pattern dominating
4) Violence between family members and others in the community
5) Non-compliance with intervention and retraction of allegations
6) The family minimising or refuting concerns
7) The state of the family home
8) Crystal having under age sexual relationships
9) Suspected involvement in prostitution by Nadira, Maryam and Crystal[2]
10) The (in)ability of Nadira to provide an adequate and appropriate level of parenting and parental control
11) Lack of regular school attendance (Crystal never seemed to attend formal schooling again after October 2001, aged 13)

Most of the above concerns continued post 2003 although it should be noted that Crystal turned 18 in 2006 and her sister in 2007 and were thus no longer children. Nevertheless, it could be argued that professionals stopped recognising them as children several years before this was actually the case.

[2] In the cases of Crystal and Maryam this is, of course, child sexual exploitation rather than prostitution.

Rameez was born in 1984. His mother died when he was two and his father died when he was 16. Rameez reported violence from his father and began smoking cannabis when he was 13 years old. In 2000 he is arrested for possessing an offensive weapon in a public place and using threatening, abusive, insulting words and behaviour with intent to cause fear of violence. In 2002 he is charged with driving otherwise than in accordance with a licence, using a vehicle while uninsured, resisting or obstructing a constable and later the same year, is arrested again for driving while disqualified, with no insurance and failing to surrender to bail.

In December 2002, Crystal is confirmed as pregnant. She is 14 years old.

2003 – 2007

This period covers some of the events which shaped the lives of Crystal's and Rameez in the years immediately to their relationship beginning although they met in 2004.

2003

January: Nadira's nine day old baby dies.

March and April: There are three non-crime domestic incidents recorded and an allegation of stalking is made by Crystal. A fourth non-crime domestic incident is made in May. In all of these incidents, Maryam is the suspect and either Nadira or Crystal are recorded as the victims.

March: Children's Social Care (CSC) hold a strategy meeting. The strategy meeting heard that there had been concerns regarding sexual, physical and emotional abuse dating back to 1993. Nadira said that she herself was sexually abused when she was 17 years of age and ran away from an arranged marriage. She reported that Crystal's father was involved in drugs and alcohol and her daughters were conceived in rape. When shouting to them, she would refer to them as 'rape babies'.

May: A pre-birth assessment is under taken in relation to Crystal's unborn baby, Rose. Reasons for this provided on file include:

- A very young mother, with little experience for caring for a baby.
- Previous concerns regarding the family relationships victims of harassment and bullying
- Non -school attendance

The meeting noted that Crystal had been informed of the Harrow Young Mothers Support Group but had not attended as yet. The father of baby was Surya (17 years old), but at the time of the pre-birth assessment, Crystal said that he would not be offering practical support. Crystal said that they were no longer together and that she would be getting support from her mother. The pre-birth assessment recommended a Core Assessment with a possible Child Protection Conference. Very little is known about Surya on file as neither Crystal nor her mother could / would provide relevant details.

July: Aged 15 years, Crystal gave birth to a daughter, Rose. There was a CSC referral made when baby was born, because of the maternal age (teenage pregnancy). The family initially declined CSC involvement. Crystal and the baby were discharged to Nadira's home.

September: Crystal reported a burglary but declined to provide a statement and the matter was closed.

October: The family home is burnt down by a firework pushed through the letter box. A homeless application was made on the grounds that Nadira was fleeing drug dealers but the application was later withdrawn.

November and December: There are two further 'non-crime domestics'; one with Crystal as a victim and the second with her as the suspected perpetrator.

During this period, Crystal is not in school.

2004

March: Crystal alleges that her ex-boyfriend (not Rameez) kicked her in the stomach during an argument whilst she was pregnant. A linked CRIS report is created for unlawful sexual intercourse. It later transpired that Crystal was not pregnant.

April: Crystal makes an allegation of rape stating she had been held against her will and raped by two suspects. However she declined to assist with the medical examination or in handing over clothing. She later identified a male during a chance meeting and this male was arrested for other matters. Crystal declined to further substantiate the allegation.

Also this month, a Child Protection Conference recommends that a parenting assessment of Crystal be undertaken to ascertain whether she was capable of raising Rose and whether she was capable of taking a more active role as a parent.

The case conference noted that Rose met all her developmental milestones, was happy, normal, clean and appropriately attired. Nevertheless, Rose is made the subject of a child protection plan. There are no records of a direct discussion with Crystal about the reasons why there is a Child Protection Plan in respect of Rose, what her views are or any documented discussion with Crystal about her circumstances and vulnerabilities.

May and November: There are a further two 'non-crime domestics' recorded, both with Crystal as the alleged victim and her sister as the alleged perpetrator.

September: Rameez is arrested for possessing a prohibited weapon and possessing a controlled drug (cannabis)

At some point this year, Rameez, a friend of the family, moved into the family home with Crystal, her sister and her mother and stayed for several months.

December: An anonymous referral to the NSPCC stated that Rose was inappropriately dressed for the cold weather, that Crystal had been seen getting into a car late at night and money being exchanged and that Crystal was dependent on her mother for the majority of Rose's care.

The matter was investigated and the allegations could not be substantiated.

2005

January: Crystal is stopped by police who believe they saw her dispose of a wrap of heroin but they cannot link it to her, so no further action is taken.

February: Rameez is again arrested and prosecuted for cannabis possession.

March: Two arguments between Crystal and her sister are reported to the police and the following month, Crystal is given a harassment warning. In May and June there are a further three verbal arguments reported, two of which also involve Nadira.

April: An anonymous caller to the Police stated that Crystal and her sister were taking heroin and prostituting from the home address. A joint investigation by Police and CSC could not substantiate the allegations.

September: The allegations in the previous entries were discussed at a Child Protection meeting. It was recorded that Maryam was spending £200 a week on heroin and crack, believed to be funded by prostitution and trafficking of drugs.

October: Crystal is referred by CSC to Harrow Drug and Alcohol Service because of her drug use – heroin, crack cocaine, and cannabis.

December: At a further Child Protection meeting, it was decided to deregister Maryam, but list her as a Child in Need. Crystal was also believed to be working in prostitution, using heroin, crack, and cannabis and abusing alcohol. Rose had recently been re-registered for emotional abuse, and it was decided to initiate court proceedings.

Crystal is formally assessed by the Harrow Drug and Alcohol Service. On assessment she declared that she wanted to stop illegal drug use. She stated that she was regularly using heroin, crack cocaine, Methadone and skunk cannabis. She claimed that she had been using drugs for about 18 months i.e. from summer 2003. It is suggested in the notes that there was concern that she had been working as a sex worker for some of that time.

NB: The term 'sex worker' was the preferred professional term for those who were engaging in sexual activity for money at the time and the term used in the agency records. Given the changes in professional terminology these terms would not be utilised today. Crystal would be described as a vulnerable young women and therefore at increased risk of being exploited - especially sexually.

Later, Crystal said that one of her motivations for seeking help was her daughter Rose who was on the child protection register. The risk assessment also highlighted problems with child care and diet. The social worker in his notes identified that contact with Crystal and her family was difficult. A review of attendance showed that she had about 50 appointments with the clinic and other agencies in Harrow between 10th of October 2005 and 30th of June 2006 of which about 30% were missed. Files also record frequent late attendance for those appointments that were kept.

2006

January: Rose becomes a 'looked after child'.

February: Crystal reports to the police that she had stayed around her boyfriends (not Rameez) the previous night. He had become abusive and pulled her hair and punched her. He then locked her in his room in the flat and would not let her leave saying that if she went to the police he would kill her. She waited about 8-9 hours until the early hours when he was asleep and had then jumped out of the first floor window to the grass below and went to find help. Crystal later declines to substantiate the allegation so no further action is taken.

At a meeting with CSC, Crystal's mother and Aunt were proactive in accessing drug and alcohol services for Crystal who agreed to attend weekly group work. She tested positively to cocaine, opiates, and Methadone. Crystal is formally prescribed with Methadone. A Family Support Worker spoke to Crystal regarding seeking help from her GP in order to refer her to a detox unit and some counselling. Rose's foster carer expressed concern about the people accompanying Crystal to the contact centre but no further information was available.

A Social Worker met with Crystal's mother and grandmother who were keen to be assessed for a Residence Order in respect of Rose. Crystal was also present and described as 'very sleepy and tired' and 'not very vocal in the meeting'.

March: Rose was moved to a more culturally matched placement against Crystal's wishes as the placement was in the neighbouring London Borough of Hillingdon. Test results for Crystal this month were positive for Methadone, cocaine, opiates and morphine. Crystal and her mother disputed the tests stating that they must have been contaminated.

Crystal misses two appointments with the Harrow Drug and Alcohol Service.

April: Crystal attended the Harrow Drug and Alcohol Service, testing positive. There was telephone contact followed by an office visit with CSC. The meeting discussed video evidence of Crystal soliciting. Both Crystal and her mother denied that it was her.

May: Three incidents are reported to the police: an assault by a gang of women; a theft and a robbery, all with Crystal as the victim. None of the reports are substantiated and thus no further action is taken.

September: A verbal argument between Crystal and her sister is reported to police. No further action is taken. The following day a third party reports witnessing Crystal being assaulted by an ex-boyfriend (not Rameez). Crystal declines to substantiate the allegation and no further action is taken. Ten days later, Crystal reports a robbery by two women but later withdraws the allegation.

April – September: Crystal's attendance at Harrow Drug and Alcohol Service is minimal. However, in September she tests positively for crack and crack cocaine. Harrow Drug and Alcohol Service report that she needs 'a lot of help to come off drugs and Methadone' and the following month report to CSC that Crystal is now also drinking 'a lot' of vodka.

October: Two verbal arguments are reported to the police with Crystal as the victim; one with her sister and one with her mother. No further action is taken.

November: Crystal makes an allegation of domestic violence (not Rameez) but later says she lied and the case is withdrawn. There are two further reports of domestic violence: one later the same month and the other in December which follow the same pattern. There are also two family arguments reported to the police involving Crystal, her mother and her sister. In one of these, Crystal is arrested for assault but her mother later withdraws the allegation.

2007

January: An allegation is made by Crystal against a former boyfriend (not Rameez). Crystal later declines to substantiate the allegation so no further action is taken. Later the same month Crystal makes an allegation of robbery and claims her 'medicine' (Methadone)

is missing. Crystal later declines to substantiate the allegation so no further action is taken.

February: An allegation is made by Crystal against a former boyfriend (not Rameez). Crystal later declines to substantiate the allegation so no further action is taken.

March: Another family row is reported to the police. The Local Authority is granted a Care Order with a Placement Order in respect of Rose.

June: CSC records that there is a smell of alcohol on Crystal during a contact session.

September: CSC are contacted by Crystal's Aunt who describes Crystal's new boyfriend (Rameez) as a 'decent guy'.

October: Crystal has a termination of pregnancy at ten weeks on the grounds of being single mother of one child and a user of crack and heroin.

The same month, Crystal, her mother and grandmother have a farewell visit with Rose. Also in attendance was Crystal's boyfriend, Rameez, who Rose referred to as 'Uncle Rameez'. This is the first time they are linked in agency records. Crystal was offered post adoption support but did not attend any of the appointments.

2007 – 2009: Children Social Care records detail reports of domestic violence but no action. This is because Crystal no longer has a child living with her and she is now over 18 years old.

2008

January: Rose is made the subject of an adoption order.

February: Crystal is arrested for possession of Methadone and cautioned.

April: A burglary is reported at the family home. The suspect is believed to be Maryam but Crystal declines to give a statement and the case is dropped.

June: An adoption order for Rose is made by the Court.

July: Police are called to a domestic violence incident between Crystal and Rameez. Crystal had gone to Rameez's address and after a drunken argument he threatened to kill her. She alleges he threatened to stab her and burn her with lighter fluid. She escaped from the address and approached a member of the public who was also assaulted by Rameez. Rameez was arrested and cautioned for the assault on the member of the public but as Crystal declined to provide evidence, there was no further action in relation to any other offences.

A week later, an allegation of Actual Bodily Harm is made to police by both Crystal and her sister, against each other. Both victims later withdraw their allegations.

Four days later, Crystal reports an assault from Rameez who she describes as her ex-partner. Records state that he made threats to kill her and held a knife to Crystal's face. Rameez was bailed to return to the police station with pre charge bail conditions not to contact Crystal either directly or indirectly. Crystal was contacted by Advance (the IDVA service in the neighbouring Borough of Brent where the offence occurred) and she disclosed physical, sexual and emotional abuse including jealous and controlling behaviour. Police and court processes are discussed. Crystal requested written information be sent to her about services and she was encouraged to call if she required further

support or information. She agreed to be referred to Woman's Trust for counselling and an information letter about Advance was sent. Rameez is given a caution.

Advance contacts Crystal a few days later and she asks for help for Rameez who is with her. Advance terminate the call explaining it is unsafe to speak to her whilst she is with Rameez. A follow up call two weeks later is unsuccessful as the number is unavailable.

August: Woman's Trust make contact with Crystal to offer counselling. Crystal says she no longer needs any counselling and this is the last contact Woman's Trust have with her.

Advance also make contact with Crystal to update her about the caution. Crystal says she has separated from Rameez. They discuss options around housing and injunctions and Crystal says she will contact them if she requires further support. Advance later refer the case to Harrow MARAC although this takes three months.

October: A further verbal argument between Crystal and her sister is reported to the police.

A week later, Crystal makes an allegation to the police that she was slapped, kicked and punched by Rameez causing bruising, swelling and cuts. Rameez was arrested and charged with Common Assault. He was convicted at Brent Magistrates Court the following March.

At this month's MARAC meeting in Harrow, a member of Crystal's family has her case heard.

At the end of the month, Crystal meets with the adopter for Rose.

December: Records from Harrow Drug and Alcohol service state that Crystal attended as arranged for her appointment. She continues to use heroin and crack on which she says she spends £20 twice a week. There is no record as to whether this implausibly small sum was challenged. She also reported using cannabis daily (4-5 joints). Physically, no complex problems were reported and she appeared stable in mood as she had started a new relationship. Records do not specify who this was. Crystal had not contacted EACH (a counselling service) as previously encouraged but planned to follow it up that day. The resulting plan was to continue on current prescription of 60mls for 2 weeks, for a care plan to be discussed and for Crystal to be drug screened.

Ten days later, Crystal was arrested at an address, along with others, after the execution of a drugs warrant and found to be in possession of cocaine. The case results in no further action.

2009

January: Crystal's case is discussed at Harrow MARAC. Risk is classified as medium. Actions arising are for the police to look into the case with regard to where the incidents are occurring (as the case may need to be referred back to Brent) and for Harrow Drug and Alcohol Service to identify the name of the person Crystal was in a relationship with and to link in with the Police.

Ten days later, Crystal reports an incident of domestic violence to the Police. Rameez had spat in her face and then slapped her around the face twice. He also breached the bail conditions not to contact her that were still in place from the previous incident. Crystal said they had been at home when all of a sudden he had become angry about something, got up and stormed out of the address at about 7pm. Crystal said that she then made her way to meet him to try to calm him down. When she met him he became angry again and

started to spit at her and told her to go away. Rameez is arrested at Wembley Police station for breach of bail conditions and common assault.

Rameez changes his plea to guilty on both the previous common assault and for the new incident of common assault. A pre-sentence report was requested and the case was adjourned for sentencing to mid-February. Meanwhile, Rameez is remanded in custody. Advance speak to Crystal at court as she had attended the hearing. Crystal indicated that she wanted to withdraw her statement and that she was reconciling with Rameez as she was two months pregnant. Crystal confirmed she did not require support from Advance but wanted to know to which prison he had been sent.

Two days later, Crystal attends Harrow Drug and Alcohol Service and is seen in the absence of her keyworker. She had dropped in to collect her prescription which she says she could not collect two days ago as she didn't have an appointment. She denied current illicit drug use, claiming to be in withdrawal. She appeared unkempt and poor personal hygiene was observed. She said she was settled in her mood, not depressed and not suicidal and wanted to continue with her Methadone treatment. She disclosed plans to have another baby with her new boyfriend and was advised to seek advice from her keyworker, with whom an appointment was booked.

February: Crystal attended Harrow Drug and Alcohol Service (right day, wrong time). She denied any drug or alcohol use since last seen. Crystal disclosed she was currently eight weeks pregnant, and would be keeping the baby. Another appointment was booked for the following day with her keyworker, along with another staff member who would be taking over as key worker, to explore pregnancy interventions that may be required. Throughout this period, Crystal is trying to reduce her drug intake, including her Methadone.

A week later, Advance make contact with Crystal to inform her that the case has been delayed due to Probation being unable to gain access to Rameez in prison for the pre-sentence report. Crystal says she wants to withdraw charges but it is explained to her that as Rameez has already admitted to the offences, it is too late to make a difference.

A week later police are called to a verbal altercation between Crystal and her sister.

The same day, Probation conduct a pre-sentence report interview with Rameez via video-link. A full report was prepared and sent to Court. Rameez was assessed as presenting a medium risk of harm to Crystal and being at medium risk of re-offending. Alcohol misuse was identified as a contributory factor which needed to be addressed. A proposal was made for Rameez to be sentenced to a Suspended Sentence Order with a requirement of Supervision and a requirement to attend the Integrated Domestic Abuse Programme (IDAP).

Also on the same day, Crystal attended Harrow Drug and Alcohol Service to collect her prescription. She denied any additional drug use for the past eight weeks. A pregnancy test was done and confirmed positive. Physically and psychologically no concerns were reported. A breathalyser showed a blood alcohol level of 0.24 mg% and Crystal admitted drinking but stated this was the first time in five days. Crystal added that she was still having problems with her sister after contacting 999 services recently. Her GP was contacted by her key worker and an appointment arranged to get booked in for antenatal care.

Three days later, Crystal makes a homeless application from her mother's address giving her sister's violence as the reason. She also mentioned that she would like her partner to be housed with her. Housing noted that at the time of the application he was in Wormwood Scrubs prison.

March: Police are called to the home address of Crystal's mother. An allegation was made that someone had tried to kick in the front door and thrown a Samurai sword at the window. The Safer Neighbourhood Team are engaged but there is no further investigation. It is suspected that this is a false report.

Crystal attended Harrow Drug and Alcohol Service to collect her prescription. She reported that she was about nine weeks pregnant and has seen the GP to be referred for antenatal care. She plans to continue with the pregnancy. She is currently pursuing a housing application as she does not intend to continue to live at her family home whilst her sister lives there. She mentioned that her daughter Rose was removed from her care as her sister was residing at the same address. A prescription was issued to cover one week.

The following day Crystal attends Harrow Drug and Alcohol Service and is seen in the absence of her current key worker as she was not available. Crystal was made aware of the plan to refer her to Children Social Care for assessment given her pregnancy and her previous involvement with the Local Authority care proceedings in relation to her daughter Rose. Crystal reported that her circumstances were different this time; before she did not want to address her problems but now she had been drug free for some time and felt guilty regarding their use. However, she then disclosed that she had smoked heroin and crack on Monday with friends as she was very stressed at being so far from her partner. She said he was away in Pakistan and was due to return soon (this is untrue; he was on remand). She also mentioned the difficulties of living with her sister, Maryam. She denied any previous or current difficulties with her partner, describing him as being very supportive in relation to her attempts to engage in treatment. Crystal did not make any reference to domestic violence and nor was she asked directly. Risks to the unborn baby were discussed and the effect on her plans to reduce her drug intake. Records state that Crystal was eager to reduce her drug use due to the pregnancy.

Her urine drug screening confirmed use of heroin and crack and Methadone (latter as prescribed).

She reported feeling well physically and psychologically; her sleep and appetite had improved and overall she was positive about her efforts to address her substance misuse issues. A note is made to contact the Local Authority for any information that they may have in terms of cognitive functioning and IQ should residential rehabilitation be put forward as an option for Crystal once the baby is born.

Five days later, Advance spoke with Crystal at the court prior to the sentencing hearing. The Defence were attempting to enter a limited plea but this was not accepted by the CPS so the earlier guilty pleas were maintained. Crystal wanted Rameez to be released as they were planning to make a homeless application together. Advance provided safety planning advice and discussed refuge. Crystal confirmed she did not require this. Advance agreed to call her later with the sentencing result.

Rameez was sentenced to four months imprisonment, suspended for two years for each common assault to run concurrently, a Community Order with 24 months supervision including the Integrated Domestic Abuse Programme (IDAP) and £200 costs to be paid to the court. Advance tried twice to call Crystal but each time there was no answer.

The following day, Crystal and Rameez made a joint homelessness application. A week later they are offered, and accept, a flat on a shorthold lease tenancy.

Also during this month, Crystal continues to attend appointments at Harrow Drug and Alcohol Service although she is often significantly late or attends on the wrong day. Alcohol consumption is detected but no illicit drug use. There is a missed appointment for antenatal care but this is rearranged for the following month. Probation begin their pre-

group work with Rameez in preparation for attendance on the domestic violence perpetrators group and arrange for him to be assessed for support with his alcohol use.

April: Crystal continues to attend appointments at Harrow Drug and Alcohol Service. Oral fluid swabs are obtained and sent to the lab for drug screen analysis. Crystal denies any illicit drug use but admits to some alcohol use early in the month. By the end of the month, however, she is testing negatively for alcohol. She continues to be prescribed Methadone. CSC records that Crystal has tested positively for cannabis but this does not appear in the records of Harrow Drug and Alcohol Service. She reports that she had an antenatal scan the day before and that she is now 16 weeks pregnant. The scan did not identify any abnormalities and she will have a 20 week scan nearer to that gestation.

In the middle of the month, Crystal reports being assaulted by a member of the X family. She and Rameez give statements and an arrest is made. CSC records about this incident state 'mother involved in common assault with another female; she is intoxicated'.

Rameez continues to attend his Probation appointments and reports that he is planning to move in with Crystal and has found work as a cab driver.

At the end of the month, a 999 call was made to the police reporting a non-crime domestic incident between Crystal and Rameez. Police had tried to speak to Crystal at the time but could not locate her after the call. However, both were detained for suspected shoplifting the next day. Police attended but it was confirmed that no offences had taken place. Officers then spoke to Crystal about the domestic violence incident. She stated that it was a minor argument over keys and made no allegations against Rameez. A referral was made to Victim Support but Crystal declined their support.

May: Harrow Drug and Alcohol Service contact the safeguarding midwife who is concerned as there is no recorded evidence to suggest that Crystal has yet attended for antenatal care. They agree to check the system again to establish if there has been a delay in information coming through to her and will liaise accordingly. Ultimately, Crystal does not attend antenatal care until she is 27 weeks pregnant although hospital records state that she subsequently attends most of her antenatal care appointments and engaged well with maternity services.

CSC make a decision to convene an Initial Child Protection Conference and to give consideration to a Legal Planning Meeting. A home visit is made to Crystal and Rameez.

Police record reports of allegations of harassment made by Rameez against a male with whom he was involved in a road traffic accident (brother of a former boyfriend of Crystal's) and an allegation of harassment by the male against Crystal and Rameez. Crystal declined to go to court and the CPS authorised no further action. CSC records this as 'parents threaten another person'.

A member of Crystal's family is discussed again at Harrow MARAC.

Crystal makes an allegation of harassment from a woman known to her and later tells Victim Support that she and her family are too frightened to go out. Despite repeated efforts, Victim Support are unable to make contact again until the end of the month when Crystal says she is fine and does not need support.

Crystal continues to attend Harrow Drug and Alcohol Service and reports continued abstinence from class A drugs but voluntarily disclosed that she continues to smoke cannabis approximately twice weekly. CSC record this as 'Drug screen. Mother positive to cannabis'.

June: Crystal continues to attend Harrow Drug and Alcohol Service. Her drug screens are all negative for cocaine, morphine, Benzos and amphetamines and positive for Methadone as prescribed. Crystal is keen to reduce her Methadone use and says she doesn't feel she would relapse. Appointments were made to take this forward. At each appointment this month, concerns about Crystal failing to book in for antenatal care are raised and efforts are made to facilitate this occurring.

CSC make a home visit to Crystal and Rameez. Four days before this visit, they record that Rameez is going to go to Pakistan for two months although the source of this information is unclear.

Rameez continues to attend his Probation appointments and although he is open with them about other events in his life, there is no record of him sharing his plans to go to Pakistan.

Harrow Drug and Alcohol Service liaise with CSC and agree to attend a case conference to look at placing Crystal's unborn baby on a Child Protection Plan. Information about Crystal's on-going drug tests is shared confirming that she remains negative for cocaine, morphine, Benzos and amphetamines and positive for Methadone as prescribed. At her request, her Methadone prescription is reduced. She discloses continued cannabis use and alcohol consumption of one shot per week and two of her blood alcohol tests are negative. Although Crystal is not being breathalysed daily, the pharmacist has daily contact and has not reported that she has presented in an intoxicated state. A case conference later this month decides to put Crystal's unborn child on the child protection register for neglect. CSC will do further announced and unannounced visits to complete the assessment.

The Police are called to a verbal altercation between Crystal and Rameez. Police are later called back and Crystal alleges a common assault so Rameez is arrested but Crystal later declines to substantiate the allegation. Police records note that Crystal was drunk. Rameez later gives his version of events to his Probation Officer in a telephone call (that it was a row about Crystal wanting to go out in the early hours of the morning to get cigarettes) and requests assistance with accommodation as Crystal has thrown him out. However, when he meets with his Probation Officer a few days later, he says that Crystal called him the next day to apologise and that they are now back together. Probation are also liaising with CSC this month and they pass on information from Rameez that Crystal is still consuming alcohol.

At the end of the month, Maryam assaults both Crystal and Nadira. Police issue her with a Penalty Notice for Disorder for a public order offence. CSC records state 'incident of DV from father'.

July: Crystal attends Harrow Drug and Alcohol Service two hours late for a review appointment. She explains that the police were called by her mother as a female neighbour (to her mother's address) had been very abusive to her, including making racist remarks. The police had to be called to her mother's address two days ago after the same neighbour smashed a window at her mother's address. There had been an injunction in place which this female seemed to have breached. Crystal planned to attend the police station tomorrow with her mother to make a statement. Crystal also reported the incident with her sister and says she does not plan to visit her mother's home again in the near future. She feels that her sister is somewhat jealous of her as her mother is constantly comparing the two sisters and more recently, praising Crystal over her sister in terms of how she has managed to address her addiction. For the remainder of her visits this month, Crystal is late and reports feeling tired due her late stage of pregnancy. She continues to test negative for illicit drugs (although discloses a reducing intake of cannabis) and her

Methadone is reduced still further. She reports being abstinent from alcohol 'for some time' although at the end of the month she admits to 'one shot of vodka seven days ago'.

Rameez attends Probation and says that he and Crystal are considering counselling to ensure that their relationship does not put the baby at risk. He says that CSC are looking at a referral to the Strengthening Families Programme to learn parenting skills. The case will be referred to the Children in Need team and a new social worker will be allocated. Housing issues are also discussed as the couple wish to move to a safer area. Rameez misses his next appointment with Probation (agreed in advance) in order to attend a scan with Crystal.

CSC make two home visits this month. Records state 'flat untidy'.

August: Crystal continues to attend Harrow Drug and Alcohol Service. Her drug screens are all negative for cocaine, morphine, Benzos and amphetamines and positive for Methadone as prescribed. Her Methadone is reduced still further.

Crystal calls the police and says Rameez woke up in a bad mood and during an argument he pushed her down onto the bed and slapped her face. He then blocked the flat door and refused to let her out. Crystal rang police and locked herself in the bathroom until the police arrived. Rameez was arrested but Crystal declined to make a statement so the CPS advised no further action. CSC record: 'Police called, alcohol smelt on mother's breath, father arrested'. CSC relay this information to Harrow Drug and Alcohol Service who confirm that Crystal has been given negative alcohol readings on attending the service and that she had not been intoxicated or smelling of alcohol during reviews. She also did not exhibit any signs of alcohol dependency as she has not been presenting in withdrawal. However Crystal had reported alcohol use once a week in the past few months but in the recent review mentioned that she had not been drinking at all recently.

CSC attempt three home visits this month but only one is successful. Records state: 'mother says father is living in Wembley. Mother admits to using cannabis.' A core group meeting is held where Crystal is asked about the domestic violence incident above. Crystal appears to play down the incident and did most of the talking, speaking on her partners behalf. Rameez admitted to the incident but claimed that things were not all they appeared to be. The couple are again urged to seek couple counselling and provided with details as to how to access this. It is thought that Rameez may have attended Hope, a counselling organisation, as he later makes reference to this when attending EACH. Unfortunately all records have been destroyed so it has not been possible to verify this. It is not known whether Crystal attended either with Rameez (if he went at all) or separately

At the end of the month there is a legal planning meeting and a decision is made to initiate proceedings and a plan for a Coram Concurrent Planning Placement for the unborn child.

Meanwhile there are on-going reports of neighbour harassment at Nadira's home, some of which is racially abusive.

September: At the start of the month, the police are called to a verbal altercation in the street between Crystal and Rameez. No offences are disclosed.

Prospective adopters are located for the unborn baby.

Crystal continues to attend Harrow Drug and Alcohol Service. Her drug screens are all negative for cocaine, morphine, Benzos and amphetamines and positive for Methadone as prescribed. Arrangements are made for her to receive Methadone when she goes into hospital to give birth.

Rameez continues to report to Probation. He shares plans for the baby and says he has not been smoking any cannabis in eight weeks and that he has also cut down on his drinking (two beers a day). He also mentioned that he got a car recently - a Lexus – which he claimed had been given to him by his cousin. He also discussed housing issues and mentioned that he had been seeking counselling and was seeking to attend a parenting class. He asked about the possibility of Probation sending him on an anger management course but was told this was not possible whilst he was also scheduled to attend the Integrated Domestic Abuse Programme (IDAP). However his Probation Officer agreed to try and locate resources that Rameez could contact if he wanted to pursue it on a voluntary basis.

The following day Rameez alleges to CSC that Crystal is smoking heroin and Crystal is arrested for making malicious calls to a female friend of Rameez's although CSC records this as his girlfriend. The day after that, Crystal alleges that Rameez picked her up and took her to his flat during which an argument ensued. He tried to knee her in the stomach, making minor contact. A female friend who was present then 'instigated a course of conduct amounting to harassment'. Rameez was arrested but due to lack of evidence no further action was taken. The other party received a caution for harassment.

A few days later a child protection conference is held which is attended by Crystal, Rameez and Nadira. Nadira calls the police claiming that Rameez was causing problems although this was not, in fact, the case. Crystal tells the meeting that her relationship with Rameez is definitely over.

Two days after the child protection conference, Rameez asks to speak to his Probation Officer; he is very distressed. He discusses the argument a few days ago saying it was caused by Crystal wanting to drink alcohol and smoke heroin despite the due date being imminent. He admitted that he grabbed the heroin from her hand and then decided to leave and to terminate the relationship. Since then she has, however, on numerous occasions, rung and texted him. The Probation Officer read and listened to some of these and noted their abusive content including a threat from Crystal to 'sleep around' before the baby was born. Rameez was advised to keep the texts on his phone in case of further problems and to refrain from having any contact with Crystal.

Three days later, Crystal gives birth to a baby boy, Rehan. A urine toxicology is positive for codeine, morphine and cocaine. The baby is closely monitored but shows no symptoms of withdrawal. Two days after giving birth, Crystal disappears from the ward overnight but returns and is discharged the following day. Rehan is released to the care of foster parents at 14 days old.

Just before Rehan's release from hospital, there is a Core Group child protection meeting which both Crystal and Rameez attend. Later the same day, Crystal calls Harrow police and alleges that Rameez has stolen her phone and assaulted her during the subsequent verbal altercation. The offence was not reported immediately but Rameez was arrested. A later review of the case leads to no further action.

Meanwhile, Rameez makes an allegation of harassment against Crystal based on the aforementioned abusive texts. She was arrested and fully admitted to sending the texts. She was cautioned.

Also occurring this month is a homelessness application from Crystal to be moved to a different Borough as she doesn't feel safe in LB Harrow and a referral for counselling for Rameez is sent by CSC and received by EACH (Ethnic Alcohol Counselling Harrow).

At the end of the month, Crystal is prevented from having a contact visit with Rehan as alcohol is smelled on her breath. Drug tests taken the same day reveal only the

consumption of cannabis but it is not known in which order the contact visit and the appointment at the Harrow Drug and Alcohol Services occurred. Whilst at her drug appointment, Crystal discloses that her solicitor is trying to get her into a mother and baby unit. She was unclear about the details but said that she needed to reduce off Methadone as a condition. Rameez is able to have contact with Rehan although he is late for the appointment. The same day he is granted a non-molestation order against Crystal.

October: This month, Crystal has eight contact appointments with Rehan. She does not attend four of these, only once giving an explanation (she was unwell). At the last two appointments she attends, records note that she is slightly unkempt and has a strong body odour. Rameez attends his three contact appointments.

Rameez also starts substance misuse counselling at EACH. He goes on to attend six weekly sessions in their entirety and a further three partially. After that, however, he disengages and EACH close the file in January 2010.

Early in the month, Maryam makes an allegation of harassment against Crystal and she is issued with a caution. The following day police are alerted to a disturbance by an anonymous female caller. On arrival, the house is in darkness and the occupants are asleep. Rameez is awoken and states he thinks the call is further evidence of harassment by Crystal. She is arrested but there is insufficient evidence to take the matter any further.

At a CSC case conference this month, Rameez claims that his relationship with Crystal ended in April when she began using class A drugs. He claims not to have used any drugs or alcohol since Rehan's birth but alleges that Crystal is using heroin and alcohol. However, Crystal's drug screening urine tests are positive only for cannabis and Methadone as prescribed but it is agreed a hair strand test will also be undertaken.

In the middle of the month, Crystal is arrested for allegedly breaching the injunction taken out by Rameez against her. Crystal admitted meeting him by accident and as Rameez declined to provide a statement, no further action was taken.

Crystal continues to attend the Harrow Drug and Alcohol Service. At the start of the month she discloses continued use of cannabis and a relapse into using heroin and crack. She also disclosed drinking alcohol before the appointment. However at her subsequent appointment she tested positive only for Methadone, and for Methadone and cannabis for all other appointments this month. CSC seek reassurance that the drug tests are supervised and are told they are not. Hair strand testing was again discussed.

In the middle of the month, Nadira and Crystal attend a housing service to discuss their rent arrears. The file notes the recent ending of Crystal's relationship with Rameez who had been 'quite violent'.

November: Crystal has nine contact visits with Rehan although she misses four more. She is noted as being late for four of the meetings and twice as smelling of alcohol. In one visit she is noted as being very quiet but there are no events near to this that may indicate why.

Rameez has five contact visits with Rehan and is noted as being late for three of these.

Housing make contact with Crystal twice to try and sort out her rent arrears.

Rameez continues to attend his supervision sessions at Probation. He discusses his housing issues as he is not currently residing anywhere permanently. He (falsely) reports that he is having contact with his son every other day and asks for help in getting a drug screen to prove that he is no longer using cannabis in his efforts to be a good parent. Probation also

receive information this month about a court appearance by Rameez with several co-defendants on charges of possessing an offensive weapon (claw hammer) from an incident back in September. The case is adjourned until the end of December where it is eventually discontinued.

At the end of the month, Harrow Drug and Alcohol Service note that Crystal has not attended the service since the end of the previous month. CSC are informed and asked to encourage Crystal to make contact if she still requires treatment or they may have to discharge her.

December: Early in the month, an anonymous call is made to the police that Rameez is planning to kidnap Rehan and take him to Pakistan on a false passport. The following day Crystal makes the same allegation to the contact supervisor. This is the only contact Crystal has with Rehan this month as two subsequent meetings are cancelled by her as she is unwell.

Rameez also has one contact visit with Rehan this month.

In the middle of the month, police are called to a hotel in Wembley where Crystal alleges that Rameez has thrown a cup towards her after a verbal altercation. Rameez was later arrested and denied the offence and as Crystal declined to give a statement, the matter attracts no further action.

Rameez continues to attend his supervision meetings at Probation where he claims not to have seen Crystal, to have not been involved in the incident for which he appeared in court last month and to be visiting his son every other day, unlike Crystal who is not visiting Rehan as regularly. He also discloses his worries about the fact that in the past Crystal alluded that he is not the father of Rehan and of his desire to get a paternity test.

Probation are contacted by CSC in the middle of the month and information is shared regarding the kidnapping allegations, the on-going relationship with Crystal and Rameez's arrest at a hotel in Wembley.

CSC say that Crystal has told them for some time that Ramee has been contacting her and suggesting that they should get back together and kidnap baby Rehan. Apparently Rameez has said that he knows where the foster family lives. Due to Crystal's past behaviour and lies, these allegations were taken 'with a pinch of salt'. However Nadira had now confirmed that Rameez had been contacting Crystal regularly and that they continue to see each other. The event at the hotel in Wembley was yet further confirmation. As such, CSC were now also treating the information as serious.

CSC records two weeks later state: 'Father denies DV incident; mother alleges parents are having a relationship & meeting in Ealing, maternal grandmother and maternal great-grandmother's house'

Probation call Rameez and advise him to surrender at his local police station.

Throughout this month, Housing are trying to contact Crystal but she hangs up whenever they get her on the phone and misses three appointments.

At the end of the month, the police are called to an incident between Crystal and Maryam. Both are arrested for assaulting each other but no further action is taken due to a lack of independent evidence.

2010

January: Early in the New Year, Crystal alleges to police that Rameez had pushed her onto the bed. When she got up, he grabbed her by the throat. She ran outside where the argument continued and Rameez threw her to the ground causing minor injury to the rear of her head. Rameez was arrested but at interview, he denied the offence. Crystal declined to provide a statement and no further action was taken.

Three days later, Rameez attends a Probation supervision meeting. Their records state: *'On the verge of tears he remained adamant that the recent information that came to light are just allegations made by Crystal and her family to discredit him. He vehemently denies that he was at the Wembley Hotel with Crystal on the evening of the alleged assault and wants the police to look at CCTV footage at the hotel. He told me that he went to Wembley Police station on the day that I rang him (although intelligence from police indicates otherwise) and he was told by the reception desk that there are no pending investigations relating to him.'*

'Rameez insisted that apart from driving past Crystal one day in Harrow he had not seen her since the last family court proceedings in October. He missed last family court proceedings at end of December due to car problems but was informed by his solicitor of all the allegations that got mentioned in court, including the allegation that he is planning to abduct Rehan. He says that he received phone calls from the police about a month ago asking whether he intends to leave the country and could not understand it at the time. However now it makes sense. He is currently living amongst friends but is of the view that Crystal and her family will not leave him alone and he is thinking of moving to [outside London] as he has some relatives living in the area. He will keep me informed.'

Crystal has six contact visits planned with Rehan this month. Three are cancelled due to poor weather conditions; one Crystal cannot attend as she says Rameez has taken all her money and she fails to attend the remaining two.

Rameez has nine contact visits arranged with Rehan this month; he attends eight but is late for five of them.

Harrow Drug and Alcohol Service discharge Crystal as a client as despite several attempts to engage her in treatment, she has not attended or made contact since October. At the end of this month, the contract for providing drug and alcohol services in LB Harrow passes to Compass. As Crystal is not a current client, information about her is not provided to them.

February: Rameez has eleven contact visits with Rehan this month. He fails to attend one of them and is late for all but three of the rest.

Crystal has four contact visits arranged with Rehan but only attends two.

Rameez reports to Probation that he is aggrieved about Crystal not being prosecuted by the police for wasting police time as a result of her false allegations. He says he is still not using any cannabis and maintains that his alcohol intake is in moderation. He is still in the process of arranging a paternity test.

In the middle of the month, a woman calls the police alleging she has been assaulted by her boyfriend but the call is then terminated. Enquiries revealed that the number belonged to Crystal but efforts to contact her for a statement were unsuccessful.

A couple of days later, Brent MARAC discusses Crystal's case. It is agreed that the case will be referred to Harrow MARAC, along with notifications to other Harrow agencies.

March: Rameez has thirteen contact visits with Rehan this month. He attends only seven of these and is late for all but two of them. On one visit in the middle of the month, he attends with Crystal and requests a joint visit which is refused. Crystal has eight contact visits arranged with Rehan but only attends one. Of those she did not attend, one was because of ill health and another because she was attending a funeral. There are no recorded reasons for the others.

Also in the middle of the month, the police are called following a heated argument between Crystal and Rameez after a drinking session at a funeral wake. No allegations are substantiated so no further action is taken. A few days later Rameez alleges that Crystal burned him with a cigarette and hit him with a shoe. He later retracted this allegation. Crystal made a counter allegation that she had been assaulted by Rameez who had bitten her on the back and grabbed her around the throat. Crystal also later withdrew this allegation.

Rameez attended his Probation supervision meeting. His Probation Officer asks him about his clean shaven head since the last time he was seen, he said he was growing it for hair strand drug tests. Rameez said he had had to shave it off as Crystal hit him on the head with an object and it had to be glued. He then had no alternative but to admit to still seeing Crystal regularly. He claimed to be playing the role of a good Samaritan, trying to help her to get off drugs and to encourage contact with Rehan.

The Probation Officer challenged him about the fact that he was now breaching the very non-molestation order that he had taken out against Crystal. Notes of the meeting state that the Probation Officer felt Rameez was 'all talk' and that his action bellied his stated desire to change his life around. The Probation Officer recommended that Rameez be instructed to report fortnightly again.

Victim Support try several times to contact Crystal and when they eventually make contact, she says that she does not need support.

Housing records state that Crystal has left her property.

An allegation is also made this month that Crystal had broken someone's windows but this was later withdrawn and no further action was taken.

April: Rameez has four solo contact visits with Rehan this month and he attends two. Crystal has three solo contact visits arranged but only attends one.

In addition, there are two joint visits by Rameez and Crystal with Rehan which are attended by all parties.

Towards the beginning of the month, the police are called to Nadira's home after Rameez smashes three of her windows. As both she and Crystal declined to give statements, no further action is taken.

Probation are updated by CSC and as a consequence, additional efforts are made to secure a place for Rameez on IDAP as it is felt his risk is higher than previously thought. Later in the month, Rameez tells his Probation Officer that he is back in a relationship with Crystal although they are not living together. However, he sees her on a daily basis and says that he also takes her to contact with Rehan. He claims that he helps Crystal with money for drugs so as to reduce the need for her to work in prostitution to get the money.

In the middle of the month, the case is once again discussed at Harrow MARAC although on this occasion it is with Rameez as the victim. The police informed the meeting that Crystal and her family were well known to them, to the point where they are considering ASBOs against the family as they take up so much Police time on call-outs to various arguments.

CSC share that they are progressing care proceedings for Rehan and that subsequent to the recent completion of reports on both parents, there is now no chance that either will gain custody.

May: Crystal self-refers to Compass, a drug and alcohol service in Harrow. She is put on a Methadone subscription.

There are seven joint contact visits with Rehan this month. On four occasions, neither Rameez nor Crystal turn up. A further two are cancelled; one is done in person by Rameez who says Crystal is unwell. He is noted to have scratches on his face, cheek and neck. The second time the contact visit is cancelled by CSC as not only are the parents late but Crystal smells of alcohol. In the one successful contact visit this month, Rameez falls asleep.

Rameez does not attend the first of Probation supervision appointments this month. He is called by the Probation Officer at 12:30pm and it is clear that she has woken him. The Probation Officer notes a female voice in the background. Rameez hung up. Eight days later, Rameez attends his next appointment with Probation when he apologises for hanging up and says he was unwell. He mentions having attended family court proceedings the day before and that it did not go very well as it looks as if Rehan will not be returned from care. Probation decide that the key priority is for Rameez to attend IDAP and thus decide not to take any sanctions against him for missing the previous appointment.

June: At the start of the month, CSC record that Crystal has been seen in the street begging for money and add ‘allegations of prostitution’. The source of this information is unclear**.**

Also at the start of the month, a joint contact visit with Rehan is cancelled by CSC. The parents arrive separately for the appointment, Crystal has injuries, smells of alcohol and discloses domestic violence by Rameez the night before. Crystal alleged that Rameez had told her to put a plastic bag over her head. She did not do this, but she claimed that he smothered her with a pillow until she lost consciousness. Although she is encouraged to report this to police, she says she is reluctant as in the past this has just led to Rameez fabricating counter allegations which have previously been believed. When Rameez arrives, he denies everything Crystal has said. He claims not to have even seen Crystal the night before but instead discloses that he had been with friends with whom he had taken drugs. He added that he would be going to Pakistan 'to get away from it all and sort his head out’ as all of this upset was making him go mad. CSC records also state that Crystal appeared to be wearing the same clothes from the previous night and smelt 'unwashed'.

Six days later, Probation receive a call from Rameez saying he is in Pakistan.

Crystal does not attend four further contact visits with Rehan this month but does attend two. On one of these she is noted to have lost a lot of weight and she says she has reconciled with Rameez.

At the end of the month, Rameez attends an IDAP orientation session in Camden, but arrived late. The absence was not enforced.

Crystal continues to attend appointments with Compass. At one of these she discloses that Rameez is also a heroin user and this is affecting her recovery.

July: At the start of the month, Police stop and search Crystal and Rameez in a vehicle. A large amount of cannabis is found and both are arrested for Possession with Intent to Supply. Rameez is later charged.

A week later, Rameez contacts Probation via email and says he is Pakistan and will not be returning for four weeks. Four days later, however, Rameez makes an allegation of common assault against Crystal who he says spat in his face and stole cash from him. He later retracted this complaint and the day after this, he attends a contact visit with Rehan. Unaware of this, Probation make continued efforts throughout this month to ensure that Rameez can still attend IDAP.

There are two joint contact visits with Rehan this month. Both parents attend the first; Crystal's cheek is noted to be swollen but she says this is toothache. On the second, only Rameez attends. He says he doesn't know where Crystal is and is noted to be subdued and unwashed.

Crystal does not attend her appointments at Compass and nor does she collect her Methadone prescription. Efforts are made to try and re-engage her.

Towards the end of the month, Police came across Crystal and Rameez arguing in public. Rameez alleges that Crystal had thrown a can at his car but declined to make a statement so no further action was taken.

CSC continue with care proceedings for Rehan and a final hearing is held at the end of the month confirming that he will be adopted.

August: At the start of the month, Rameez attends his Probation appointment. He agrees to return to court for an extension to his suspended sentence in order to attend IDAP. Despite his apparent co-operation, his Probation Officer notes uncertainty about his motives. Rameez also mentions his impending court appearance for cannabis possession which clashes with one of his few remaining contact visits with Rehan. Probation contact the court to arrange for his appearance to be moved to the afternoon. He also tells Probation that although he takes Crystal to contact sessions, they are no longer in a relationship. He also mentions that she came to his work place again about two weeks ago and caused problems but there was no police involvement on this occasion.

Crystal has three contact visits with Rehan this month; two joint visits with Rameez and one with Nadira also present. Subsequent to these visits, neither Crystal nor Rameez have any further contact with Rehan and shortly afterwards he is adopted.

Also early this month, police are called to Rameez's address as, despite bail conditions, Crystal has arrived to collect property. Crystal is removed from the scene by police but no further action is taken.

September: Rameez reports to Probation and is quite emotional as he recounts his impending last contact with Rehan (which has in fact already occurred). He says that he has moved back in with his friend in Wembley, but continues his relationship with Crystal and admits to staying over at her place some nights and on weekends. Probation offer to see him on a fortnightly basis to which he agrees. However he does not attend his next appointment as he has a job interview. At his next appointment at the end of the month, Rameez says he has met Rehan's adoptive parents and although still quite emotional, believes they will provide Rehan with a good home. He discloses that he has been smoking cannabis in the last two weeks as it helps him to mask his feelings.

He also confirms that he is still in a relationship with Crystal and that they are getting on better and relying on each other for moral support. He says there has not been any violence and that Crystal is trying to reduce her heroin use.

The police have two contacts with Crystal and Rameez this month. On the first occasion, they were called by a neighbour who said Crystal had knocked at her door saying she had

been assaulted by her boyfriend. By the time the police arrived, Crystal had left. On the second occasion, Rameez called the police saying that Crystal was in his house and was refusing to leave. Police attended and spoke to her outside. They noted that she was drunk and upset but as no offences were alleged or injuries noted, no further action was taken.

Towards the end of the month, Crystal attends a doctor's appointment and is prescribed daily Methadone to be taken under supervision.

October: Rameez calls the police alleging that Crystal had gone to his house and caused a disturbance outside the property. He had invited her inside to calm down at which point she became abusive and he alleges she spat at him. Crystal was arrested and gave a different account of events, claiming it was a counter allegation for one she had previously made against him. No further action was taken.

Also this month, Crystal's Methadone dose was increased.

November: Rameez has two appointments with Probation this month. At the first, Rameez reports a low mood and poor sleeping. His GP has signed him off for a month. He says that he and Crystal have been getting on quite well in recent weeks although he is still finding it difficult to cope with Rehan's adoption. He says he has been using cannabis daily and also been drinking more than in the past. At his second appointment, he also admits to sometimes using crack and heroin but is adamant this is not daily and in small quantities.

Probation review his risk rating and increase it to high and implements weekly reporting.

At the end of the month, Crystal tells Compass that Rameez is going to attend treatment with her and she is hopeful that they will both succeed.

Rameez self refers to Compass this month and is assessed for treatment. He screens positive for opiates. He has two further appointments this month and is significantly late for them both, which means it is not possible for him to be seen by the doctor.

December: Rameez visit his GP and tells him that he had a breakdown in March and harmed himself with a razor. He ascribes this to losing his son to the care system and Crystal's drug use. He reports that he is drinking around a bottle of vodka each night to help him with his insomnia and claims to be in receipt of drug services. He is assessed as experiencing moderate to severe depression and is prescribed Citalopram (an anti-depressant).

Rameez misses his next appointment at Compass and the following day sends a letter of complaint about not being treated. Compass make repeated efforts to contact Rameez to discuss his complaint. Eventually an appointment is arranged for January.

Rameez reports for supervision with Probation. He says he has been back to the doctor who has now signed him off for another two months due to depression. He was also prescribed medication and says that now that he is taking Citalopram he feels less on edge and also sleeps better at night. He says there has been no controlling or aggressive behaviour. He mentions that Crystal and her mother have been having arguments recently and Nadira keeps trying to involve him but he is keeping his distance.

Crystal makes an allegation of sexual assault to Harrow police by several unidentified males. She is issued with a fixed penalty ticket for wasting police time.

Crystal attends all her appointments at Compass this month.

At the end of the month, Rameez and Crystal are arrested for ABH and the theft of alcohol. Crystal is charged with theft and a public order offence and Rameez is charged with battery and criminal damage.

2011

January: Early in the New Year, Crystal alleges that she had an argument with Rameez about money. She alleges that during this incident, Rameez attempted to strangle her by putting both hands around her neck. Crystal also alleged that Rameez spat at her, bit her and punched her before holding a pillow over her face until she blacked out. Bite marks and reddening to her neck was observed by the officer. Rameez was arrested and subsequently charged with ABH and held on remand. Crystal later made a withdrawal statement so the matter is withdrawn at court due to lack of evidence.

Rameez did not attend the meeting with Compass to discuss his complaint so another is arranged for the end of the month which Rameez also fails to attend as he is on remand. He is discharged from the service.

Crystal attends all of her appointments at Compass this month and her Methadone dose is increased again.

February: Rameez has his final appointment with Probation as his supervision order has now expired. He says he continues to be in a relationship with Crystal even though he recognises that this isn't healthy.

At the end of the month, Rameez re-establishes contact with Compass. He tests negatively for opiates and they discuss counselling at EACH with him.

Crystal attends all of her appointments at Compass and although she tests negative for opiates, says she is using cocaine once a week.

March: Police are called by Rameez who, on arrival, are told that Crystal had been at the address in an intoxicated state. He had asked her to leave which she then did. No offences are disclosed so no further action is taken.

Crystal attends all of her appointments at Compass and although she still tests negative for opiates, says she is still using cocaine once a week.

April: At the start of the month, Crystal misses an appointment at Compass. A week later, Compass receive a call from the Pharmacist to say that Crystal has not picked up her Methadone for five days. She had attempted to collect early that day but it was not dispensed as her prescription was void. The Pharmacy also reported that Crystal had claimed to be pregnant.

Three days before this, Crystal had a pregnancy test at her GP which was confirmed as positive. However, when Compass made contact after the call from the Pharmacist, she said that she had had flu and was not pregnant. She claimed she had said this to the Pharmacist to try and get the Methadone dispensed. For the rest of the month, she attends her appointments at Compass.

May: Crystal attends two out of three of her appointments at Compass and Rameez is referred to EACH.

At the end of the month, police are called by a member of the public saying that Crystal had made an allegation of assault from her boyfriend. Upon Police attendance, Crystal

Rameez and the third party were spoken to and Crystal made no such allegation. All parties were intoxicated.

The following day the police were called again, this time by Nadira who made an allegation of common assault against a woman known to her. Crystal witnessed this assault but it was decided there was insufficient evidence to take any further action.

Three days later, Rameez called the police after Crystal attended his home in an intoxicated state. No further action was taken.

CSC close their file.

June: Crystal misses a couple of appointments at Compass which she says is due to her supporting her sister with an injunction against some attackers. Before her next appointment, Compass are contacted by the Pharmacist to say that Crystal has not collected her Methadone at all this month. When Crystal attends, she explains that she has been self-medicating with illicit Methadone at a level substantially lower than her prescription. She declines further treatment from Compass.

EACH call Compass to inform them that Rameez is not attending his counselling sessions and two weeks later add that they have had a call from Rameez saying he is too busy to attend and so he is discharged.

Crystal books in late for pregnancy care and in the self-completed form, discloses no history of drug and alcohol abuse, domestic violence or child protection issues. Later in the month when Crystal is asked again, she discloses a past history of cannabis and cocaine use but says there are no current social issues. Nevertheless she is identified as a high risk pregnancy and a referral is made to the Safeguarding Nurse. Crystal discloses her anxiety that 'something bad might happen' with this pregnancy.

July: The only event of significance this month is that Crystal is discharged from Compass as she says she is tolerating the reduction of Methadone and is motivated to come off completely. At the final appointment Crystal mentions that she is intending to go to India for six months.

August: Crystal fails to attend her antenatal appointment and it is rearranged for early September.

September: Crystal misses her first antenatal appointment this month but attends all others. No concerns are raised with the pregnancy.

Meanwhile, all relevant authorities are alerted to Crystal's pregnancy and an Initial Child Protection Conference is agreed by CSC.

October: Crystal is referred back to Compass for help from the Hidden Harm Coordinator who works with substance using mothers.

CSC hold a pre-birth Initial Child Protection Conference and make a Child Protection plan for neglect. Further alerts are made on systems to ensure that Crystal is prevented from leaving any hospital with her child.

Crystal misses another antenatal appointment.

November: CSC arrange for a Legal Planning Meeting to take place to begin the process of removing the unborn child from Crystal's care.

Crystal misses another antenatal appointment but at the end of the month, attends Ealing hospital in labour. Rameez is with her and staff note that they both smell of cannabis. She gives birth to Iqbaal around five hours later who tests positive for cannabis and cocaine but not at a level to be classified as 'in withdrawal'. Approximately 3.5 hours after giving birth, Crystal disappears from the hospital returning some six hours later. On return she declined to undergo a drug screen and was informed it would be assumed she would have tested positive. She still declined. However, she did undergo a drug screen test the following day which was negative.

Compass challenge CSC records that stated Iqbaal was in withdrawal from opiate use and point out that the drug tests suggest that Crystal has, in fact, been largely drug free throughout her pregnancy.

An hour later, Crystal and Rameez visit the baby for the first time since delivery.

Meanwhile, all relevant authorities are notified of Iqbaal's birth. Crystal is discharged the following day. Ealing Hospital notify Northwick Park Hospital of recent events as this is where Crystal was registered for antenatal care and where she had been expected to give birth.

At the end of the month, Crystal is drug screened again and tests negative for all illicit substances. Iqbaal is discharged from hospital into foster care. He is eight days old.

December: At the start of the month, both Crystal and Rameez attend Compass for an appointment with the Hidden Harm Co-coordinator. Crystal is seeking contact arrangements with Iqbaal and information is given about the parenting group. Over the next week, Crystal and Rameez have five joint contact visits with Iqbaal and Nadira also attends one of them. At one of these, it is noted that Crystal seems lacking in confidence and at the last, it is noted that Rameez is ordering Crystal around and telling her what to do.

An interim care order is issued for Iqbaal.

A few days later, an allegation is made by Crystal that Rameez had entered the flat with his brother and had stolen her keys. She also made an allegation of false imprisonment relating to being kept in a taxi. A withdrawal statement is later made by Crystal but Rameez is arrested and interviewed and placed on police bail until 11th January 2012.

On the same day, Rameez attends his contact appointment with Iqbaal but Crystal does not attend. Rameez tells workers that his relationship with Crystal is over after fighting the previous night about her drug use. Crystal had passed out so Rameez took her money and went to get the drugs that she had chosen over their relationship. He also tells workers that the police had called him earlier to say that Crystal wanted to come to the flat to collect her belongings.

Four days later, Crystal once again does not attend her for her contact visit with Iqbaal.

The next day Rameez attends a contact visit with Iqbaal although he is ten minutes late and the following day Crystal attends for her contact visit with Iqbaal. Records state that she is anxious.

There is a further contact visit with Iqbaal by Rameez the day after at which he asks if Crystal attended the day before.

Three days later a Core Group Meeting is held which both Crystal and Rameez attend but they are seen separately due to bail conditions on Rameez. They are both offered support

from Compass and whilst Crystal agrees to engage, Rameez declines saying he doesn't use illicit substances. Iqbaal is removed from the Care Plan.

The next day Crystal has contact with Iqbaal as does Rameez the following day. He reports that he has moved in with his brother.

The next contact visit occurs two days later. Rameez does not attend his allotted contact visit. Crystal has contact with her Iqbaal for what will later prove to be the last time.

Less than 48 hours later Crystal's body is found in the canal, wrapped in a black bin liner.

10. Analysis

The Individual Management Reviews have been carefully considered through the view point of Crystal, to ascertain if each of the agencies' contacts was appropriate and whether they acted in accordance with their set procedures and guidelines. Where they have not done so, the panel has deliberated if all of the lessons have been identified and are being properly addressed.

The Review Panel is satisfied that all agencies have engaged fully and openly with the Review and that lessons learned and recommendations to address them are appropriate.

The authors of the IMRs and Reports have followed the Review's Terms of Reference carefully, and addressed the points within it that were relevant to their organisations. They have each been honest, thorough and transparent in completing their reviews and reports.

10.1. Each agency's involvement with the subjects of the Review.

As noted elsewhere, the rate of agency contact was exceptionally high. With the exception of the drug and alcohol services, the DHR Panel noted how little of the involvement of professionals seemed to improve Crystal's life.

10.2. Whether an improvement in any of the following might have led to a different outcome for Crystal:

(a) Communication between services and, in particular, between services in different London Boroughs;
(b) Information sharing between services and, in particular, between services in different London Boroughs;
(c) Joint assessment, decision-making, intervention and monitoring.

Communication cross-Borough in respect of children was generally good. This was particularly true for Iqbaal who was born in a hospital where Crystal was previously unknown and where she arrived out of hours. Despite this, her history was effectively tracked and acted upon by the receiving midwifery team.

Nevertheless, gaps in communication with regard to Crystal and Rameez, both within and across Boroughs, were often below the expected standard. The delays on the part of the police in contacting Crystal to advise of police updates, court outcomes and bail decisions, and in making MARAC referrals; the delays on the part of Advance in making a MARAC referral, the failure to confirm verbal information sharing in writing between Compass and Children's Social Care, the lack of fact-checking by London Probation with regard to

Rameez's claims to be out of the country and in regular contact with his son, the lack of any evidence of Children's Services entering into joint assessments, or partnership intervention, in respect of supporting and protecting Crystal and the failure of EACH to communicate and liaise with external agencies and professionals involved with the Rameez are just some of the many available examples of sub-standard information sharing and joint decision making.

There are also many examples of records on Children's Social Care in respect of Crystal's involvement with the police and her drug use that are curiously at odds with information recorded in the referring agency.

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

(d) Professional standards;
(e) Domestic violence policy, procedures and protocols; and
(f) Whether these standards, policies, procedures and protocols are consistent with current best practice and what more could have be done to increase access and take up.

It should be noted that much of the period under review also coincided with much activity within the domestic violence sector, with many agencies introducing domestic violence policies and procedures for the first time and practices that are now embedded such as MARACs and risk assessments being introduced. Nevertheless, even taking this into account, there remain many examples of agencies falling below the expected standards. Some examples are given below:

Advance: The quality of the risk assessments were not in evidenced on case files and case recording is not clear as it could have been. Although there is some reference to discussion in supervision with managers about closing cases and making MARAC referrals, these do not seem to have been monitored or reviewed.

Children's Social Care: There was a failure to recognise that Crystal was herself a child when she gave birth to Rose. Thereafter, domestic violence policies were in place and continually reviewed throughout this period with each iteration giving more weight to working with the mother as well as the children. Unfortunately these were developed too late to benefit Crystal.

CNWL: There is no evidence that Crystal's repeated non-attendance and non-engagement was followed up.

Compass: Those involved in her treatment seemed primarily focused upon her substance misuse and there is little evidence of consideration of her wider social support needs which may have underpinned her illicit substance use. Additionally Crystal and Rameez were treated in isolation. Although Crystal had disclosed domestic violence there is no evidence that links were made between her situation and his risk assessment, which included a history of self-harm, violence towards others and depression.

EACH: Case file and notes were incomplete and did not follow required policies and procedures related to record keeping and care-planning.

NWLH: There were inconsistencies in approach and there were instances where the domestic violence and Did Not Attend (DNA) policies were not strictly adhered to such as

routine enquiry of DV during pregnancy especially with a woman with past history of domestic violence. DNA policy was not followed effectively as one of the Northwick Park community midwives could have visited Crystal at home following persistent DNA of antenatal appointments. Furthermore, Crystal's DNA antenatal care appointments were not escalated to senior management or the supervisor of midwives at NWLH which is not in line with the DNA policy. The postnatal care received by Crystal at Ealing Hospital does not reflect best practice and was not in line with national policies for a woman with complex safeguarding social needs and domestic violence.

Metropolitan Police: Although coming to the attention of the police for numerous incidents, each one was often treated in isolation and there was a failure to see the 'big picture'. This subsequently led to inaccurate risk assessments; for example between 2008 and 2009 there had only been one risk level of 'medium' recorded despite Rameez's convictions for domestic violence on Crystal and a total of 14 reports. This had consequences as it meant no MARAC referrals were ever made and the necessity to obtain an in-depth secondary risk assessment was not triggered as this is only done when the risk level is either 'medium' or 'high'.

Probation: In terms of agency policy and procedures, Rameez was adequately assessed and reviewed in a timely fashion in the initial stages of the order but in the latter stages of the order, supervision was less in line with policy, for example to (correctly) assess risk of harm as having risen, but then not to sustain an increase in the frequency of reporting. There were also points during the course of the order when a manager's view should have been sought, not least when Rameez failed to attend appointments for several weeks and advised his probation officer that he had left the country. Enforcement action could have been taken and the order returned to court in June/July 2010 which would have then afforded the opportunity to extend the order to enable him to complete IDAP.

Across all agencies, much more could have been done to engage with both Crystal and Rameez and this would have been aided if agencies had perceived both of them as complex individuals with a range of issues occurring in their lives. Instead, there appeared to be a sole focus on the presenting issue with little professional curiosity as those issues might be interacting with other parts of their lives.

10.4. The response of the relevant agencies to any referrals relating to Crystal or Rameez, during the period covered by this Review concerning domestic violence or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact within the period covered by this review onwards.
(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

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

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

As noted elsewhere, each IMR was subjected to rigorous scrutiny and agencies were challenged in particular over this area. Many missed opportunities were identified both in

the original IMRs and following scrutiny where assessments and services offered could have been improved. Some examples are given below.

Opportunities to intervene and to offer support were missed during the periods that Crystal did not have Rose with her and following the births of her other two children. In particular there was a period between the granting of the final Care Order for Rose and the birth of Rehan in which information about domestic violence was not responded to by Children's Social Care. The child protection and looked after process did not challenge the lack of support for Crystal and whilst there were two referrals made by Children's Social Care to MARAC, other episodes of domestic violence, in particular the forced imprisonment and suffocations, both indications of high risk, were not referred to MARAC. It is clear, from the records of Child Protection Conferences and other meetings, that there was genuine concern about Crystal's safety and that she was encouraged to disengage herself from Rameez. However, professionals working with Crystal were equally aware that she would not be able to do this on her own and once she nolonger had Rose living with her, did not respond at all

Advance also note in their IMR that there were missed opportunities. There is no mention in their records of safeguarding issues that may have arisen due to pregnancy nor was there enquiry in to whether Crystal had contact with her children; consideration of her vulnerability as an adult with additional support needs is also not evident from their files. Compass files showed that one of their doctors did note that future key work should explore Crystal's relationships and feelings around her children but there is no evidence on file that this was taken forwards and nor were any referrals made to Children's Social Care at this time. Their files also record that in September 2010, Crystal had said she was using contraception properly but she not keen to discuss further. Given her history of having children taken into care and her use of substances and chaotic presentation to the service – including her frequently missing collecting her methadone prescription – this is an area that should have been followed up further. There is no record of Crystal being asked about what form she was using or being given advice on longer term options.

EACH noted that the information they obtained through their assessments, including risk assessments, was not utilised effectively to inform the treatment goals with the client, which would have helped to ensure issues related to Rameez's behaviour were also at the forefront. To improve practice, proactive treatment planning based upon the reason(s) for referral assessments as well as the client's own expressed needs is required by counsellors.

The Police also missed opportunities by the police: Rameez could have been arrested for the outstanding domestic violence offence in March 2010 when he was arrested for cannabis possession; the incident in January 2011 was assigned a 'medium' risk rating which was then reduced to 'low' based on faulty reasoning. There were also missed opportunities to make MARAC referrals.

Probation notes that risk assessments were predominantly based on the information and version of events presented by Rameez and that more robust partnership work and information sharing should have been undertaken. Moreover, more effort should have been made to secure a place on the IDAP programme for Rameez before his order expired.

The Panel also noted the lack of any robust effort to engage Crystal with services in relation to the domestic violence and to think through what kind of support she may have been willing to accept. This particularly related to the period when she was pregnant with Rehan when she was more willing to engage; after it became clear she would lose him, Crystal rapidly deteriorated.

10.5. The training provided to child focussed services to ensure that, when the focus is on meeting the needs of a child, the welfare of adults is also a significant consideration.

Across the agencies that this concerns, it is fair to say that this was not the case at the time of the events in question. Training has now been introduced in all the relevant agencies to rectify this matter and there is significantly more emphasis on 'think family'. In addition, there has been a wholescale review of all domestic violence training within the Borough.

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

There were many instances where this was not achieved.

Given the concerns in relation to Crystal and her immediate family, a Child Protection Conference should have been convened following the initial pre-birth assessment on the unborn Rose. This should have resulted in them both being the subject of a Child Protection Plan. In addition, an intervention strategy in relation to Crystal should have been continued following the final Care Order on Rose. Subsequently to this, Children's Social Care should have discussed reports of domestic violence with Probation, Police and, of course, Crystal herself. The escalation of domestic violence incidents should have been referred to MARAC and CAADA-DASH risk assessments completed.

Likewise, Ealing Hospital focused on safeguarding Iqbaal and not on safeguarding Crystal as a vulnerable adult. As such, risks to Crystal were never assessed.

Risk was not properly assessed on several occasions by the Metropolitan Police but even when the case was referred to MARAC, there was an over-emphasis on information sharing and scant regard to reducing risk.

Compass was aware of both domestic violence and safeguarding issues but these were not adequately explored or followed through. As a result interventions were focused upon Crystal's substance misuse in isolation from the other issues in her life. Services that might have been offered and referrals on to specialist domestic violence or Children's Social Care were not made. There was a reference to EACH counselling but there is no evidence this was followed up. It is acknowledged that Compass staff at the time completed basic risk assessments but did not update these or review potential risks to Crystal when Rameez disengaged from treatment.

As noted above, Probation and Police did not always correctly calibrate risk with resulting acts on what interventions were made.

10.7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of those involved and whether any special needs were explored, shared appropriately and recorded.

All nine protected characteristics in the 2010 Equality Act were considered by the DHR Panel. Several protected characteristics were found to have relevance to this DHR. These were:

Age: Crystal was only 14 when she became pregnant with her first child. She was using heroin and crack by 15 and suspected of involvement in prostitution. She was only 23 when she died.

Marital status: Crystal was not married to Rameez. Evidence from the Crime Survey of England and Wales indicates that unmarried women are more at risk of domestic violence than married women although the highest risk group is separated women. Crystal and Rameez were in a cycle of break-ups and reconciliations at the time of the murder.

Ethnicity: Crystal and other members of her family were subjected to racist abuse and harassment on a number of occasions. At one point, their family home was burned down. The Panel do not know the specifics of any impacts this may have had but suggest that these are traumatic experiences which are unlikely to have had no impact.

Pregnancy: Over the course of the Review period, Crystal had four pregnancies of which three resulted in a live birth. None resulted in her having a child who lived with her except for Rose who did so for a few years. Pregnancy is a well-known time for domestic violence to begin or increase in severity and Crystal was assaulted several times when pregnant.

Sex: Sex is also relevant as there is extensive research to support that in the context of domestic violence, females are at a greater risk of being victimised, injured or killed[3]. Latest published figures show that just over half of female victims of homicide in the UK aged 16 or over had been killed by their partner, ex-partner or lover (54%). In contrast, only 5% of male victims aged 16 or over were killed by their partner, ex-partner or lover.

With respect to the agencies involved in this review, no IMR found that any of the protected characteristics impacted on the services delivered. Nevertheless, it should be noted that six IMRs found there were no records of the relevant information in their files so it is difficult to see how these issues could have been appropriately explored.

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

The Panel found a number of instances where matters ought to have been escalated but this did not occur. In CSC there was no evidence of Senior Management involvement in relation to the incidents of domestic violence and the practice at the time was that Team Managers did not routinely attend Child Protection Conferences or Looked After Reviews. There is little evidence that the personal impact of the domestic violence on Crystal was discussed in supervision, either between the Social Worker and the Team Manager, or between the Team Manager and Senior Management. Similarly, it is not clear from the records what discussion took place with senior managers around escalating the matter to legal proceedings in relation to Rose.

Within Compass, risk issues during Crystal's first treatment episode do not appear to have been recognised and were therefore not escalated to senior management or other organisations and professionals in a timely manner. However, there was close liaison with Children's Services during her second treatment episode. However, this tended to be focused on the safeguarding of the child and not Crystal.

Within Probation, there were points during the course of the order when a manager's view should have been sought, not least when Rameez failed to attend appointments for several weeks and advised his Probation Officer that he had left the country. Enforcement action could have been taken and the order returned to court in June/July 2010 which

[3] Smith, K. et al. (2011) Homicides, Firearm Offences and Intimate Violence 2009/10. Home Office Statistical Bulletin 01/11. London: Home Office

would have then afforded the opportunity to extend the order to enable him to complete IDAP. In addition, the slow progress in the IDAP referral should have been referred to senior managers.

Crystal's poor attendance at the antenatal clinic was not escalated to the Matron or the supervisor of midwives according to the Northwick Park Hospital DNA policy.

At Advance, although there is some reference to discussion in supervision with managers about closing cases and making MARAC referrals, these do not seem to have been monitored or reviewed.

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

Given the length of time under review, it is unsurprising that many agencies underwent significant changes during this period. For many, this was a period of particular change in response to domestic violence with each change leading to improvements in their ability to respond effectively. There was once instance in particular, however, where organisational change led to a less than desirable outcome.

In February 2010, there was a change of provider for the Harrow Drug and Alcohol Service from CNWL to Compass. A number of permanent staff, in particular nurses, did not transfer to Compass; some cited a reluctance to leave the NHS as an employer. This resulted in reliance upon agency staff for some months which impacted upon the training and induction available and the continuity and consistency of care.

Only basic information was provided on current (and not recently closed) clients. This was restricted to information such as name, date of birth, contact details and what was currently being prescribed. No risk assessments or care plan overviews were handed over. No information was provided for recent clients, including those with a track record of engaging, dropping out and re-presenting at services. These issues are common to many contract changes and analysis suggests they did have an impact on the quality of services provided.

10.10. Whether there are lessons for the further development of the Multi Agency Safeguarding Hub (MASH) and information sharing with the diversity of service providers.

The Panel identified a range of lessons for the MASH which have subsequently been incorporated. These include:

- Information sharing protocols have been put in place
- Identification and collaboration at an early stage is encouraged, with an emphasis on the protection of both children and adult victim
- Virtually every case referred to MASH where domestic violence is an issue, now receives some degree of social care assessment.
- The Violence Against Women and Girls Co-ordinator now attends the MASH meetings to help identify appropriate actions for cases where there is domestic violence.
- Staff within MASH have had training in domestic violence.
- Midwives are employed as part of the MASH's team
- Greater attention is given to women's complex and multiple needs to improve engagement with services

11. Was Crystal's death predictable and / or preventable?

The Panel considered this issue at length and were unable to reach a consensus. On the one hand, as far as agencies were concerned at the time of the death, Crystal and Rameez were once again separated and Crystal appeared to be drug free. Historically, Crystal had been most open to making changes in her life when separated from Rameez. The escalation of violence seemed very sudden and whilst different agencies had parts of the picture, no-one seemed to have a complete overview. On the other hand, there were a range of high risk indictors: recent separation, a recent birth, past history of violence that included strangulation and the use of weapons, Rameez's depression, Crystal's history of drug use, Rameez's history of breaching bail conditions, his criminal history and the most agency observation of their relationship was that Rameez was ordering Crystal around and telling her what to do. Taken together, it is clear that Crystal was at risk of serious harm or death and in this sense, the murder could have been predicted.

It is more complex to address the issue of prevention. Certainly it was possible to engage Crystal in services as shown by her lengthy engagement with Harrow Drug and Alcohol Services although even here a third of appointments were missed and Crystal was often hours or even days late. Whether there was a service that could have engaged Crystal at the time of the murder was debated at length by the Panel, concluding that it was unlikely given her history of being continually failed and the recent removal of her third child into the care system.

Nevertheless, there were missed opportunities to have intervened earlier not least at the MARACs. More assertive outreach from a number of agencies may have helped, as might more support for Crystal subsequent to losing her children into care. Similarly, had Rameez started the IDAP course he may have learned techniques that would have prevented his escalation to murder. And, of course, had appropriate interventions occurred for Crystal as a child, the trajectory of her life – and ultimate death – could have been very different indeed.

12. Key findings and lessons learned

1. There were several missed opportunities, particularly intervening early with Crystal. From the point of view of her history, more should have been done seeing Crystal as a child in need and more support was needed to aid the transition from being a child in need to an adult in need, which Crystal was, though not identified at the time.
2. Crystal's early engagement with services appeared to have shaped her view of authority thus resulting in professionals viewing her as 'difficult to engage' and as 'manipulative'. What is clear is that Crystal engaged with agencies on her own terms and that her 'manipulation' could just as easily be fear and /or mistrust. Nevertheless, this indicates the importance of influence on early intervention by agencies. The Panel noted that Rameez never had the label 'manipulative' applied to him despite the discrepancies between events and his claims that are evident in the chronology.
3. Services failed to see Crystal's resilience given her childhood experiences and abusive relationship. They also failed to acknowledge she may not have viewed herself as a 'victim' in her relationship.
4. Crystal being 'unwilling' or 'difficult' or 'hard' to engage is echoed in many reports. The lesson is that this should be considered a high risk factor and as suggestive of a trauma response. A shift in culture is required to support an alternative way of viewing such cases as 'hard to hear' and for a willingness to examine the appropriateness of the service rather than label the service user.

Crystal's coping strategies were addressed but not the underlying cause of her needing strategies.

5. The 'difficult to engage' was viewed as an end point by most professionals rather than the start of proactive engagement. Services did not appear to be equipped to work with Crystal's level of need and few seemed to offer her a vision of hope and recovery.
6. There were individual errors across all agencies but also some cross-agency errors, particularly in relation to Crystal being failed by not receiving the attention needed; Rameez not being given the opportunity to access a domestic violence programme; and no cohesion to the sharing of information.
7. There is evidence to suggest that there was no real thought into what communication and information sharing means, or for what purpose. Information sharing was seen mainly as an outcome in itself rather than as a process. There was a lack of action across agencies following the information sharing and in general it was seen as a 'tick box' exercise. The exception to this was the sharing of information in relation to Crystal's children where there was evidence of cross-borough partnership and subsequent action. Unfortunately this was not as successful when it came to the sharing of information across Boroughs in relation to Crystal or Rameez.

   > *'Given the balancing act in managing consent, duty of care and privacy law in multi-agency work, it is important that referrals are made for the purpose of providing tangible service outcomes that improve the safety of women and children referred to the case conference, and not just for the sake of deeming a situation 'high risk' for the sole purpose of information sharing.' (*'Survivor-led ethics in multi-agency work' Erin Davis 2015)

8. Agencies seemed to have had knowledge of other agencies involvement but there was a lack of collaborative working. This was apparent over the numerous incidents and police reports that took place.
9. The numerous times the case came to police attention should have been viewed as high risk. Risk needs to be seen as cumulative and as a pattern rather than focusing on single incidents in isolation.
10. There is evidence of the difficulty in trying to get the balance right within organisations particularly for those of authority, eg: criminal justice compliance and a welfare/supportive approach.
11. Practice was not always aligned with organisational policies. For example, there should have been more referrals to MARAC (albeit since rectified), better record keeping was needed in several agencies and more professional curiosity. There was some evidence of fear/uncertainty from professionals in engaging with individuals with complex needs as well as a need to improve supervision practices. Very few of the agencies in this DHR met all their professional standards.
12. The Panel note the apparent lack of reflective practice and case management. This meant that each new event was often seen in isolation, patterns were missed and matters were allowed to drift. It also meant that some agencies kept repeating the same intervention over and over again; that the same ineffective outcome was achieved each time seemed to not to attract attention.
13. There appeared to be a lack of expertise in working with pregnant women and their abusive partner. This would suggest a need for service development in this area.
14. The length of time Rameez waited to attend a perpetrator programme – and never finally accessing one - is unacceptable. There is no programme in Harrow outside of the Probation run programme and consideration should be given to joint funding with other west London Boroughs.

15. There is evidence to suggest that the voluntary sector should be used more in domestic violence cases, particularly when statutory involvement ceases, including more robust outreach. There was never, for example, a single referral to Harrow Women's Centre who provide specialist support for women like Crystal. All services working with survivors and perpetrators need to include skilled, assertive outreach that can actively encourage and help service users to engage with the help being offered.
16. We cannot be sure that the outcome for Rameez is that he will not go onto re-offend upon release from custody and sincerely hopes he is getting the support he needs to reduce this possibility. The Panel recognised that Rameez too, had not had an easy life.
17.

> *'Going through the judiciary system, and being convicted of domestic or sexual assault is insufficient to suggest that the perpetrator has the skills and the preferences to avoid reoffending, and broadly, the absence of engagement with a rehabilitation or offence-specific intervention may indicate a continued risk of perpetration'* (Itzen,C., Taket, A., and Barter-Godfrey, S.(2010*) Domestic and Sexual Violence and Abuse- Tackling Health and Mental Health Effects* Routledge London).

13. Recommendations

Much has changed since the events detailed in this report took place. The Panel has examined current policies and procedures and in many instances is satisfied that the identified gaps have been addressed. Appendix C sets out a sample of just some of these changes and it should also be noted that since the MASH was created within LB Harrow, that all of the potential multi-agency recommendations have been taken forward as indeed have many of the single agency recommendations below.

The recommendations below, therefore, address those areas where gaps persist.

London Borough of Harrow Children's Social Care:

1. That there is an Independent Domestic Violence Advocate based within the Multi Agency Safeguarding Hub (MASH) who will provide advice and support to victims of domestic violence as appropriate.
2. That the post of a Young Person's Violence Advisor is created, based within the Early Intervention Service.
3. Development of a domestic violence toolkit to inform assessments within Targeted Services
4. Provide sessions for staff with regards to learning the lessons from the DHR.
5. Children and Families provide Senior Management representation on The Domestic Violence Steering Group.
6. The Domestic Violence Champion within Quality Assurance to undertake advanced training in domestic violence, cascade this knowledge to Targeted Services staff and to be a consistent member of the Harrow Domestic and Sexual Violence Forum.
7. Targeted Services to be actively involved in the research project '*Cultural Encounters in Interventions Against Violence'* including considering how best to implement recommendations.

Metropolitan Police

1. The MPS to update the domestic violence and Hate Crime tab within the CRIS system to reflect the new DASH model rather than the older SPECSS+ risk assessment system
2. The MPS makes changes to the Standard Operating Procedures for the investigation of Domestic Violence so that initial 'standard' risk assessments are subjected to secondary supervision by the BOCU CSU to ensure that the appropriate level of risk has been attributed from the outset of an investigation.
3. The MPS creates warning markers within the CRIMINT + system for subjects that have been referred to the MARAC process (a similar marker to that which is seen regarding officer safety issues). This will alert officers to the fact that a subject had been involved in a prior MARAC referral and alert officers to the potential need to re refer a subject to the MARAC process.
4. The MPS uses the CRIMINT + system to retain a record of the minutes, actions and outcome of MARAC meetings. This will ensure that an accurate MPS record is maintained of the MARAC process
5. The MPS is to implement a system to ensure that the risk assessment process in cases of domestic violence is reviewed when there has been a significant change in circumstances. This should include a mandatory requirement to review the risk assessment following an individual's subsequent arrest (if not arrested at the time of the initial report) or subsequent release from police custody whether an individual is charged or granted conditional or unconditional bail. This measure should also be adopted following an individual's court appearance.
6. The MPS to ensure that all officers responding to domestic violence incidents receive mandatory training in the use of the DASH 2009 risk identification, assessment and management tool in order to effectively assess risk.
7. It is recommended that the CSU Service Delivery Team conduct an internal quality assurance assessment of the MPS MARAC working practices and administration to ensure corporacy and understanding MPS wide of the referral process and record keeping.
8. Ensure that if a victim wishes to withdraw an allegation of domestic violence, that the case is reviewed by a substantive supervisor within the Community Safety Unit (CSU).
9. Ensure that when officers attend a Domestic Incident, intelligence research is undertaken to include at least the last five years using the Integrated Information Platform, as required by the MPS Operating Procedures. Where possible officers should be encouraged to search beyond five years.
10. Ensure that supervision and risk assessment during the secondary investigation of domestic violence is conducted by trained CSU supervisors. This is required by both the MPS Standard Operating Procedures (SOP) and by CAADA guidelines
11. BOCU must ensure that the supervision of domestic violence investigation is intrusive and contain well detailed action plans including specific reviews of the risk. Risk assessment must be dynamic
12. BOCU should ensure that cases that have been referred to the MARAC process have been flagged appropriately with the MARAC referral flag within the CRIS system

North West London Hospitals

1. Safeguarding training should reinforce the seriousness of domestic violence and the need for opportunistic domestic violence screenings.
2. Joint assessment must take place between hospitals for vulnerable pregnant women with complex social needs by the safeguarding midwives. This is irrespective of the stage of transferred in or out. This also includes postnatal period.
3. Inter organisational maternity safeguarding check list or a Performa is to be

developed to aid effective communication and transfer of care between organisations
4. NPH to carry out an antenatal quality assurance audit on frequency of domestic violence screening during pregnancy
5. Supervisor of midwives to reflect with the booking midwife on the need to explore safeguarding issue especially when the client discloses unusual information
6. NPH safeguarding team to commence case-loading vulnerable women with complex social needs.
7. The safeguarding team should reiterate the importance of following policies and guidelines especially women who persistently DNA their antenatal appointments during monthly mandatory training.
8. Strengthen midwives' Involvement in MARAC as this will also help to improve communication and co-ordination of care for women who are victims of domestic violence.
9. Maternity senior management team should mitigate circumstances that prevent the main hospital notes to be available at every care contact with clients

Harrow CCG:

1. Harrow CCG should ensure a health practitioner is included as part of MASH's team as this will also help to improve communication and co-ordination of care.

Each:

1. That there is mandatory training for all staff on:
   - undertaking effective assessments and risk assessments
   - establishing treatment goals
   - providing effective care, including through challenging clients on their motivation and behaviours
   - on how to use genograms and/or relationship and significant others mapping to inform practice.
2. That there is mandatory training for all staff on working with perpetrators effectively and safely
3. That there is a rolling training programme on identifying and responding to safeguarding and risk, including through information sharing and joint working with other agencies and professionals
4. That core training on substance misuse, domestic violence and mental health is delivered to all staff
5. That there is a record of attendance at above training by staff to be kept up to date annually, evidenced through e-learning and audited through supervision
6. That a standardised care pathway is reviewed, developed and implemented for all clients, detailing information and recording requirements from point of referral to point of exit, including through communication and liaison with external agencies to share information.
7. That a baseline framework is established for each individual through clinical audit and practice monitored against the pathway through clinical audit undertaken during probationary period, individual supervision and appraisals, and through annual service practice checks
8. That the standardised format is revised and issued for staff to use for session notes, incorporating prompts to identify and respond to and record safeguarding, substance use, violence and abuse and mental health issues of client
9. That all clients' care plans and discharge plans to be signed off by team leader or senior practitioner
10. That all counsellors and keyworkers provide standard reporting to their respective

team leader on their individual case management weekly where there are safeguarding issues or potential safeguarding concerns related to the individual, family and children

11. That EACH's programme of annual clinical audits (including spot checks) of client case records, safeguarding and clinical supervisors' notes continues to be implemented to identify gaps and address, including through use of appropriate policies and procedures where necessary
12. That all records of clinical supervision notes are filed and kept within the organisation at a central point established as part of governance oversight
13. That team case management sessions are noted, signed off by team leader or senior practitioner and filed at each service in central folder
14. That all safeguarding issues are presented by counsellors at bi-weekly case management meetings overseen by team leaders (or senior practitioners), with notes to be signed off and reviewed by safeguarding lead.
15. That relevant policies (Violence & Abuse, Safeguarding, Health & Safety, Clinical Practice) are revised to incorporate working with perpetrators of violence specifically
16. That the findings from the DHR are cascaded to the SMT and to staff and within the partnerships within Brent and Harrow

Advance:

1. Internal case management procedures requires regular performance management of timely, high-quality responses to clients that includes prompt MARAC referrals whilst also progressing risk management and safety-planning actions in between meetings
2. Case management procedures review to introduce consistent assessment / support plans across teams to improve engagement of survivors with complex needs; improve the quality of safety planning with women who reconcile or remain in relationships with perpetrators; promote use of Respect phoneline for perpetrators to ensure women have access to this source of help.
3. Update and improve safeguarding procedures and practice –and a lead safeguarding professional (manager) to be identified to hold expertise to advise internally on complex cases, including where adult and child safeguarding issues coexist.
4. Review our internal management case closure system to ensure this is timely and appropriate, that no necessary actions are outstanding, and that service quality and practice issues are addressed with front-line staff.
5. Improve cross borough working and communication between advocacy services so that there is a system of referral between specialist domestic violence services where cross-Borough MARAC referrals are made, where court support is provided out of borough and where cases are closed because women have moved out of area and there is still perceived to be high-risk to survivors.
6. Improve communication with referring agencies when women do not engage with our service.
7. Review / update our service level agreement with Brent police to ensure consistency in referring victims as close as possible to the time of the incident being reported. This needs to be consistently applied across all our IDVA services so women do not get different responses depending on where they live or where the incident happened.
8. Improve communication and referral with probation services and integrated offender management partnerships so women experiencing domestic violence and involved in offending / CJS access specialist women's support service.
9. Work with commissioners and other strategic and operational partners to ensure the widest possible access to our service and clarity and consistency of referral

routes, especially where co-located specialist posts are placed.

CNWL:

1. The Trust will review to ensure that it has the right infrastructure to support local borough Multi Agency Risk Assessment Conference (MARAC) processes.
2. The Trust will review with the London Borough of Harrow its support for MARAC and structures for information sharing and awareness rising of the specific risks of domestic violence for adults at risk.
3. The Trust will review safeguarding adult policies and processes and domestic violence policies and processes, considering overlap between the two. The Trust will update policies and processes to ensure the dynamics of domestic violence are fully considered. Policies and processes to be reviewed annually
4. To work with a local domestic violence agency and the Trust Recovery College to co-produce a training package that will compliment an e-learning programme.
5. The Trust will relook at local and trust non agency policies and its links to the services' duty of care.
6. The domestic violence training commissioned to support staff will address the use of risk assessments as a robust tool to manage risk and inform actions and outcomes, particularly where domestic violence is suspected.
7. To work with local MARAC and agencies to address a whole system perspective. To look at partnership strategies of working with abusers.

LB Harrow Housing

1. Housing Services policy on domestic violence needs to be reviewed and on completion compulsory training for front line staff should be introduced and refresher training provided annually. Sign posting to a support service at the very least should always be provided to victims of violence and evidence of this should be added to file notes.

Compass

2. Provide training on domestic violence for the Compass Harrow Team
3. Improve quality of practice in identifying and responding to domestic violence – including consideration of risk where partners in volatile relationships who are both in treatment engage/ disengage
4. Establish Clinical Meetings
5. Embed Hidden Harm Co-ordinator within Adults Team
6. Improve management overview of domestic violence by creating domestic violence specific flag on Care Path to enable reports to be run for service level audit and review purposes
7. Establish on site services for domestic violence to improve referral and engagement
8. Increase awareness of MARAC and increase number of appropriate referrals to MARAC
9. Improve quality and timeliness of case note recording – including review of risk assessments and proactive sharing of risk and information with other agencies
10. Improve quality of practice around holistic approach to recovery
11. Make recommendations to commissioners about minimum client data sets for transferring services to promote continuity of care, to include:
    - Basic Information
    - Summary of current Recovery Plan

- Latest Risk Assessment

12. This should be provided for both current clients and clients discharged within the last six months (pre-transfer date) where they have had 2 or more treatment journeys (and are therefore likely to re-present)
13. Make recommendations to commissioners about their role in proactively ensuring the transfer of leases and premises for service delivery to reduce the risk of incoming services operating from
14. Make recommendations to commissioners about their role in proactively overseeing the transfer of services to reduce the risk of staff leaving if there are anxieties about TUPE being applied.
15. Review Prescribing Guidelines so that they explicitly address pregnancy tests before each new episode of prescribing – including re-titrations.
16. Improve Safeguarding practice (for children) so that alerts are made more proactively.

Ealing Hospital

1. Include safeguarding of vulnerable adults in the programme for Child Protection Training.
2. Discuss in Leaders Meetings ward meetings and handovers.
3. Discussion in multidisciplinary meeting forums such as Monday Morning Case Review Meeting
4. Feedback from Community Team Leaders to teams to facilitate shared learning
5. Remind all staff at group and forums meetings of the need to make contemporaneous records of plans of care and support and to whom and how, the plans have been communicated.
6. Case scenario to be presented to LW Forum / audit meeting to reiterate the importance of Contemporaneous documentation of plans of care for vulnerable adults within case notes.
7. Audit of notes and record keeping of cases where Child Protection and/or Domestic Violence have been identified as a cause for concern.
8. Review the job description for the Maternity safeguarding midwife to include Safeguarding Adults as part of the role.
9. Pathway to be documented and disseminated widely to all maternity staff.
10. (Safe Transfer of Women) STOW project in progress to transfer postnatal discharge information electronically from nhs.net to nhs.net address across London.
11. Person to person discussion between Trusts regarding the discharge of a client to the community where serious adult or child safeguarding concerns are identified.

Victim Support

1. Develop referral pathways between health and Victim Support
2. More comprehensive recording of interventions with domestic abuse clients and contacts if any with any other supporting agencies
3. The new CMS logs who has updated the system which enables a more effective audit trail. Updates on cases need to be input in real time which has sometimes been an issue for Police based IDVA.
4. Initial Contact attempts must follow the instructions as laid out in the Domestic Violence Service Delivery Operating Procedures.

Hestia

1. Provide training for MARAC Coordinator

2. Incorporate CAADA minutes template or alternative smart template
3. All MARAC referrals have information on consent
4. Review coordinator resource against demand to provide quality service
5. Ensure that there is consistency and presence by the referring agency for cases
6. Where high risk cases are referred directly to the IDVA service who then refer to MARAC, the MARAC Coordinator records where the originating referral came from in order to ensure that referrals are accurately recorded.
7. Outstanding actions to be included in the minutes of the subsequent MARAC meeting.
8. As a safeguard, the MARAC Coordinator will check with the referrer that a safeguarding referral has also been made where children are present.
9. To ensure that all non-police referrals are contacted by the Hestia IDVA prior to the MARAC meeting
10. To ensure a delegate is identified in the action plan to feedback to the victim and that is it recorded as an action in the minutes especially where both the IDVA and referring agency are involved, or where there is no IDVA involvement and a victim is not engaging.
11. To ensure the MARAC list is distributed at least 8 days prior to the MARAC meeting, and to consider using CAADAs recommended pro-formas for case list, minutes and action plan agenda, to ease administrative demand
12. Get information from other London boroughs in terms of how they are measuring outcomes.

Probation

1. MARAC training for London Probation Trust staff including attendance at a MARAC.
2. The expectation that in all cases where the perpetrator and victim resume co-habitation that a home visit is undertaken, preferably with other key professionals involved in the case.
3. Improve cross-Borough information sharing
4. To improve communication between probation staff and IDVAs at PSR stage

14. Conclusion

From agency' reports, Crystal and Rameez seemed to act like a couple in almost constant conflict and emotional distress, but it is also possible to see from their actions that their relationship was very important to both of them. That their relationship was destructive and unsafe is obvious, but it should not be forgotten that neither had the childhood experiences, role models, or life skills needed to sustain a secure intimate partnership. It also seems that neither had experience of being successfully cared for themselves, so that perhaps, in turn, they lacked the skills and life experiences needed to effectively parent or to make use of the support that was offered by professionals.

Whilst there can be no doubt that much has changed since the events described in this report took place, it is still the case that systems still fail for far too many, often the most vulnerable with complex needs. Crystal's short life encompassed a complex combination of issues; each one alone is challenging to address, collectively they point to the continuing need for vulnerable women to be perceived first and foremost as just that: vulnerable women and not as a set of issues to be addressed in isolation.

Despite an enormous quantity of agency contacts with Crystal and her family from the age of seven onwards, with a handful of exceptions, these interventions resulted in little positive change to the quality of Crystal's life and in some instances, such as the removal

of her children, actually made it worse. This is not to dispute the validity of the decision to permanently remove the children into care; simply to point out even though a child / young woman herself, no-one seemed to 'see' Crystal as a person in her own right with vulnerabilities that remained unaddressed. This is a powerful example of what happens when the consequences of trauma are viewed as 'challenging behaviour' rather than maladapted coping strategies. Crystal was frequently viewed *as* a problem rather than as someone *with* a problem. It is hoped that the experience of the DHR and the lessons learned will contribute to improved understanding so that others are not similarly failed in the future.

Crystal was failed three times by agencies: as a child, as a teenager and as a vulnerable young adult. In the end, she was murdered by her partner who afterwards dumped her body in a canal. The final insult, the destination of unwanted, broken, expended consumables, rubbish. She deserved so much more.

Appendix A:

DOMESTIC HOMICIDE REVIEW (DHR)

TERMS OF REFERENCE

Note: Following careful consideration, the Local Safeguarding Children Board (LSCB) has agreed that this case does not warrant initiating a Serious Case Review. However it has been agreed with the LSCB that, where not already covered by the Review, any issues pertaining specifically to the child or safeguarding should be integrated into the work of the DHR Review Panel. Similarly, Adult Safeguarding have agreed that any issues pertaining to adult safeguarding will be part of the work of the DHR.

To consider:

1. Each agency's involvement with the following people between the beginning of the relationship between Crystal and Rameez and the murder of Crystal in December 2011:

(a) Crystal of address 1

(b) Rameez of address 2

(c) Daughter: Rose – Now adopted

Son: Rehan – Now adopted

Son: Rehan – LAC with ICO/foster care

It is thought that the relationship between Crystal and Rameez began in 2008 *(Author's note: This was later discovered to be 2007 and eventually the Panel settled on the years 2003-2011 as the scope).*

2. Whether an improvement in any of the following might have led to a different outcome for Crystal:

(a) Communication between services and, in particular, between services in different London Boroughs;

(b) Information sharing between services and, in particular, between services in different London Boroughs;

(c) Joint assessment, decision-making, intervention and monitoring.

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

(a) Professional standards;

(b) Domestic violence policy, procedures and protocols; and

(c) Whether these standards, policies, procedures and protocols are consistent with current best practice and what more could have be done to increase access and take up.

4. The response of the relevant agencies to any referrals relating to Crystal or Rameez, during the period covered by this Review concerning domestic violence or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

(a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact within the period covered by this review onwards.
(b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

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

(d) The quality of the risk assessments undertaken by each agency in respect of Crystal and Rameez.

5. The training provided to child focussed services to ensure that, when the focus is on meeting the needs of a child, the welfare of adults is also a significant consideration.

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

7. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of those involved and whether any special needs were explored, shared appropriately and recorded.

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

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

10. Whether there are lessons for the further development of the Multi Agency Safeguarding Hub (MASH) and information sharing with the diversity of service providers.

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

11. The primary role of this element of the Review in relation to children is to highlight any learning from this case which would improve safeguarding practice in relation to domestic violence experienced by the parents or guardians of children at risk.

12. In particular the Review should identify whether there is any learning in relation to effective communication, information sharing and risk assessment for all those children's services involved in Harrow. It should also highlight any good practice that can be built upon.

Appendix B: Cross-Government definition of domestic violence

The cross-government definition of domestic violence and abuse is:

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

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

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

Coercive behaviour

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

Appendix C: Sample of significant changes in agency practice

NB Still further changes in practice can be viewed within the action plan.

Developments within Children and Families since December, 2011 and current practice:

- The Service Level Agreement and Service Plan: Quality Assurance and Service Improvement states that all Child Protection Plans, where domestic violence is a factor, reflect the action to be taken to safeguard the adult victims as well as the children.
- There is an identified championing role for domestic violence attached to one of the Quality Assurance Managers. This person is currently undertaking advanced training in domestic violence and provides a link from Targeted Services to other relevant organisations and a knowledge base for staff within Targeted Services to help ensure more consistency in approach to cases where domestic violence is an issue.
- The relevant Senior Practitioner or Team Manager from Children and Families now attend all Initial Child Protection Conferences and there is a discussion between them and the Child Protection Conference Chair with regards to whether their attendance is required before each Review Child Protection Conference. This ensures management involvement within child protection conference planning.
- Consideration is given at all Child Protection Conferences where domestic violence has been identified, as to support for the victim, including how that will be provided and by whom.
- The Chair of a Child Protection Conference, where there has been domestic violence, would now routinely consider splitting the conference so that the victim and the perpetrator were not in the conference together.
- Child Protection Conferences, where the parent is still a child ie under eighteen, must consider whether there are safeguarding issues for the parent, should they be subject to a Child Protection Plan in their own right or is there any other support or service that they should receive.
- Young people where there is a concern about their vulnerability, particularly with regards to sexual exploitation, are now referred to the multi-agency Vulnerable Young Person's Panel.
- Social Workers within Targeted Services use the CAADA-DASH Risk Checklist with the victims of domestic violence that they are working with to help identify the risk to the victim.
- There has been a significant rise in the number of referrals from Targeted Services to MARAC due to the increase in understanding about the MARAC process.
- The named Children and Families representative for MARAC is situated within the Multi Agency Safeguarding Hub which ensures identification of appropriate cases for referral to MARAC at an early stage.
- Virtually every case referred to MASH, where domestic violence is an issue, will now receive some degree of social care assessment.
- The Violence Against Women and Girls Co-ordinator now attends the MASH meetings to help identify appropriate actions for cases where there is domestic violence.
- Staff within MASH have had training in domestic violence.
- There is a specific domestic violence training course delivered on a regular basis by the Local Safeguarding Children Board to improve knowledge and understanding of domestic violence across agencies.

- A number of staff within Targeted Services have attended advanced training in domestic violence which has helped to raise the standard of practice in working with victims, perpetrators and children where there is domestic violence.
- There are systemic practitioners based within Children and Families who undertake work with families where there has been domestic violence including with victims and lower risk perpetrators.
- Targeted Services are currently taking part in a research project, 'Cultural Encounters in Interventions Against Violence' (CEINAV) with the London Metropolitan University, to investigate cultural encounters in relation to women and children's safety from violence. This will also help to inform service development within Targeted Services.
- The Service Manager, Children's Access Team has worked in partnership with the Asian Women's Resource Centre to develop an Outreach Surgery for victims of domestic violence and Targeted Services staff to take place at the Civic Centre on a weekly basis.
- There is a timetable of groups run by the Early Intervention Service for children who have experienced domestic violence and their mothers.

EACH: Since 2010, there have been the following changes to organisational practice which addresses some of the areas identified:

a) Clinical supervision – this has been brought in house for staff and an integrated model (managerial and clinical supervision provided by line manager) is being piloted within EACH's specialist Violence and Abuse Counselling Service (Ascent). However, there is the need to address record keeping of the clinical notes.

b) Case management notes are required to be sent to the Safeguarding lead by team leaders, providing a level of assurance of safeguarding issues

c) A central record of safeguarding concerns has been instigated, maintained by the Safeguarding lead

d) A clinical audit cycle has been implemented of all sites with a review of actions taken in response to the gaps highlighted due March 2014

Compass:

There is significant learning for the organisation in relation to this case and a number of changes have been made in the last two years since Crystal's death:

Domestic Violence training has been provided for the Compass team in Harrow, which took place on 2012. The Harrow Domestic Violence Co-ordinator attended team meetings in 2012 to advise the team on identifying domestic violence and what services for support exist in the borough.

An IDVA from Hestia also attended a team meeting in 2012 to explain their role.

The Service Manager attends MARAC meetings or sends an appropriately briefed delegate from the service; eight MARAC meetings have been attended by Compass since January 2013 and 1 referral was made to MARAC in April 2013. Another case was discussed at clinical meeting but the risk was reduced by the perpetrator receiving a lengthy custodial sentence. There is an increased awareness of Domestic Violence and the importance of effective information sharing and joint working.

Compass Harrow secured and refurbished the 21 Building which is central to Harrow and offers a high quality dedicated environment for treatment services, with group rooms, clinical rooms and one to one interview/ counselling rooms. This enables us to offer space for other services to offer satellite surgeries and services from the premises. IDVA workers are able to see clients on site – which can be convenient for the people involved as they can receive different servies from a single location.

EACH provide Domestic Violence Counselling on site at 21 Building (Compass Harrow) for clients referred by Compass staff; this both raises awareness of the service (for staff and clients) and increases engagement as clients do not have to attend another location to receive the specialist counselling.

The Hidden Harm Co-ordinator is now part of the integrated team and inputs onto the Care Path case management system in a timely manner to ensure all staff have sight of and access to up to date information about services.

Weekly clinical meetings are held at which complex cases are discussed with senior operational and clinical management input. This provides an additional layer of support and clinical supervision in place, in addition to individual staff line management.

Regular case file audits have been introduced to quality assure the timeliness, accuracy and content of case notes. Case files are also reviewed with staff in regular supervisions.

The team is also more stable with nurses on permanent contracts.

The team has been restructured to replace Senior Practitioners, who held sizeable direct caseloads, with Team Leaders who will hold caseloads of no more than 10 clients and whose role is to provide line management and clinical supervision to team members to provide proactive support and direction on case management.

These measures provide greater assurance and monitoring of the clinical effectiveness and recording of practice and treatment interventions than was presence in the first period of Crystal's contact with Compass Harrow.

Ealing Hospital:

Ealing Hospital NHS Trust has a robust domestic violence policy which was ratified in May 2012 by the Safeguarding Adults Group. This policy provides guidance and advice for managers to support employees who are currently suffering or have suffered as a result of domestic violence. The policy also provides evidence based information for professional to escalate concerns using risk assessment tools. The policy is in line with the current best practice guidelines and considers recommendations from the Violence Against Women and Girls Strategy. Following the ratification of this policy, professionals are expected to routinely screen for domestic violence if suspected. Professionals would be expected to complete a risk indicator checklist and comply with the organisations existing policy on information sharing and best practice guidelines.

With regard to protecting any future victims of domestic violence from repeat victimisation and possible homicide, the organisation has evolved in terms of its roles and responsibilities. Professionals are advised to risk assess both the impact of domestic violence on the victim and consider the safety and welfare of any children. This good practice is laid out in the 2012 Domestic violence policy which was not in place to protect Crystal.

The purpose of the Caada- Dash Risk Indicator Checklist is a practical tool to assist the professional in obtaining and gathering a broader understanding into the level of risk

posed to a victim by the perpetrator. The tool is an excellent decision making checklist for consideration to the Multi Agency risk Assessment Conference (MARAC).

Professionals are advised that MARAC is a victim focused meeting where information is shared on the highest risk cases of domestic violence between multi agencies to implement action planning, risk assessment and safety planning.

The MARAC initiative has been endorsed by the Home Office as good practice. Ealing MARAC was established in 2010. The monthly meetings are well represented by Health. The Named Nurse for safeguarding children or Named midwife attends the meeting and shares proportionate and relevant information with appropriate colleagues. This is seen as good practice because other professionals such as school nurses, health visitors and midwives are alerted to the high risk cases of domestic violence in the Borough.

There is Trust wide domestic violence leads in clinical areas and a senior A&E staff nurse all situated within Ealing hospital. These professionals are well placed to offer support and advice to colleagues. The domestic violence lead is an active member of the Domestic Violence Task group and also represents on the Ealing Hospital Safeguarding Adults group. This provides the Forum for dissemination of any new guidance, an example being the recent Home Office 2013 definition of Domestic Violence.

Training around domestic violence awareness, MARAC processes and risk assessment tools is embedded with the Level 3 Child Protection training study days. It is a mandatory requirement for staff working frontline with children and families to attend Level 3 training. This captures staff working throughout the maternity services. Further to this the author recommends that all staff working clinically with adults should attend domestic violence training, the organisation should consider this as a key performance indicator and mandatory requirement. Domestic violence training should be embedded within the Safeguarding Adults Level 3 training as victims are more commonly adults.

The job description for the role of the Safeguarding Midwife has been re-evaluated to include responsibility for the identification of risk and provision of support for Safeguarding Adults.

The electronic maternity database has been renewed and it incorporates routine enquiry regarding the involvement, identity and social history of the partner and father of the baby. The notes used when a client books at Ealing Hospital also incorporate a section detailing the partner's demographic details. All women are asked about any history of Domestic Violence at their booking interview and given the opportunity to speak to their midwife privately without the presence of a partner. The maternity notes and Euroking maternity IT system in use at Ealing Hospital both have alert systems in place which are completed by the health professional undertaking assessment at any point in the maternity pathway where domestic abuse is either disclosed or suspected.

Safeguarding supervision has been introduced on a monthly basis for all midwives involved in safeguarding cases.

Each team of community midwives has a midwife identified as the safeguarding link for the team and liaises with the Safeguarding Midwife regarding plans of care for clients with identified child and adult safeguarding concerns and risks.

The maternity unit has implemented a diary recording all meetings regarding Child Protection and Safeguarding including Discharge Planning Meetings identifying staff

designated to attend. Named midwives assigned to attend these meetings are supported by senior staff or safeguarding leads.

A standard operating policy has been formulated documenting the care pathway for postnatal care for women whose babies are admitted to SCBU ensuring robust follow up arrangements should the patient fail to attend for postnatal care in the future. A new diary appointment system was been implemented within the Day Assessment Unit (DAU). All women who are to attend for postnatal checks are written in the diary. They are given appointments before 1pm. If the patient fails to attend, the DAU sister will follow up the patient as per policy and refer where necessary to the community midwives for home visits and onward from this to other agencies such as Supervisor of Midwives, Social Services and/or Police Community Safety Unit should there be concerns regarding their safety or if contact was not possible. The case would also be escalated to the MARAC contact as soon as possible.

Since this incident there is a heightened awareness of the importance of effective handover both verbally and as written evidence in case notes. This has been strengthened by the implementation of the SBAR (Situation – Background – Assessment – Review) handover tool and the ratification of the guideline supporting this in August 2013. For vulnerable women this supports the verbal handover to a different care provider.

Currently a Safe Transfer of Women (STOW) project is in the process of implementation across London and has been piloted at several sites. This will ensure that information from the maternity service to the GP and to the Community Midwives accepting responsibility for ongoing care is transferred by secure email at both ends. Women without a GP recorded will indicate to the discharging midwife the lack of an email address to send the information to and will trigger further action in identifying the GP for the client.

Hestia (Co-ordinators of Harrow MARAC):

The role of the Harrow MARAC co-coordinator has developed since this incident and a number of positive changes has occurred which address some of the issues identified by the authors. The Harrow MARAC coordinator now ensures that:-

- All referrals received from agencies, other than the police, are assigned to an IDVA within 48 hours (usually on the same day).
- All Police referrals are passed to a Victim Support IDVA.
- All cases presented at MARAC are treated as high risk either due to a high CAADA score of 14 plus or professional judgment.
- The community and Victim Support IDVAs liaise regularly to ensure they are not supporting the same client.

- The MARAC referral form (for non police referrals) now ask if Victims have been made aware of the referral and have consented and if not why? The Reason for Referring without consent is discussed at MARAC as part of the intervention process.

- The circulation list is sent to all MARAC members at least seven working days before the MARAC meeting. And all agencies know that the person making the referral is always expected to attend.

- Actions are allocated to agencies at the MARAC meeting. The agency accepting the action takes responsibility for ensuring that it is carried out and feed back to the MARAC Coordinator

- Actions are tracked and recorded and any that are still outstanding are brought to the next meeting. The MARAC Chair monitors uncompleted actions (or where information has not been fed back).

- The MARAC Coordinator records and the circulation list highlights if the case is a repeat or escalated case and the MARAC coordinator brings the notes and actions from earlier cases to the meeting. This reduces the risk of missing vital information on victims of repeat abuse
- Monthly statistics of cases discussed at the MARAC are collated and sent to CAADA quarterly. This includes the number of repeat cases.

- Clients unwilling to engage with services have actions assigned to several agencies to maximise opportunities for support. For example, IDVAs have supported clients to attend appointments at Probation or substance misuse projects.

Metropolitan Police:

Domestic Abuse Diamond Group

Chaired by Deputy Assistant Commissioner who provides strategic direction, commissions and monitors progress of working groups (Prosecutions / Recommendations / Training / Offenders / Community Safety units / Communications and Technology), escalates risks and recommendations identified by working groups where appropriate and agrees domestic abuse policy changes. All recommendations from Domestic Homicide Reviews are forwarded to the chair. The group meets monthly.

Domestic Abuse Working Groups

Towards the end of 2014, in response the HMIC report, domestic abuse working groups, which feed back to the Domestic Abuse Diamond Group, were introduced. These problem solving groups provide assurance, escalate risks that could impact upon delivery of MPS objectives and raise concerns where service delivery is ineffective. The groups provide quarterly reports.

- Prosecutions - improve case file quality, increasing unsupported prosecutions and identifies barriers to prosecution.

- Recommendations - Reviews Domestic Homicide Reviews (DHR) / Independent Police Complaints Commission (IPCC) recommendations, converts organisational learning to policy.
- Training – Identifies gaps in current training provision and ensures training is current.
- Offenders – Review offender identification methods and identifies best practice.

- Community Safety Units – Escalates Borough Operational Command Unit (BOCU) issues, identifies best practice and performance monitoring.

- Communications – Provides consistent messaging and internal / external media campaigns.

- Technology – Explore new technology, apply existing technology to reduce risk, manage offenders and increase prosecutions. Leading to Body Worn Video trial and MPS wide rollout in 2016.

Body Worn Video

In August 2014 the MPS piloted body worn video to:
Provide an extra option to gather evidence at incidents.

- Support evidence at court and help show the court the camera view of what happened or set the scene.
- Increase early guilty pleas when camera footage is available
- Help the MPS and justice system appear more transparent: camera footage can demonstrate our response to specific incidents.
- Support officers in defending their actions upon receipt of a public complaint.
- Defuse violent or potentially violent situations without the use of force.

Following the pilot, on 24/11/2015 The Mayor of London and MPS Commissioner confirmed plans to introduce police body worn video, to all frontline police officers, from the spring of 2016 onwards.

Front line officers will use the body worn cameras to capture scenes in full including the demeanour of the parties involved, this will focus the officers on the need to be "initial investigators" at crime scene and not just "reporting officers". The result of this will be an improved initial response to 'DV' / 'DA' incidents across the borough and better quality of evidence gathering at the scene of these incidents.

The gathering of vital scene evidence will be used to provide a fuller picture to the Crown Prosecution Service (CPS) when requesting charging advice.

Body camera footage is also proven to garner more early anticipated guilty pleas, reducing the need for extensive case papers and court cases (which is the point where victims often withdraw from the process)

In addition this visual evidence could negate the need for victims and witnesses to provide written statements as the allegations will be captured on film. This will support the Community Service Unit's ability to present "victimless prosecutions" to the CPS

Community Safety Unit Detective Inspectors Meeting

Monthly meeting with a requirement to attend or send representation. The meeting provides a platform for networking and discussing emerging trends / themes, innovative ideas, good practice, organizational learning and service delivery difficulties. Guest speakers are invited and the Critical Incident Advisory Team represented.

Offender Management

- Bail Conditions - rigorously enforced. Suspects should be kept away from the family home through the use of bespoke conditions. Where alcohol is a catalyst to offending, request alcohol prohibitive bail conditions from the custody sergeant/courts to prevent re-offending. Where bail is breached using a vehicle, ask for a temporary driving ban
- Covert / Overt cameras - Consider covert cameras to capture offending and assist with unsupported prosecutions

- Restraining Non Molestation / Non Harassment Orders - obtained through the civil courts or upon conviction / acquittal
- Domestic Violence Disclosure Scheme (DVDS) - Clare's Law
- Domestic Violence Protection Orders (DVPO)
- Disqualification upon conviction - where a vehicle is used in any way, request a period of disqualification (S146/7 Sentencing Act)
- High Risk Offenders – High Harm RFGR offenders to have Tactical Plan created with STOP IT plan and Achilles Heel principles overlaid, plan owner identified.
- Named suspects / Emerald Warrants Management System (EWMS) - review weekly Performance Information Bureau (PIB) list for detection opportunities and to ensure activity
- Legally held firearms – currently 100,000 within the MPS, raise awareness

In 2012 all staff undertook the NSPCC training for Safeguarding which was an enhancement of previous safeguarding trainings provided

New Safeguarding Policy May 2013 which provides greater emphasis on referrals of vulnerable adults. In circumstances such as Crystal we may have been able to refer as a vulnerable adult as routine

Probation:

1. The MARAC process has become more firmly embedded in probation practice, with more understanding of the threshold for referral, such that this case would have been referred earlier in its currency.

2. London Probation Trust has reviewed offender managers' understanding of Safeguarding processes with greater attention to considering the risk to children when assessing the risk posed by the individual. To enable this, arrangements for routine information sharing has been undertaken in the majority of boroughs and Local Delivery Units. Clearly the development of the MASH will assist with this and should alleviate the difficulty where there is movement across boroughs, as our database covers the Greater London area.

3. Routine checks with the Borough Intelligence Unit or the Community Safety Unit, or a local system to ensure that all agencies received up to date information regarding the call-outs, would have raised concern regarding risks in the relationship between Ms Love and Rameez. I had the sense that there was a resignation on the part of the Offender Manager and others across the network that there had been yet another incident but there were no consequences and "no further action".

Advance:

Unlike in 2008, our IDVA service is now available 24-hours 365 days a year and the service is not closed between Christmas and New Year. Furthermore, if no contact can be made with women or if women do not engage with our service, we let referring agencies know this, so that it is not assumed we are providing support simply because a referral has been made.

Current practice is moving towards ensuring case management notes are recorded on a secure online database (MODUS online) which enables more comprehensive case recording and performance management across all our projects. CAADA DASH risk assessments are now used across all our IDVA services and this is recorded and reviewed as part of the case management procedure. Managers now dip-sample MARAC referrals and risk assessments

to maintain quality standards, and a comprehensive case closure procedure is followed which means cases are not closed if there are outstanding actions or practice issues to be addressed.

cases are regularly reviewed; managers review MARAC referrals to ensure quality of referrals is maintained, and that actions are followed up. MARAC systems and operational procedures have developed since 2008/09 and there should be clearer protocols about cross-borough working in place.

Unlike in 2008, we now also have a dedicated maternity IDVA who takes referrals across West London if women attend Queen Charlotte or St Marys maternity services and disclose domestic violence. Analysis of these referrals indicate that women referred through maternity and health services are younger, more vulnerable and have higher levels of complex needs, and have had more care / safeguarding interventions compared with our client group as a whole. Having IDVAs based in maternity and other health settings in Brent at that time, in addition to being police-station based, may have helped Crystal engage more with our service to meet her own health and support needs without being too court-focussed. The last known police incident in Brent before her death occurred around the time of the birth of her child so had she been referred by health/maternity services to independent advocacy support, this may have provided the turning point needed to achieve safety for Crystal.

Improvements have been made to our safeguarding practice and joint work with children's services now occurs in Brent. We have also developed services that co-locate IDVAs and Family Support Workers in Children's Services and in Early Help and Family Services in Brent. Had this been available at the time, this may also have provided an opportunity to engage with our services and provided a more joined up approach from a safeguarding perspective. There is scope for further improvement in our practice in this area, which is currently underway.

Greater attention needs to be given to women's complex and multiple needs and how we can improve their engagement with our service. Since 2010, we have developed the ADVANCE Minerva service which now supports women in Hammersmith & Fulham, Brent and Kensington & Chelsea who are considered at risk of breaking the law or who are involved in the justice system (e.g. through substance abuse, anti-social behaviour or other offending, or who are on probation). This women's centre service is not specific to domestic violence survivors but has high engagement levels as it delivers individual, peer and group support for survivors and others. Had this been available at the time of Crystal's referral, increased engagement with our service through groupwork or peer support may have been achieved so that her safety could be maximised. We are also currently reviewing how we can improve our support women who are care leavers and whose children are at risk of being taken into or are in care already; we have many examples of outcomes where children have been returned to their mothers as a result of our support but more needs to be done to ensure this success is extended.