



SAFER CROYDON PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

OVERVIEW REPORT

Report into the death of Christopher

November 2014

Independent Chair and Author of Report: Nicole Jacobs

Standing Together Against Domestic Violence

Date of Completion: May 2017



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Permission has been granted by the Home Office to publish this final report

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1. Introduction

1.1 Domestic Homicide Reviews

- 1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.
- 1.1.2 This report of a DHR examines agency responses and support given to Christopher, a resident of Croydon prior to the point of his murder. In late November 2014, the lifeless body of Christopher, the adult son of James, was found in the boot of James' car by the police. James was convicted of murder and sentenced in early June 2015 to life imprisonment.
- 1.1.3 The review considered agencies contact/involvement with Christopher and James from 2008, the year when Christopher's daughter Lilly was born, to the time of Christopher's murder in 2014.
- 1.1.4 In addition to agency involvement this review examined the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.
- 1.1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.
- 1.1.6 This review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.
- 1.1.7 The Review Panel expresses its sympathy to the family and friends of Christopher for their loss and thanks them for their contributions and support for this process.

1.2 Timescales

- 1.2.1 The Safer Croydon Partnership, in accordance with the 2013 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, commissioned this DHR.
- 1.2.2 Safer Croydon made an initial decision that the circumstances of the case may not merit a DHR as little agency information was known about the family. This was put to the Home Office (HO) who decided that the circumstances merited a DHR and directed Safer Croydon to undertake a DHR and cited the HO guidance related to proportionality. The HO

were notified of the decision in writing on March 27, 2015. It is for this reason that a DHR panel was convened a year after the date of Christopher's death.

- 1.2.3 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent Chair for this review and the first meeting was held on November 13, 2015. The report was handed to the Safer Croydon Partnership on 22ND September 2017.
- 1.2.4 A further delay was caused when James agreed to meet the chair (via communication with his spouse) and time was taken to make arrangements with the prison to set an appointment date (for December 2016) which then was cancelled by James in the days before the appointment date. In early 2017 the chair was in contact with Cheryl (the long-time partner of Christopher) to review the content of the final draft of the overview report. Cheryl fed back to the Chair about this report and expressed that she felt it was an accurate reflection. Her desire is that lessons are learned from this review that will help others in the future in Croydon and elsewhere.

1.3 Confidentiality

- 1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the HO Quality Assurance Panel. Information is publicly available only to participating officers/professionals and their line managers.
- 1.3.2 This review has been suitably anonymised in accordance to the 2016 guidance. The specific date of death has been removed and only the independent chair and Review Panel members are named.
- 1.3.3 To protect the identity of the victim, the perpetrator and family members the following anonymised terms have been used throughout this review:
 - 1.3.4 The victim: Christopher
 - 1.3.5 The perpetrator: James
 - 1.3.6 The pseudonym for the victim was agreed by the long-term girlfriend of Christopher, Cheryl, and the chair selected the other pseudonyms used in this report.

1.4 Terms of Reference

- 1.4.1 The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning for the tragic death of Christopher and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.
- 1.4.2 The Review Panel comprised agencies from Croydon, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible

after the DHR was established to inform them of the review, their participation and the need to secure their records.

- 1.4.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from early May 2008 to the date of the homicide which covers the time from which Christopher's daughter was born to the time of his murder. Agencies were asked to summarise any contact they had had with all parties prior to May 2008.
- 1.4.4 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2013 Guidance and identified and considered the following case specific issues related to caring responsibilities, gender and age. Christopher was a young father and the lines of responsibility for caring for his young daughter were often blurred as it was perceived by outside services and agencies that the child's grandmother was the main carer. Also Christopher was a young parent and as a father the panel explored his perceptions and awareness of support for him as a young father.

1.5 Methodology

- 1.5.1 This review has followed the 2013 statutory guidance for DHRs issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Christopher, James, James' wife (Karen) and Christopher's daughter (Lilly). A total of 8 agencies were contacted to check for involvement with the parties concerned with this Review. 4 agencies returned a nil contact, 4 agencies submitted IMRs and chronologies.
- 1.5.2 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Christopher, James, Karen and Lilly, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. The IMRs have informed the recommendations in this report.
- 1.5.3 *Documents Reviewed:* In addition to the 4 IMRs, documents reviewed during the review process have included a court report, information from the Family Liaison Officer (FLO), STADV and HO DHR Case Analysis.
- 1.5.4 The Chair of the Review has undertaken 2 interviews in the course of this review. This has included 1 face to face interview with the long term girlfriend of Christopher (referred to in the this report as Cheryl) and 1 extensive telephone interview with the spouse of James

and adoptive mother of Christopher (referred to in this report as Karen). The chair is very grateful for the time and assistance given by the family and friends who have contributed to this review.

1.6 Contributors to the review

1.6.1 The Croydon Family Justice Centre reviewed their files and notified the DHR Review Panel that they had no involvement with the families who are part of this review aside for unrelated support of Christopher's former partner and mother of Lilly. This support was not in relation to Christopher or his family and therefore had no information for an IMR.

1.6.2 The following agencies reviewed their files and notified the Review Panel that they had no involvement with this family relevant to the case and therefore had no information for an IMR:

- Croydon Office for Public Safety
- The Croydon Health Centre
- Croydon Adult Safeguarding

1.6.3 IMRs were received from:

- Metropolitan Police (summary of limited involvement with Police prior to the date of the murder)
- Children's Services
- London Fire Brigade (James' former employer)
- South Norwood Hill Medical Centre General Practice Surgery

1.6.4 The Chair contacted Virgo Fidelis Preparatory School to provide information to the chair about their safeguarding policy and practice and their interactions with this family and their referral to Children's Social Care. The school was not responsive although information about the response from the school was gained in family interviews.

1.7 The Review Panel Members

Job title, Organisation
Carl Parker, Partnership Officer (CSP Lead), LB Croydon
Rachel Blaney, Lead Nurse for Safeguarding Adults, Croydon CCG
Chris Howell, Met Police – Homicide & Serious Crime Command
Maureen Floyd, Manager Croydon Safeguarding Children's Board, LB Croydon
Paula Doherty, Strategic Lead DASV & Troubled Families, LB Croydon

Steve Hall, S+QA Manager, Children's Social Care
David Lindridge, Borough Commander Croydon, London Fire Brigade
Sally Luck, Clinical Quality Manager (Patient safety), NHS England London
Janice Cawley, CIAT, MPS
Patricia Clarke, Adult Safeguarding Lead, Croydon Adult Integrated Health Service (SLAM)
John McQuade, Senior Investigator, Croydon Police
Andy Opie, Director of Safety, LB Croydon
Pratima Solanki, Director of Adult Care Services, Croydon Council
Nicole Jacobs, CEO, Standing Together Against Domestic Violence, independent Chair

- 1.7.1 The Review Panel met on the 13 November 2015. The next meeting was on the 27 July 2016 and it was agreed by the Review Panel that this would be the final meeting to be proportionate to this particular review and the Review Panel would sign off the Overview Report via direct contact with the chair unless information changed substantially due to an upcoming appointment with Karen and also James from prison (which was subsequently cancelled by James).
- 1.7.2 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.8 Independence of the chair and author of the review

- 1.8.1 The Independent Chair of this Review is Nicole Jacobs, CEO of STADV, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. She has conducted domestic abuse partnership reviews for the HO as part of the STADV team that created the HO guidance on domestic violence partnerships, 'In Search of Excellence'. She has worked in the field of domestic abuse intervention for over 20 years.
- 1.8.2 STADV is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety.

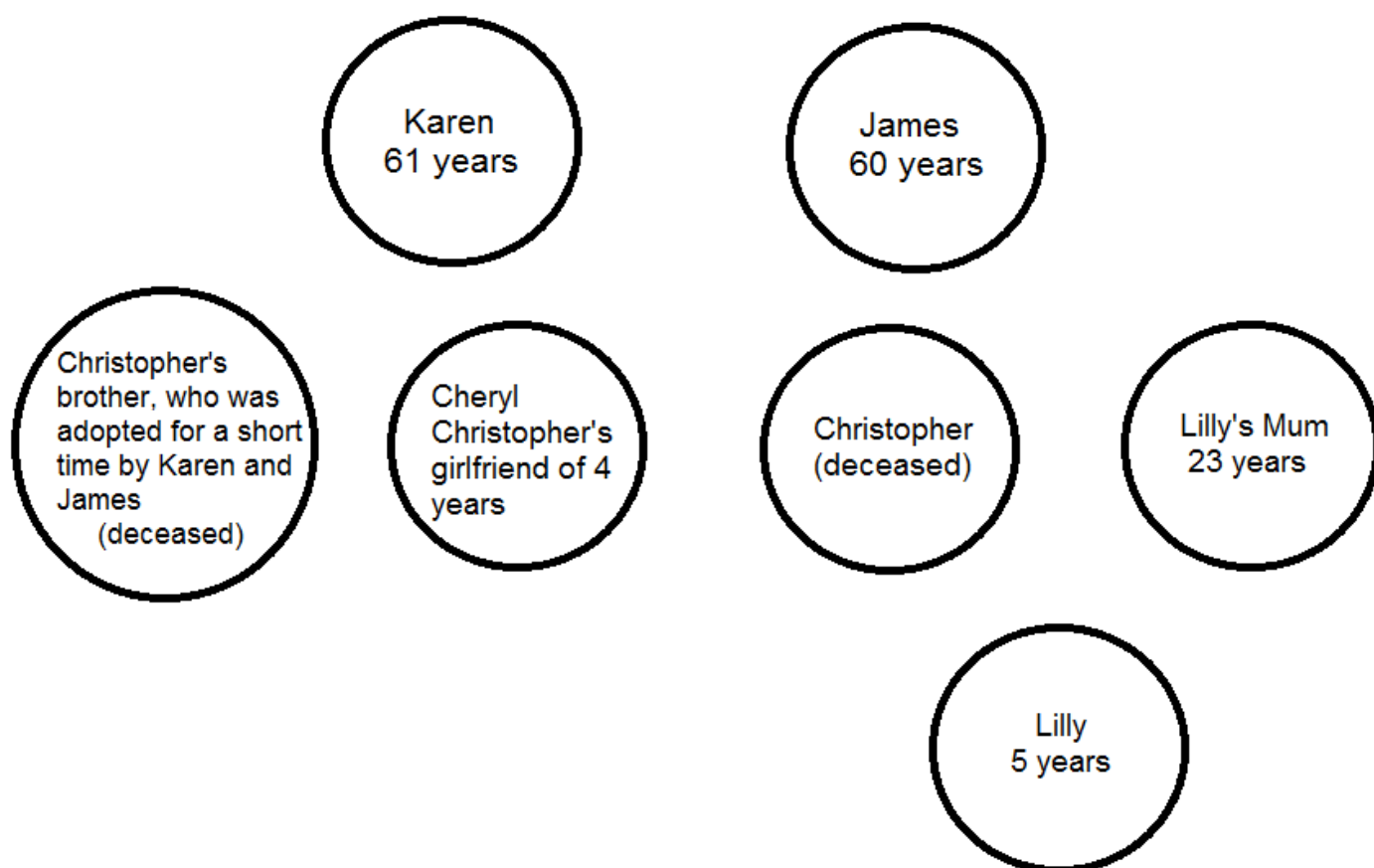
It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides

1.8.3 Independence: The chair has no connection with Croydon Council or any of the agencies involved in this case.

1.9 Parallel Reviews

1.9.1 There were no reviews conducted contemporaneously that impacted upon this review. The criminal trial concluded on early June 2015 which was several months before the first panel meeting.

1.10 Contact with the family and friends of Christopher



1.10.1 The independent chair sent a letter to Karen to invite her to be part of this review with the relevant HO leaflet. She contacted the chair by telephone on 31 August 2016 and spoke with the chair for a three hour interview. Her views and input are appreciated by the chair and are represented in this report.

1.10.2 The panel took advice from the Croydon Justice Centre that Christopher's previous partner and mother of Lilly has limited involvement with the family over the past 6 years and decided it would not be appropriate to approach her for this review. Since Lilly was a baby,

she had resided with Christopher and his family as primary caregivers of Lilly. Since the murder, Lilly and her mother have been successfully reunited. Input from Lilly's mum about her time when Lilly was born is provided through her contact with the Met Police and also via the interviews with the wider family and Cheryl.

1.10.3 The Chair met with Cheryl for a face to face interview, the long term partner of Christopher aided by a member of the Victim Support Homicide Service on 25 May 2016. She had been dating Christopher for four years and planned to move in with him and Lilly at the time of the murder. The chair would like to thank for her courage and interest is participating in this review.

1.11 Contact with the perpetrator

1.11.1 The independent chair attempted to make contact with James by sending a letter to him in prison. HM Prison service confirmed to the chair that the letter had been received. James initially did not respond to the invitation from the chair to visit him in prison but subsequently indicated through his wife, Karen, that he would be willing to meet with the chair. Additional letters were sent to James in prison and contact was made with the prison service and an appointment was arranged for December 2016. The week of the visit, James contacted the chair via the prison to say that he no longer wished to be involved with this review.

1.12 Dissemination

1.12.1 The following recipients have received copies of this report:

- Panel members listed above in par 1.7.
- Cheryl- long term partner of Christopher
- STADV DHR Team

2. Background Information (The Facts)

2.1 The Homicide:

- 2.1.1 In late November 2014, at 2:50 am, police were called to South East London. Witnesses reported that a male had been seen to remove a large object from the boot of a vehicle and head towards the river's edge. The object was wrapped in tarpaulin and appeared to be hard to carry. At the time, the river was at low tide with the foreshore exposed. The male attempted to lift the object over the waterfront wall but was unable to do so and returned it to the boot of the car. The witnesses described how the tarpaulin fell away and exposed a body. They saw the victim's hand being dragged along the pavement. The male drove off but was stopped by police, who found the lifeless body within the boot. The driver, James, was arrested for murder and taken to Lewisham police station.
- 2.1.2 The body found in the car was his adult son Christopher. His life was pronounced extinct by the London Ambulance Service (LAS) at 3:40 am. Officers attended the family home. James's wife, Karen and his granddaughter Lilly were found at the address and were unharmed.
- 2.1.3 Karen was arrested and conveyed to Croydon police station, where she was interviewed and denied any involvement. Lilly was taken into police protection and Children's Social Care (CSC) informed. She was then placed in the care of her mother.
- 2.1.4 James lived with his wife Karen and his adult son Christopher and Christopher's 5 year old daughter Lilly. Police found in the garage of their home a tarpaulin sheet with blood splatter on it. There was a substantial amount of blood in the garage and a baking tray and cling-film in garage. There were no other signs of disturbance in the remainder of the property. Karen was also arrested on suspicion of murder but later not charged.
- 2.1.5 Post- Mortem: On the day of the arrest, a special post mortem took place at Greenwich Mortuary. The cause of death was recorded as 'blunt force trauma to the head'.
- 2.1.6 Criminal Trial Outcome: James was convicted of murder and sentenced in early June 2015 to life imprisonment. No further action was taken against Karen.
- 2.1.7 Judge Sentencing Remarks: When sentencing James at the Old Bailey, Judge Richard Marks, the Common Sergeant of London, said: "The word tragedy is greatly over-used but if ever it is appropriate to describe a case in these courts, this is that case." "It is a tragedy for you as well, as you will have to live until the end of your days with the terrible knowledge of what you did, with all the pain and suffering that has caused."

2.2 Background Information on Victim and Perpetrator:

- 2.2.1 Christopher was a white British male and was 24 at the time of the homicide. At the time of the homicide, he worked at an auto-glass company.
- 2.2.2 James is a white British male and was 59 at the time of the homicide. He is a retired fire-fighter.
- 2.2.3 Christopher is described by friends as a well-liked, affable character who enjoyed being with his friends, his girlfriend and his daughter Lilly. He had a challenging upbringing and as a young father he required help from his parents in the raising of Lilly. Karen's caretaking of Lilly enabled Christopher to work and to carry out his daily routines. In some ways, this pattern made it difficult to assert himself as Lilly's parent but in his last year in particular he was asserting his need to move out of his family home and live with his girlfriend Cheryl and his daughter as a family. He was on the brink of this move at the time of his murder.
- 2.2.4 Christopher was born in 1990 and was one of seven children. He was taken into the care of the Local Authority in 1992 initially with one brother and one sister into the same foster care setting. In 1995, he was considered for adoption. He was placed with James and Karen in 1996 and formally adopted by them in 1999 along with his older brother. His brother did not remain with the family and Christopher was the only child to remain adopted by James and Karen. Karen noted that Christopher's older brother was not able to remain with their family due to issues relating to his mental health and the felt unable to adequately care for him and fully address his needs related to mental health. Sadly, Christopher's brother later died by suicide in his early adulthood, many years after leaving the family home of Christopher.
- 2.2.5 Christopher maintained links with his birth family which in some years were more active than others.
- 2.2.6 There is a discrepancy between Karen's description of Christopher and his home life and the description provided by Cheryl. However, it is clear from both accounts that some aspects of his childhood with James and Karen had been positive. They were involved in Boy Scouts and Christopher described enjoyable family holidays to Cheryl. It is also clear that his relationship with his family deteriorated after Lilly was born.
- 2.2.7 Christopher became a father to Lilly in May 2009. His partner at the time and Lilly moved in with Christopher and his parents. There are conflicting accounts as to how well this arrangement worked for these young parents. Lilly's mum eventually moved out with Lilly into a foster placement. She later agreed that Lilly live with Christopher and his parents. Christopher was subsequently granted custody of Lilly.
- 2.2.8 At the time of his murder, Christopher had been in a relationship with Cheryl for approximately 4 years. She was a frequent visitor to the family home.

- 2.2.9 There are conflicting accounts from Karen and Cheryl regarding the dynamics of the family home but clearly there were tensions related to who was the primary caregiver of Lilly and there was conflict between Christopher and his parents about day to day arrangements.
- 2.2.10 Christopher and Cheryl planned to move out with Lilly as they felt it was time to live independently of James and Karen. Christopher had worked for months on the logistics of this move. For example, he had to find a guarantor for the flat they would rent and he felt unable to ask his parents. Cheryl recounts that they were very concerned about when and how to tell his parents about the move. Cheryl felt that perhaps he should not tell them until the day Christopher and Lilly moved out but Christopher wanted to be honest with his parents so that they could get used to the idea prior to the planned move out date.
- 2.2.11 He informed James and Karen that he wanted to remove Lilly from the private school they had placed her in and enrol her in a state school, as he would not be able to afford the fees. In mid- November 2014, a week prior to the murder, Christopher told his parents that he planned to move out the following week. In both interviews with Karen and Cheryl, it was clear that Christopher's parents disagreed with the plan to change Lilly's school and move out with her to a rented flat.

2.4 Summary of information known to the agencies and professionals involved:

2.5 Children's Social Care

- 2.5.1 CSC provides a statutory level three / four service to families and provides a social work service which includes assessment and care planning. In addition, the CSC provides social work support where there are safeguarding concerns and where as a result children are looked after by the Authority.
- 2.5.2 The social care case file indicates that Christopher was adopted as a child by James and Karen. There is no record of this adoption within Croydon as the adoption was overseen by Greenford Social Services (in the London borough of Ealing).
- 2.5.3 During the time-frame for this review, social work teams were divided into assessment and long term teams with a hospital team based at Mayday Hospital (now called Croydon University Hospital). This latter team was responsible for pre-birth assessments for families booked into the maternity services based at the hospital as well as general children's social work. Following the end of the hospital involvement, cases were transferred from this team to the community based care and child protection teams.
- 2.5.4 Lilly's mum, the girlfriend of Christopher became known to CSC in February 2009 when a referral was received from the midwifery service at Mayday Hospital. She was 16 years old and pregnant and was living with her mother and two siblings. The family home was

considered chaotic with the younger siblings identified as children with special needs and as such there were concerns regarding the suitability of the home for a new born child. The case was allocated three months later to a social worker within the Mayday Social work team following an initial assessment, a parenting assessment was commissioned at a local family assessment centre.

- 2.5.5 Lilly was born in May 2009 and the assessment formally commenced while Lilly and her mum were living with Christopher and his family. In August 2009, the social worker allocated to Lilly's mum left the team and the case was reallocated to another social worker. The outcome of this parenting assessment in November 2009 was that whilst Lilly's mum had the capacity to parent, she was not at a stage where it would be appropriate for her to resume full time independent care of the child. The records indicate that Lilly's mum reported that the relationship between her and Christopher came to an end during this period of care, although his parents and Christopher maintained contact with her.
- 2.5.6 Following the assessment, Lilly and her mum were both accommodated by the Local Authority and placed in a mother and baby foster placement. The placement progressed, but in February 2010, Lilly's mum felt unable to remain in the placement and was moved to a semi-independent provision. This, she found difficult to adapt to and, as a result, she asked Christopher to assume care of Lilly. Lilly moved to live with Christopher and his parents in February 2010 with the support of the Local Authority. At this time Lilly's mum was allocated to another social worker (the third in a period of a year) and she then returned to live with her mother and siblings.
- 2.5.7 In May 2010, Lilly's mum gave birth to a second child from a new relationship. Christopher, with support from his parents, assumed full care of Lilly and an application was made for a Residence Order. In July 2010, Lilly's case was closed and CSC withdrew.
- 2.5.8 A further intervention and assessment was initiated in July 2010 regarding the support needs for Lilly's mum's second child (not related to Christopher).
- 2.5.9 In September 2010, a letter was sent by Lilly's mum's social worker to Christopher passing on concerns that she had noted during contact regarding Lilly's clothes and care. Christopher responded in an angry manner and made counter complaints regarding Lilly's mum's care and commitment to Lilly.
- 2.5.10 In December 2010, a Residence Order under section 8 Children's Act 1989 was granted to Christopher in respect of Lilly.
- 2.5.11 On 13 November 2013, a police Merlin* was received following an altercation between Christopher and his mother, Karen. (Merlin is the name of a database run by the Metropolitan Police that stores information on children who have become known to the

police for any reason. In all Domestic Violence incidents reported to the police, where there is a child is present, this information is recorded on the Merlin database) It is noted that this is a different date than the actual incident reported from the police which was 21 October 2013 which indicates that the Merlin was received late. It was recorded or acted upon late by CSC or it was an administrative recording error on the file. The Merlin referral recorded that Karen alleged to police that her son had grabbed her by the throat in the presence of Lilly. This had occurred whilst Christopher had been drinking in his room. Lilly became distressed and her grandmother was comforting her as Christopher passed her room. He argued that he was Lilly's father and should be comforting her and during the argument Christopher grabbed her by the throat. In order to release his grasp, she kned him in the genitals. Lilly witnessed this incident. Karen advised police that Christopher was jealous of her relationship with Lilly, that he was drinking heavily and that his behaviour was getting worse. The referral was considered by the Multi-Agency Safeguarding Hub (MASH) service and, as Lilly was not harmed during the incident, it was not considered to warrant further intervention.

2.5.12 On 19 March 2014, CSC was contacted by Lilly's school raising a number of concerns. They reported that:

- Karen had reported to a teaching assistant that her son Christopher had punched her in the head;
- In March 2014, Lilly reported to staff that "Daddy" wouldn't let her do her homework;
- In March the school were advised by Karen that during a hospital visit, Christopher was abusive, had told Lilly the doctor would "drill a hole in her head", and after the appointment became abusive to Karen and kicked furniture;
- Karen reported that Christopher tried to act like an older brother and then became angry when he was not able to exercise authority over Lilly. He appeared to threaten to take Lilly away. This was of particular concern to the grand-parents as they reported he was now in a new relationship.

2.5.13 The school also reported that the grandparents care of Lilly was good and her attendance was excellent. The referral was considered by a Duty Manager but not felt to meet the threshold for a child protection intervention. As a result, the file indicates that as Christopher was the only person with parental responsibility, his consent would be required to assess Lilly's circumstances. It therefore recommended that the grandparents continue

to report incidents of violence and aggression by Christopher, and that the grandparents should seek legal advice should Christopher decide to move out and take Lilly with him.

2.5.14 There was no further contact with, or about the family, until the day of the murder when the Emergency Duty Team (out of hours team) received notification of the alleged murder and that Lilly was in police protection. A foster placement was identified for Lilly.

2.6 London Fire Brigade

2.6.1 James was employed by the London Fire Brigade between 28 November 1983 and end of March 2014 when he accepted voluntary redundancy.

2.6.2 James was appointed as a Firefighter with the London Fire Brigade in 1983. He was promoted to Leading Fire Fighter in 1989; Crew Manager in 2003; and to Watch Manager in 2006. All performance assessments were satisfactory and James was awarded the Fire Service Long Service and Good Conduct Medal in March 2004. There are no records of any disciplinary action.

2.6.3 James had a long involvement with Scouts (the 16th Clapham Scout Troop) as he took regular special leave between 1990 and 2008 to attend the annual Scout camp.

2.6.4 James had approval for secondary employment as a fire officer at a theatre (Royal National Theatre).

2.6.5 In February 1996, James submitted a special leave application for 'adoption leave' which was supported by a letter from Ealing Social Services (Greenford) that described the medical care arrangements for Christopher and his brother.

2.6.6 Between May 1997 and January 2000, there are several special leave requests to attend The Maudsley. These are supported by letters from The Maudsley Children and Adolescents Department "in conjunction with your foster son's health care" (Christopher's brother).

2.6.7 On 25 September 2009, James submitted a request for special leave "To instigate legal proceedings and organise court action over a child protection issue within my immediate family". This was approved by his manager who noted "I did not require any supporting documentation as I had direct involvement with the arrangements described". Presumably this was in the early weeks of Lilly's life and there was uncertainty related to James's living arrangements with Christopher and his family.

2.6.8 On 12 January 2014, James submitted a request for special leave for "My son was detained in hospital with a head injury". It is unclear from other information submitted in this report what incident this is linked to if any. There was not a record of this injury from health services although it may be possible that Christopher sought medical advice in a trust which was not in his local area.

2.6.9 On 9 March 2014, James submitted a request for special leave for “Urgent domestic personal problem involving violent family member” which is 5 days before the school reported concerns to CSC reported to them by Karen.

2.6.10 James was made voluntarily redundant on 31 March 2014.

2.7 Metropolitan Police Service

2.7.1 There is no recorded police history of violence between Christopher and James. However, there is one reported incident of Domestic Abuse between Christopher and his mother.

2.7.2 On 12 October 2013, Christopher contacted police to a domestic disturbance. Karen alleged that Christopher had strangled her as she tended to her crying granddaughter; Lilly (aged 4 years). To escape his grip, she kned him in the groin and bit his finger. Christopher was arrested and conveyed to Croydon Police Station where he was interviewed. He made a full admission, expressed remorse and agreed that his behaviour was unacceptable. He was of previous good character. Karen was consulted and agreed for him to return to the family address. A DASH Risk Assessment was completed which was graded as ‘Standard’. Alcohol use, strangulation and jealousy were recorded as risk factors. A Merlin report was created with regard to Lilly and shared with Croydon Social Services. The CSC records indicate receiving the Merlin on 13 November 2013 and referring it to group assessments on November 21 2013.

2.7.3 Christopher was then released by to the home address where he resided with Karen. As an adult caution was administered there was no option to add bail conditions.

2.8 Croydon Medical Services

2.8.1 Primary care service records were viewed for Christopher, Lilly, James and Karen.

2.8.2 There are incomplete notes for Karen as she may have been deducted from the GP surgery list in 2012 due to “non-response.” She reregistered in 2015.

2.8.3 All records show medical visits by Christopher, Lilly, James and Karen for common complaints or routine examinations.

2.8.4 Lilly’s records show that Christopher is recorded as her legal guardian and he is noted as accompanying her to immunisations and regular appointments.

2.8.5 Contacts with CSC are recorded in the GP records with full detail relating to assessments and concerns reported to them in relation to Lilly. There is no record in the documentation that the GP will have mentioned or brought up the CSC information to the family at subsequent visits.

3. Analysis

3.1 Domestic Abuse/Violence Definition

3.1.1 The government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners

or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

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

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

- 3.1.2 James is solely responsible for the death of Christopher.
- 3.1.3 There are conflicting accounts related to the level of conflict and by whom within family accounts. For example, there are the allegations made by Karen to the school and there is the one police incident where Karen was the primary victim. This was further referenced by Karen in discussion with the Chair of this Review. Yet, it is clear that Christopher reported to his long term partner Cheryl a pattern of controlling behaviour and Cheryl witnessed visible injuries to Christopher which he told Cheryl were inflicted by Karen.
- 3.1.4 Therefore, without the narrative from the victim and without any agency investigation into the dynamics of the relationship, we are left to acknowledge some incidents of physical violence between both victim and his parents with one or the other as aggressors.
- 3.1.5 The fact that the murder took place shortly after Christopher's announcement to move out with Lilly indicates James' intention to maintain control over both Christopher and Lilly.

3.2 Children's Social Care

- 3.2.1 Following and immediately prior to Lilly's birth, the social work service provided to the family centred around assessing Lilly's mother's capacity to parent Lilly and to evaluate her circumstances. The file indicates a thorough assessment was completed of Lilly and her home circumstances. It is noted that responsibility for the assessment and support of Lilly and her mother changed case workers three times which would have made the building of trust, support and rapport challenging.
- 3.2.2 During this time James and Karen were seen as supportive and protective factors towards Lilly. However, whilst it was recognised that Christopher was the father, there is no indication that he was assessed as a father or a potential carer to Lilly.
- 3.2.3 The invisibility of fathers in child protection is an area recognised by Croydon as an area of previous weakness and is an area being actively addressed, with training being provided to

social work staff engaged in assessments and in developing support for fathers to engage more. This is of particular importance in this case as Cheryl described Christopher as often feeling alienated by services as not having parental responsibility. His experience was that often services would speak to James or Karen in relation to his daughter and not to speak to him. If his responsibility and role as a parent was more clearly identified in his early experiences as a parent, it may have helped him feel more confident in later situations with the school and with his own parents in day to day circumstances.

- 3.2.4 There was month gap between the police incident and the Merlin noted and acted upon by Children's Services which indicates that either records were unclear, there was an administrative error or that the assessment was delayed and not acted upon quickly.
- 3.2.5 When the school reported concerns about Christopher as reported to them from Karen, there was very little proactivity to explore the potential child protection concerns raised by the school and Karen. These concerns should have been assessed which may have provided Christopher with an opportunity to discuss the care of Lilly and for CSC to understand his concerns as well as those of Karen.
- 3.2.6 There was a six day gap between the Merlin being completed by the police and the being recorded by CSC. This gap is not acceptable given it is a critical time to understand the aftermath of a police incident within a family. Policy and procedure should be adhered to so that gaps extending to a week do not happen. At the time the Merlin was received, CSC were receiving an excess of 600 Merlins per week which is why the delay took place. Following changes in the MASH, delays in reviewing Merlins by social work staff have been significantly reduced.

3.3 London Fire Brigade

- 3.3.1 James was perceived to be a good employee with a good record of employment and service. He was deemed to be transparent in the information provided regarding his requests for leave in relation to his family.
- 3.3.2 The violence noted by James to his employer was not deemed to trigger a safeguarding concern for James or others in his family and his co-workers and his supervisors did not record or recollect a safeguarding concern. His employer took a supportive view to allow James the time off he requested and when on the job, James did not report to any supervisors or co-workers anything related to his home life which caused concern or required further action.

3.4 Metropolitan Police Service

3.4.1 The Metropolitan Police accurately recorded the incident on the 12 of October, 2013 as a non- crime domestic and did undertake an assessment of risk. Christopher was compliant and made admissions that he had been violent towards his mother which is why she had been physically violent towards him. The police did correctly record a Merlin and offered support to the family.

3.5 South Norwood Hill Medical Centre

3.5.1 Christopher, Lilly, James and Karen were all registered at the practice but they were not seen frequently or regularly. James was not seen in the year prior to Christopher's murder. Karen had not been seen in the ten years prior to Christopher's murder. Christopher had been seen in 2014 for a cough but not in the five years prior to that and Lilly had only been seen for routine immunisations.

3.5.2 At every attendance of a child, it should be documented who the child was accompanied by. The nurses consistently identified who brought Lilly for examinations but there is less consistency by other medial professionals.

3.5.3 Changes to the registration process should include questions regarding if the child is known to CSC, name of the child's school and who is the guardian of the child. The GP surgery was missing the social history in relation to Lilly and her wider family. There is little probing into the reason or outcome of a custody case mentioned in notes in June of 2010. When family dynamics do not appear straight forward, clinicians should be encouraged to sensitively gain further information and document it.

3.5.4 As reflected in HO findings related to DHRs as well as other DHR related findings such as done by STADV, the GP surgery is a critical point of possible intervention and information and support for families where domestic abuse related incidents are known should be addressed and patients should be offered follow up support and advice in these situations.

3.6 Virgo Fidelis Preparatory School

3.6.1 Lilly's school were clearly given conflicting information by Christopher and Karen. Karen was very active and supportive of the school and was the primary carer at the school gate for Lilly. Accordingly, the school understood Karen's view of the situation with Christopher and they knew and saw her more often. However, Cheryl reported that Christopher said that he had tried to speak to the head teacher and to assert his right to know directly from the school about issues relating with Lilly as he was her father. It appears that due to Karen's accessibility to the school, their overriding contact was with Karen. There is also no

record of the school following up with CSC to resolve the ongoing concerns between the adults caring for Lilly. Every school, including fee paying schools, should be aware of wider dynamics in relation to domestic abuse and proactive in their practice with regard to safeguarding.

- 3.6.2 Despite several attempts to contact the school more actively, the chair was not able to engage the school actively in this review. There is good practice in other London boroughs in relation to safeguarding networks for fee paying schools which link more actively to the Safeguarding Children's Board and operational work and learning networks within boroughs for domestic abuse. Dissemination of learning from all local DHR and Serious Case Reviews (SCRs) in Croydon should be disseminated to fee paying schools in Croydon.

3.7 Equality and Diversity

- 3.7.1 The Chair of the Review and the Review Panel considered all the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.
- 3.7.2 Christopher and James were both White British heterosexual males. James was 59-years old at the time of the homicide and Christopher was 24 years old. James was married to Karen and Christopher was not married. The protected characteristics of disability, gender reassignment, religion/belief and sexual orientation do not pertain to this. They did not hold particular religious or other beliefs as far as we can tell from the records.
- 3.7.3 Christopher was only 18 when he became a father and the Review Panel provided special consideration to age throughout this review to determine if responses of agencies were motivated or aggravated by these characteristics.
- 3.7.4 As Christopher was a young father and his mother was perceived by many to be the main carer, his status as a parent was invisible to many services including Lilly's school and Children's Social Care. This impacted on his ability to assert his views as a parent and to interact with services in a proactive way. This was something he was clearly attempting to rectify in the year prior to his murder.

4. Conclusions and Recommendations

4.1 Issues raised by the review and lessons to be learned

- 4.1.1 Invisibility of fathers: There are examples from both the CSC and Lilly's school where Christopher was allowed to be invisible to services. This reflects wider learning from other DHRs and SCRs in terms of the need to engage with fathers as parents more generally and for services to understand more fully the nature and relationship of the child and the father. A previous DHR in Croydon (referred to as Janice) highlighted learning about the need to improve early help for families and it was thought that the introduction of a MASH would help enhance the sharing of information and ensuring that targeted and timely support is offered to families who come to the attention of services. The "team around the family"

approach and CAF process was to incorporate this learning. As this is a further example of learning in this area, the CSP and Child Safeguarding Board should audit its progress to date in this area to ensure that there is adequate oversight at senior levels to support this ongoing process of improvement.

- 4.1.2 **Lack of advice services:** Cheryl noted that Christopher required support and advice but he would not have found it easy to access the support he needed as it did not fit neatly into any one box. He may have needed support to assert his role as a parent. He may have needed financial support and advice to become more independent from his family. He may have needed support for feeling intimidated at home or for conflict between him and Karen. Perhaps more overt information and support targeted for fathers of young children may have caught his eye. He may have only seen this in the waiting area of services that he attended such as the GP surgery. However, if health visitors, CSC, schools and other key services, were focused more on understanding the role of the father in a family, it may have supported Christopher to be a more proactive parent. And if Christopher felt controlled in his family home, as cited by Cheryl, he may have wanted support and advice as to how to live more independently. Services such as the Citizens Advice Bureau (CAB) would be ideal places for people to seek advice and support as adult children struggling with their home environment as they seek financial advice and if there is a need for signposting for those who may feel intimidated or threatened in their home environment. Learning from this review should be shared with existing advice services and public information should include a wide range of images so that men are included and targeted for support by the wide range of services provide in Croydon.
- 4.1.3 **Knowledge of Informal networks:** The one place the Christopher sought advice and support was through Cheryl, his friends and co-workers. He spoke at work and was supported in his pending move in the weeks before his murder. This information was managed within these social networks who equally would not have had an awareness of where Christopher could have sought advice and support. Some may have pointed to the CAB for example but others may have struggled to find the right support and advice for Christopher. Any increase in public information and awareness which include a range of images so that men are included and targeted for support by services in Croydon would improve knowledge within informal networks.
- 4.1.4 **Safeguarding and Schools:** Schools are often a first point of contact for young families and the support and advice they give is critical for families and to address issues related to safeguarding. Lilly's school was proactive in alerting CSC when concerns were alleged by Karen about Christopher. However, it appears that further contact for follow up between the school and CSC was not made. It may be that the school did not have ongoing concerns

but it is not clear that they followed up with CSC to know the outcome of their assessment. As the assessment did not result in further action, it may be that the school was left with the false sense that more was being done to safeguard Lilly. In addition, Cheryl asserted that Christopher approached the school to assert his desire to have direct contact from them with regard to Lilly. Their judgement of Christopher would have been informed by what Karen had reported about him. Christopher did not appear to achieve a positive channel of communication with the school. Learning from this review should be shared with safeguarding leads in schools. Again, in a previous DHR in Croydon (referred to as Janice) there were three recommendations related to work to improve domestic abuse understanding and referral pathways in schools. They were to disseminate learning from the review in written briefing form, to commission a borough wide multi-agency training and to develop an early intervention approach to domestic abuse through local schools. The CSP and the Safeguarding Children's Board should review progress on these recommendations and to incorporate this further learning into these activities.

- 4.1.5 GP surgeries: This review highlights the potential role of GP surgeries in providing services and advice to the whole family. In this case, the GP was aware of the referral information from CSC yet there is no documentation that this was followed up in subsequent visits to inquire safety concerns at home. Again, in previous DHRs in Croydon, there have been recommendations related to proactive work with GP surgeries to support them to improve their knowledge of the dynamics of domestic abuse and the referral pathways for their patients. The Safer Croydon Partnership should undertake a review of progress to date to ensure these recommendations are being acted upon.

4.2 Recommendations

- 4.2.1 The recommendations are multi-agency recommendations arising from the review which should be acted on and initial reports on progress should be made to the Safer Croydon Partnership quarterly. Recommendations should be considered alongside other similar reviews and findings.
- 4.2.2 It is the expectation that all agencies involved in this review or the wider Safer Croydon Partnership will share the learning from this review as widely as possible and will incorporate its findings into existing learning and development frameworks.
- 4.2.3 Consolidate work in relation to invisibility of fathers in the context of CSC and other frontline family services and audit progress to date in relation to this area of work to ensure both the Safer Croydon Partnership and the Children's Safeguarding Board has adequate oversight on progress to date and further development required.

- 4.2.4 Consider if the public information provided in a wide range of services such as the CAB, Croydon Family Justice Centre, GP surgeries and general support and advice centres target a range of potential service users including men so that there is wider understanding to those seeking help and their social networks of the range of service provided locally.
- 4.2.5 Report on progress to date in relation to work in both schools and primary care which relate to recommendations and actions from prior reviews which are reflected and further understood in this review.



Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with **Christopher**, and **James** following **his** death in **November 2014**. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with **Christopher** and **James** during the relevant period of time: early May 2008 – the date of the murder.
3. To summarise agency involvement prior to **May 2008**.
4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

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6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
7. To commission a suitably experienced and independent person to:
 - a) chair the Domestic Homicide Review Panel;
 - b) co-ordinate the review process;
 - c) quality assure the approach and challenge agencies where necessary; and
 - d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
9. On completion present the full report to the **Croydon Community Safety Partnership**.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel.
11. meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
12. The following agencies are to be involved:
 - a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)
 - b) General Practitioner for the victim and perpetrator
 - c) Local domestic violence specialist service provider e.g. IDVA
 - d) Education services
 - e) Children's services
 - f) Adult services
 - g) Health Authorities
 - h) Substance misuse services
 - i) Housing services
 - j) Local Authority

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- k) Local Mental Health Trust
- l) Police (Borough Commander or representative, Critical Incident Advisory Team officer, Family Liaison Officer and the Senior Investigating Officer)
- m) Prison Service
- n) Probation Service
- o) Victim Support (including Homicide case worker)

13. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and if appropriate ask the organisation to join the panel.

14. If there are other investigations or inquests into the death, the panel will agree to either:

- a) run the review in parallel to the other investigations, or
- b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

15. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

16. Each agency must provide a chronology of their involvement with the **Christopher** and **James** during the relevant time period.

17. Each agency is to prepare an Individual Management Review (IMR), which:

- a) sets out the facts of their involvement with **Christopher** and/or **James**;
- b) critically analyses the service they provided in line with the specific terms of reference;
- c) identifies any recommendations for practice or policy in relation to their agency, and
- d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

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

Analysis of findings

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

Liaison with the victim's and perpetrator's family

19. Sensitively involve the family of **Christopher** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.
20. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
21. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

22. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.
23. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

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24. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.
25. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
27. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
28. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Disclosure

29. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

Appendix 2: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<i>What is the over-arching recommendation?</i>	<i>Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the Review Panel can suggest recommendations for the national level)</i>	<i>How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?</i>	<i>Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?</i>	<i>Have there been key steps that have allowed the recommendation to be enacted?</i>	<i>When should this recommendation be completed by?</i>	<i>When is the recommendation and actually completed? What does the outcome look like?</i>

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