SAFER CROYDON COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Louise

May 2018

Independent Chair and Joint Author of Report: Mark Yexley

Independent Co-Chair and Joint Author: John Trott

Associate Standing Together Against Domestic Abuse

Date of Completion (sent to CSP): February 2021

A dedication from Louise's mother:

'I am dedicating this to my beautiful daughter who was brutally taken away from me and her family due to domestic violence. She was a beautiful young woman, she was a quiet, loving daughter who didn't have a bad bone in her body, the reason why whoever she met loved and respected her. She is so sadly missed by everyone who knew her, especially myself, her sister and children. It is something we have to live with but will never come to terms with.'

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1. Preface

1.1 Introduction

1.1.1 The Review Panel firstly wishes to expresses its sympathy to the family and friends of Louise for their loss and thanks them for their contributions and support for this process.

1.1.2 This Domestic Homicide Review (DHR) involves the murder of Louise by her estranged husband, David. At the time of her death, the couple were separated. Louise lived with their children in Croydon and David lived alone in Bromley. In May 2018 Louise met with David, and their two young children for a day out together. Louise had been asked by David to meet him, on the pretence that he was due to be arrested by the police and may not see his children again. Louise and David took the children out for the day to a wildlife park in Kent. They all returned to David's flat to stay there overnight. The following day David took his children from his flat to his mother's house and left them there. Family became concerned David had not returned home and went to his flat to find him. David could not be found but the family discovered Louise dead in David's flat. She had been murdered by David.

1.1.3 As Louise and David were married and had previously been in an intimate relationship, the incident was a Domestic Homicide. Safer Croydon Community Safety Partnership (CSP) commissioned a Domestic Homicide Review (DHR) as required by Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.4 This review examines agency responses and support given to Louise, a resident of the London Borough of Croydon prior to the point of her murder in May 2018.

1.1.5 This review will consider agencies contact/involvement with Louise and David from March 2012 to May 2018.

1.1.6 In addition to agency involvement, the review will also examine 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.

1.1.7 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.

1.1.8 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.

1.2 Timescales

1.2.1 The Safer Croydon Community Safety Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review.

1.2.2 Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an independent chair for this DHR in January 2019. The review was co-chaired by an established associate chair of Standing Together and another chair new to the organisation. The completed report was handed to the Safer Croydon Community Safety Partnership in February 2021.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. There were a number of factors that resulted in the delay of the DHR. There was an initial delay in the Croydon CSP obtaining case details from another local authority area. There were also structural changes within the Croydon CSP that had an impact. The role of Domestic Abuse and Sexual Violence Coordinator was unfilled for six months leading into 2019, resulting in a backlog of work. This resulted in the delay in commissioning the review chair. It was also established that the Home Office were not notified of this DHR at the outset of the process and they were finally informed in December 2020. Measures have since been put into place to ensure that the coordination and progress of DHRs is not reliant on a single post. There is now assurance from the CSP that the Home Office will be notified of all new DHRs in a timely manner.

1.2.4 Further delays took place due to the late submission of IMRs and the need for a second IMR meeting. The final stages of the DHR, including drafting the Overview Report, took place during the 2020 COVID 19 crisis. This had an impact on the panel being able to meet to discuss the draft report and added an additional challenge around agencies capacity. This also caused a significant delay in the progress of actions from an NHS Trust managing acute services.

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office 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 with the 2016 guidance. The specific date of death has been removed, and only the independent Chair, Co-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: Louise

1.3.5 The perpetrator: David

1.3.6 Eldest child of victim and perpetrator: Child A

1.3.7 Youngest child of victim and perpetrator: Child B

1.3.8 Mother of victim: Adult U

1.3.9 Sister of victim: Adult W

1.3.10 Friend of victim: Adult X

1.3.11 In some DHRs pseudonyms are used to represent the persons involved, but these need to be agreed by family and friends. If names are chosen without family input, then there is potential to inadvertently cause distress or concern to the family. The family were asked to consider an alternative name for the victim. The victim's mother suggested the name of Louise to represent her daughter. The family have also agreed to a proposed name of David for the perpetrator. All other persons referred to in the report will referred to by an anonymised letter. Louise's mother wrote the dedication at the opening of this report.

1.4 Equality and Diversity

1.4.1 The Chair and Co-Chair of the DHR and the Review Panel did bear in mind 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.

1.4.2 Louise was a 31 year old heterosexual White-British woman. David was a heterosexual White-British man and was 35 years old at the time of Louise's murder. They were married but separated. During the review period Louise gave birth to two children, they were aged six and four at the time of their mother's murder. The protected characteristics of gender reassignment, religion/belief and sexual orientation do not pertain to this case and neither party was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs.

1.4.3 **Sex:** Sex should always require special consideration. Recent analysis of domestic homicide reviews reveal gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males

representing the majority of perpetrators.[1] Sex, and gender, is therefore relevant for this case, the victim of the homicide was female and perpetrator of the homicide was male.

1.4.4 **Pregnancy and Maternity:** The Review Panel considered pregnancy and maternity of the victim. Pregnancy and maternity were considered for Louise as she had a difficult first pregnancy which required an emergency caesarean section. Following the delivery of the baby, the baby was passed to a midwife who subsequently dropped the baby causing the new-born bruising to the right eye and the baby was immediately transferred to the Special Care Baby Unit. The birth of her second child was a much better experience for Louise.

1.4.5 **Disability:** At the outset of the process the panel were informed that David was known to have arthritis. This was known to Louise's family, and to the homicide investigation, as a reason why David was not working at the time that he murdered Louise. The full details of David's condition were not revealed to the panel until after the IMR process was completed and the report was at draft stage. It was then established that David had rheumatoid arthritis and he had been certificated sick for some time with this condition. Although the full medical diagnosis was not known at the outset, the panel still considered disability as a protected characteristic that could be relevant to this review throughout the process.

1.4.6 **Marriage:** The marital status of Louise and David was a key factor in this review. It is known that they moved in together within three to six months of first meeting. Her family considered this to be very quick.. Louise's mother believed that the marriage was significant factor in David's control over her daughter. She stated that Louise was not allowed to get ready for the wedding at her mother's house. She believed that, once married, David thought he 'owned' Louise. Louise saw her family less frequently after her wedding. During the period under review there were a number of times when the parties were separated. It was also established that Louise had drafted a divorce application, but this was not submitted to a Court. Separating and ending of a marriage are events that are known to increase risk of domestic abuse. This area was given particular attention by the panel and included in the lines of enquiry for the review.

1.4.7 No additional equalities issues were identified during the course of the review.

[1] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from Louise's and David's case, 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.

1.5.2 The DHR Panel was comprised of agencies from the Croydon and Bromley areas. Louise and David had first lived together in Bromley, and later moved to Croydon. At the time of Louise's murder both parties were separated, Louise remaining in Croydon and David in Bromley. Agencies were contacted in February 2019, to inform them of the review, their participation and the need to secure their records.

1.5.3 At the first meeting, the DHR 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 March 2012 to the date of the homicide. The start date of the review was initially set as the panel were made aware from a police review and family contact that this was when the family considered that things changed in the relationship between Louise and David. All agencies were asked to check any records held from before this period and summarise information for the panel. There were recorded incidents of abuse or of concern before the time period set. These events were summarised in IMRs for the information of the panel. It was considered that there was no need to reset the terms of reference period as there was sufficient information available to the panel to consider systems, processes and communication.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2016 Guidance and identified and considered the following case specific issues:

- Whether Louise was subject to any economic abuse;
- How the separation of Louise and David affected abuse;
- Whether concerns of Louise's risk of self-harm or the threat of self-harm from David was a factor in the case;
- Whether stalking behaviour, including cyber stalking and the misuse of technology, by David towards Louise, took place; and
- Review any evidence of substance misuse by David.

1.5.5 Consideration was given regarding expert panel membership including Substance Misuse Services. As such two services were scoped with and invited (Turning Point and Bromley Alcohol and Drug Service) – both had no contact as per 1.7.1 but were invited to remain on panel, however, due to capacity were unable. Around the cyber-stalking, it was agreed due to John Trott's expertise around stalking this was not required (see Chair information 1.12.2). Consideration was also given to inviting

Surviving Economic Abuse however the additional funding for this consultancy was not agreed.

1.6 Methodology

1.6.1 Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross government definition of domestic violence and abuse as issued in March 2013 and included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

1.6.2 "*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.*

1.6.3 *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.*

1.6.4 *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*."

1.6.5 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.6.6 This review has followed the 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. In considering cases that should be subject to a DHR, Section 2 Para 5 of the 2016 Guidance states:

"This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)1. The Act states:

(1) In this section "domestic homicide review" means 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death."

1.6.7 On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. An initial meeting was held to discuss the findings of the agencies. A total of 26 agencies were contacted to check for involvement with the parties concerned with this review. 12 agencies returned a nil contact. The chronologies were combined, and a narrative chronology written by the chairs.

1.6.8 **Independence and Quality of IMRs:**

1.6.9 The majority of the IMRs were written by authors independent of case management or delivery of the service concerned. One of the IMRs was completed by a GP in the victim's medical practice and the author declared that they were not independent. The panel accepted the report on the basis that there was no independent person available to conduct the IMR and the information held by the practice was essential to conduct an effective review. This report was found to be of a good standard. Additionally, the IMR from the school was written by the Head Teacher. It is clear that the author is not independent of contact with the parties subject of this review. The Head Teacher is the Safeguarding Lead for the school, and the IMR was comprehensive. Whilst clear independence could not be provided by the school, the report provided valuable information to the panel. Two IMRs were submitted almost a year after the DHR process was started and after the first draft of the overview report was completed. One of the late IMRs was of poor quality and contained inaccuracies, this will be subject to further comment in the report.

1.6.10 All other IMRs received were comprehensive and enabled the panel to analyse the contact with Louise and/or David, 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. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this review.

1.6.11 **Documents Reviewed:** In addition to the IMRs and chronologies, documents reviewed during the review process have included, draft divorce paper found at Louise's home, Croydon Housing Register Application Form dated 7 February 2017, police case summaries, CQC reports on GP Practice, Croydon DHR Overview Report Into the Death of Victoria March 2016, Standing Together and HO DHR Case Analysis, and London Borough of Croydon's Domestic Abuse and Sexual Violence Strategy 2018-2021.

1.6.12 **Interviews Undertaken:** The Chair and Co-Chair of the review have undertaken three interviews in the course of this review. These were a face to face interview with the victim's mother, sister and friend (this is further discussed in Section 1.9 of this report).

The Chair also offered the perpetrator an opportunity to contribute to the review which he declined. The Chair and Co-Chair are very grateful for the time and assistance given by MPS Family Liaison Officer (FLO) and AAFDA who have contributed to this review.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Bromley Drug and Alcohol Service
- Bromley Lewisham and Greenwich MIND Mental Health Charity
- Croydon Court Services – County Court
- Croydon Family Justice Centre (FJC)
- Community Rehabilitation Company
- London Ambulance Service NHS Trust
- London Borough of Bromley – Adult Social Care
- London Borough of Croydon – Adult Social Care
- MIND in Croydon Mental Health Charity
- National Probation Service
- Oxleas NHS Foundation Trust – Mental Health
- Turning Point – Substance Misuse Service

1.7.2 The following agencies had contact with the family during the period under review, or held relevant information, and their contributions to this DHR are:

Agency	**Contribution**
Bromley Clinical Commissioning Group (CCG) (for David's records at General Practice)	IMR and Chronology
Bromley General Practice (for the Louise and Children)	IMR and Chronology
Bromley Healthcare - Improving Access to Psychological Therapies (IAPT)	IMR and Chronology
Bromley Healthcare Universal Health Visiting and School Nurse	IMR and Chronology
Croydon Clinical Commissioning Group (CCG) (for the General Practice)	IMR and Chronology
Croydon Health Services NHS Trust	IMR and Chronology
Kings College Hospital (KCH) NHS Foundation Trust	IMR and Chronology

London Borough of Bromley Children's Social Care	Summary of Engagement
London Borough of Croydon Children's Social Care	IMR and Chronology
London Borough of Croydon Housing Services	IMR and Chronology
South London and Maudsley (SLaM) NHS Foundation Trust	IMR and Chronology
Metropolitan Police Service (MPS)	IMR and Chronology
Primary School	IMR and Chronology
Victim Support	IMR and Chronology

1.8 The Review Panel Members

1.8.1 The Review Panel Members were:

Panel Member	**Job Title**	**Organisation**
Dr Shade Alu	Director of Safeguarding	Croydon Health Services (CHS) NHS Trust
Sandra Anto-Awuakye	Safeguarding Children Advisor	Bromley Health Care - Health Visiting
Rashida Baig	Head of Service Social Work with Families, CWD and Transitions and YOS	London Borough of Croydon – Children's Social Care
Caroline Birkett	Head of Service	Victim Support
Not listed - to protect identity of children	Head Teacher	Primary School
Janice Crawley	A/Detective Inspector Review Officer	MPS – Serious Crime Review Group (SCRG)
Kate Dyer	Named GP for Safeguarding Children	Bromley CCG
Alison Eley	Named Nurse for Safeguarding Children	South London and Maudsley (SLaM) NHS Trust
Sian Foley	Head of Service Department	London Borough of Croydon Housing
Ciara Goodwin	Domestic Abuse & Sexual Violence Coordinator	London Borough of Croydon
Sarah Hayward	Director Violence Reduction Network	London Borough of Croydon
Alison Kennedy	Operations Manager	Croydon FJC (Domestic Abuse Agency)
Estelene Klaasen	Designated Nurse Safeguarding Adults	Croydon CCG

Tessa Leake	Named GP for Adult Safeguarding	Bromley CCG
Sharon Murphy	Interim Head of Tenancy & Caretaking services	London Borough of Croydon Housing
Heather Payne	Head of Adult Safeguarding	Kings College Hospital (KCH) NHS Foundation Trust
Russell Pearson	Review Officer	MPS – Serious Crime Review Group (SCRG)
Alvin Romero	Clinical Service Lead	South London and Maudsley (SLaM) NHS Trust
John Trott	Independent Co-chair	Standing Together
Guy Van Dichele	Executive Director Health Wellbeing and Adults	London Borough of Croydon – Adult's Social Care
Mark Yexley	Independent Chair	Standing Together
Jenab Yousuf	Interim Safeguarding Adults Lead	Croydon Health Services NHS Trust

1.8.2 Independence and expertise: Agency representatives were at the appropriate level for the Review Panel and demonstrated expertise in their own areas of practice and strategy and were independent of the case and line management of anyone involved with the case.

1.8.3 The Review Panel met on four occasions, with the first meeting of the Review Panel on the 9 May 2019. There were panel meetings to review the IMRs on 25 September 2019 and 11 December 2019. Interviews with the family and friend then took place. The Overview Report was then drafted in April 2020, at the start of the COVID 19 'lockdown' period. The COVID 19 impact on services resulted in a delay to the next meeting. There was an online meeting to review the draft Overview Report on 22 June 2020. The family of the victim were not offered a meeting with the panel, as the timing of this would have fallen within the 'lockdown' period. The family did maintain contact with the Chair throughout the process.

1.8.4 The Chair and Co-Chair of the review thank everyone who contributed their time, patience and cooperation to this review.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 The Chair and Co-Chair of the review and the DHR panel acknowledged the important role Louise's family could play in the review. In March 2019 the CSP wrote to the family of Louise, via the Police Family Liaison Officer, notifying them of the DHR. A copy of the Home Office DHR leaflet was provided. The family were supported by an advocate

from Advocacy After Fatal Domestic Abuse (AAFDA). The family were kept informed of the progress of the review. They were invited to read the draft report and comment before submission to the Home Office.

1.9.2 Initial contact, on behalf of the Chair, was made with Louise's mother through AAFDA. It was established that AAFDA had been supporting the family for approximately a year before the DHR process started. The family had already been provided with the Home Office information by AAFDA. Letters of introduction and an explanation of the DHR process were provided through AAFDA. A draft terms of reference was provided to the victim's family before they met the chair. Louise's mother and sister agreed to be interviewed as part of the review. Louise's mother also facilitated contact with a friend of Louise. The family and friend provided a valuable insight into Louise's life and experiences and this is considered as an essential part of the review.

1.9.3 Contact with the family was maintained through AAFDA. There was a period of time, during the COVID 19 pandemic, when there was limited contact between the family and AAFDA. The AAFDA worker assigned to the family was furloughed during the early stages of the pandemic and returned to work in July 2020. AAFDA did provide contact details for the service during the absence for the furlough. Contact was later re-established, and the family reviewed the final draft of the report in November 2020, with the support of AAFDA.

1.9.4 In reviewing the report, the family expressed concerns that Louise's voice was overlooked by agencies and David was more strident in his contact with agencies. They also had concerns that David's ill health was given more focus than Louise. The Chair explained to the family that the panel were under a duty to reflect all contact made by both parties during the process. There was a legal duty to consider any disability of either party.

1.9.5 Consideration was given to interview the man that Louise had started a relationship with shortly before her death. There was no suggestion that there was any form of abusive element to the relationship and any interview would be to provide further information to the panel. The CSP advised that they believed that there was already substantial information gathered from family and friends and there was a wish to avoid further delays to the review in conducting further interviews.

1.9.6 Consideration was given to contact employers of Louise but it appears she had a number of jobs throughout the period of review and the family were unable to provide details for them.

1.10 Involvement of Perpetrator and/or his Family:

1.10.1 On 17 January 2020 the perpetrator was sent a letter from the chair via his Probation Officer with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back.

1.10.2 On 14 February 2020 the Probation Officer confirmed that they had discussed the review with David and that David had read the letter and declined to be involved in the review.

1.10.3 The panel expresses thanks to the Probation and Prison Service for their support of this review.

1.11 Parallel Reviews

1.11.1 **Criminal trial**: The criminal trial concluded in December 2018 at the Central Criminal Court. David was found guilty of the murder of Louise. He was sentenced to life imprisonment with a specified minimum term of 16 years.

1.11.2 **Inquest**: The Coroner decided no investigation was required and therefore, no inquest was held. Consequently, following the completion of the criminal investigation and trial, there were no reviews conducted contemporaneously that impacted upon this review.

1.11.3 There were no other known parallel reviews.

1.12 Chair of the Review and Author of Overview Report

1.12.1 The Chair and author of the review is Mark Yexley, an Associate DHR chair with Standing Together. Mark has received Domestic Homicide Review Chair's training from Standing Together and has chaired and authored 14 DHRs. Mark is a former Detective Chief Inspector with 36 years' experience of dealing with domestic abuse and was the head of service-wide strategic and tactical intelligence units combating domestic violence offenders, head of cold case rape investigation unit and partnership head for sexual violence in London. Mark was also a member of the Metropolitan Police Authority Domestic and Sexual Violence Board and Mayor for London Violence Against Women Group. Since retiring from the police service he has been employed as a lay chair for NHS Health Education Services in London, Kent, Surrey, and Sussex. This work involves independent reviews of NHS services for foundation doctors, specialty grades and pharmacy services. He currently lectures at Middlesex University on the Forensic Psychology MSc course.

1.12.2 The Co-chair and author of the review is John Trott, an Associate DHR chair with Standing Together. John has worked for over 34 years in the domestic abuse sector. He retired from the Devon and Cornwall Police in January 2016, having served as the Detective Chief Inspector and head of the Cornwall Police Public Protection Unit. John currently works with victims and survivors of domestic abuse and additionally he

delivers consultancy and training within his specialist knowledge areas of domestic abuse, coercion and control and stalking. He has also been the CEO of a National Stalking Advocacy Service (Paladin) and speaks at various conferences throughout the UK on coercive control and stalking.

1.12.3 Standing Together 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.

1.12.4 Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 70 reviews.

1.12.5 *Independence:* Mark Yexley has no current connection with the London Borough of Croydon or other agencies mentioned in the report. He retired from the MPS in 2011 and whilst serving in the MPS, he was never posted to Croydon Borough. John Trott has no connection with the London Borough of Croydon or other agencies mentioned within the report.

1.13 Dissemination

1.13.1 The following recipients have received/will receive copies of this report:

- Victim's mother, and family/friend contributors
- Panel members
- Standing Together Against Domestic Abuse DHR Team
- Police and Crime Commissioner

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to Victim**	**Age at time of Victim's death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Louise	Victim	31	White British	NK	UK National	N
David	Perpetrator and estranged husband of victim	35	White British	NK	UK National	Y
Child A	Child	6	White British	NK	UK National	N
Child B	Child	4	White British	NK	UK National	N

2.1 Summary of background information known to family and agencies

2.1.1 ***Background Information relating to Louise:*** Louise was born and raised in South London with her parents. Louise had a younger sister, Adult W. Louise's parents were later divorced. Louise went to school and college in South London. Her family recalled how she loved to Ice Skate and saved money from her first Saturday Job to buy skates. From the age of 17 she worked in a Jewellers.

2.1.2 At the age of 18 she moved out of her family home for a short while to live with a boyfriend and then moved back home. Louise then had another boyfriend until they broke up when she was 19 to 20 years old. Louise then moved out of her family home and got her first place, renting a room in Beckenham, London Borough of Bromley. Louise loved to travel and socialise and go partying with friends. Louise always had a very close relationship with her sister, Adult W.

2.1.3 ***Louise's relationship with David:*** In 2008 Louise and her sister went out together to a pub in Beckenham where they met David. David was four years older than Louise. A relationship developed and Louise subsequently moved in with David at his mother's house in 2008 They lived there for a short period, before getting a flat within 2009 or 2010.

2.1.4 Louise and David married in September 2011. The couple's first child, Child A, was born in March 2012. Their second child, Child B, was born in January 2014. They lived at an address in the London Borough of Croydon.

2.1.5 Louise's mother and sister have recounted how David's behaviour towards Louise and her family changed once she became pregnant with Child A. For a period of time

Louise and David used to visit her sister, her partner, and their children, and they would all get on well. Both mother and sister described that David manipulated Louise into believing that her mother favoured her sister, Adult W and her children over Louise and their child. This caused tension and disrupted their relationship, causing Louise to put distance between her mother and sister. Although her mother tried to maintain contact with Louise, she said David would always be present when she visited and that she rarely had a chance to be alone with Louise.

2.1.6 Louise's sister stated that on the occasions when Louise did come to visit her, David would phone her and accuse her of being with other men, being verbally abusive during the call and following this up with abusive text messages. This went on for several years.

2.1.7 In December 2016, Adult W noted her sister Louise was becoming depressed, this culminated in Adult W going to babysit for them whist David took Louise to the Hospital to be assessed. Louise then told her the doctor concluded she wasn't "mad or mental" but just unhappy in her relationship.

2.1.8 Louise and David separated at the end of December 2016. The children remained resident with their mother in the family home in Croydon after the separation. David moved out and lived initially with his mother in Beckenham before moving to a flat in Bromley.

2.1.9 Once David and Louise separated on 26 December 2016, Adult W said her relationship with Louise improved. Adult W stated that every time Louise started to meet other men post the separation David would find out and he would then ruin the relationship.

2.1.10 Louise's mother, Adult U, provided a similar account and described how David caused problems in the relationship between her and Louise. He also sent her text messages in 2016 claiming that Louise had mental health problems.

2.1.11 ***Louise and David after separation:*** In early 2017 Louise's mother recalled that David started relationships with other women and would text Louise to tell her about them, stating he wanted the children to meet them.

2.1.12 Information gathered from Louise's friends during the review also reinforced the picture that David exhibited controlling behaviour towards Louise. He would change childcare arrangements at the last minute to frustrate Louise's plans which also made it difficult for her to hold down a job. David did not work and was in receipt of benefits due to an arthritis-related medical condition.

2.1.13 Family and friends noticed that Louise seemed much happier after she separated from David and although she struggled financially, she began to "get her life back". At that point Louise did not have many friends outside of David's family, but she started to see her sister more and spent time with her neighbour. Louise saw her sister at least four

times a week and she started to see Louise being more like the person she was, before she met David. Louise started to socialise more, started meeting old friends

2.2 The Homicide

2.2.1 In the days before the murder, David contacted Louise and asked if they could go on one last family day out. It is believed he told Louise he was going to be arrested and would not be around for a while. In May 2018 Louise, David and the children spent the day at a wildlife park in Kent before meeting friends for drinks and returning to David's flat in Bromley. The friends subsequently described Louise and David as being in good spirits.

2.2.2 Enquiries conducted during the homicide investigation revealed that Louise's bank card had been used to withdraw £250 from an automated teller machine (ATM) in Bromley. A witness gave evidence at the trial to say that David contacted him saying he could pay back the money he owed. This person drove to David's address and took him to the ATM. David paid the witness the money which he claimed was owed in relation to a social event and was driven back to his flat. It is suspected that this money related to drugs.

2.2.3 On the morning after the wildlife park visit, David took the two children to his mother's house and asked her to look after them as he said he needed to go to the police station. By 14:00 hours when neither David nor Louise had returned for the children and she did not receive any response from calling David's phone, she asked a friend of David's to go to David's flat to find him. David's friends went to the address and found no sign of David. They looked in the bedroom and noticed feet protruding from the edge of a quilt and concerned by what they saw, called David's mother. David's mother attended the flat and the police were called as a result of them finding the body of Louise.

2.2.4 The police officers found a message written on a wipe board in the kitchen. The message mentioned that the family would be together for ever and that 'she deserved it'. It included the initials of David and the children.

2.2.5 David returned briefly to his mother's house at around 19:00 hours and said goodbye to his children. He then disappeared, but eventually returned to his mother's address four days later. David then presented himself for arrest at Bromley Police Station. He was found to be in possession of Louise's bank cards and some money. He was interviewed and denied responsibility for Louise's death. David was charged with her murder.

2.2.6 ***Post Mortem*****:** A post mortem was conducted at the Princess Royal University Hospital, Bromley. Cause of death is recorded as compression of the neck (strangulation).

2.2.7 ***Criminal trial outcome*****:** David was found guilty of murder. He was sentenced to life imprisonment with a specified minimum term of 16 years.

3. Chronology

3.1 Chronology from March 2012 to May 2018

Organisation Name	Contact with Louise (Y/N)	Contact with David (Y/N)
Bromley CCG (GP)	*Y*	*Y*
Bromley Healthcare - Universal Health Visiting and School Nurse	*Y*	*N*
Bromley Healthcare IAPT	*Y*	*N*
Croydon Clinical Commissioning Group (CCG) (for the General Practice)	*Y*	*N*
Croydon Health Services NHS Trust	*Y*	*N*
Kings College Hospital NHS Foundation Trust	*Y*	*Y*
London Borough of Croydon Children's' Social Care	*Y*	*Y*
London Borough of Croydon Housing Services	Y	*N*
Metropolitan Police Service	*Y*	*Y*
Primary School	*Y*	*Y*
South London and Maudsley NHS Foundation Trust	*Y*	*Y*
Victim Support	*Y*	*N*

3.1.1 Louise first met David when she was in her early 20s. They were married in September 2011 and living in the London Borough of Bromley. There were no known safeguarding concerns recorded by agencies before this time.

3.1.2 At the outset of the period under review Louise was registered with a GP practice in Bromley. She was seen by the practice for ante-natal care for her pregnancy with Child A.

3.1.3 Early in 2012 the GP referred Louise to hospital urgently with reduced fetal movements indicating a problem with her pregnancy. Child A was born by emergency caesarean. After the birth of Child A the practice continued to see Louise and she reported being traumatised by the delivery of her child because the midwife had dropped the baby on delivery. Louise was referred to the counsellor at the practice but did not take up the appointments.

3.1.4 Louise then received ante-natal care from the practice during her pregnancy with her second child. During this period the GP wrote a letter supporting the family being rehoused in Beckenham.

3.1.5 Child A was seen at all appropriate times by the Health Visitor (HV) and had completed routine vaccinations.

3.1.6 In late October 2012 the MPS Bromley JIGSAW team (dealing with violent and sexual offenders) conducted a visit to the home of David's father. The visit established that a close member of the family, living in the household, was a Registered Sex Offender (RSO). David, Louise and Child A had been living in that household for three weeks. The RSO had failed to notify police that they were in the same house as a child and was arrested. The police submitted a MERLIN report to Children's Social Care the following day.

3.1.7 In late November 2012 Social Services contacted the HV to inform them that the family had moved to live with the paternal grandfather. It was known that there was a Schedule 1 Offender on the Sex Offenders' Register living in the household. The HV informed the GP and visited the household. The HV checked that Multi-Agency Public Protection Arrangements (MAPPA) were involved. MPS JIGSAW records confirmed this.

3.1.8 In January 2013 the HV informed the GP that they were liaising with Social Services on a "Working Together Agreement". There were no other agency notes recorded regarding MAPPA.

3.1.9 David was seen by his GP for minor medical issues during 2013.

3.1.10 In mid-October 2013 Louise saw her GP reporting low mood and poor sleep. She was living in temporary accommodation with David and Child A. Louise was assessed by her GP to have moderate depression. She was signed off work and prescribed antidepressants. Louise was over six months pregnant, and her GP noted that she was "depressed and tearful, irritable with her child" and that her marriage was falling apart. It was also recorded that she had housing problems and was finding work stressful.

3.1.11 The GP referred Louise for counselling with Bromley Healthcare Improving Access to Psychological Therapies (IAPT) services. The referral indicated that Louise could be suffering from Post Traumatic Stress Disorder (PTSD) concerning a traumatic birth in 2012. This service was an "opt in' service and Louise did not take up the offer. In a follow up appointment at the end of October 2013, the GP noted that she had improved a little. Louise was seeing a Specialist Midwife and was going to her housing association. Louise did not take up the counselling.

3.1.12 In December 2013 Louise's midwife made a further referral to IAPT. A further letter was sent to Louise but she did not contact the service. This was followed up with calls to Louise but no contact was made.

3.1.13 In January 2014 Louise informed the GP that she was now living in the London Borough of Croydon. She said that David was away in Birmingham and that she was staying with her in-laws and would be registering with a new GP soon. Louise registered with her new GP at the end of January 2014.

3.1.14 Early in 2014, Louise gave birth to her and David's second child (Child B). Louise later reported to her new GP that the delivery of Child B had been a much better experience for her and she was bonding with her baby better than she had before.

3.1.15 In February 2014 Louise attended Kings College Hospital (KCH) having been involved in an "altercation" where she was punched to the head and nose multiple times, thrown to the floor, received bruising and scratching to her lower back, and her nose was visibly deformed. There was insufficient detail in the medical records to show how these injuries were caused and there is no record of this being reported to the police.

3.1.16 Twelve days after she attended KCH, Louise was seen for a routine post-natal check. Louise reported that her low mood was worsening and affecting her relationship with David. The GP noted that Louise had been taking antidepressants towards the end of her pregnancy. The GP noted that Louise's Post-Natal Depression score was significant and prescribed a new antidepressant.

3.1.17 In March 2013 IAPT contacted Louise's midwife. The midwife confirmed that Louise had given birth and had moved out of Bromley Borough.

3.1.18 On 25 April 2014 Louise was seen by her HV. This was a "removal visit" where a family with children under five years move across healthcare boundaries. The HV noted that Louise had high levels of anxiety and concerns on the birth and Child A being dropped. She said the relationship with the children's father, David, had ended. At this point it was assessed that they should receive the "Universal" service.

3.1.19 Throughout 2014 there were many visits by the HVs focussing on the children's health.

3.1.20 Louise was seen throughout 2014 by her GP for the treatment of potential post-natal depression. In June 2014 Louise self-presented to her GP because of abnormal weight loss, resulting in her being underweight.

3.1.21 In January 2015 Louise saw her GP with Child B. Child B was reported to have fallen against a wardrobe and hit their head. The GP enquired about the family and was told by Louise that she was separated from her husband, David. Louise and Child B were seen later the same month by the HV. There were no health or social issues reported to the HV and no safeguarding concerns noted.

3.1.22 Throughout 2015 the children were seen by the GP for minor and routine medical complaints.

3.1.23 In August 2015 Louise saw her GP reporting that she had mood swings affecting her relationship with David. She felt her antidepressants were not helping. She was working full time, with two small children and a husband who worked away from home.

3.1.24 In October 2015 Louise attended the GP due to ongoing problems with her mood. She said that she had been feeling low in mood for over the past two to three months. She could cope with the children. She had no thoughts of self-harm or suicide. Louise revealed a childhood trauma to the GP. She had previously had counselling and did not think this would help. The GP prescribed antidepressants.

3.1.25 In November 2015, during a routine appointment, Louise told the GP that David had recently lost his job.

3.1.26 In December 2015 David went to hospital with joint pain, it was considered that he could have mild arthritis.

3.1.27 At the start of 2016 Louise was seen at Croydon University Hospital (CUH) for routine medical appointments. During the same period David started routine appointments in Bromley with Rheumatology services.

3.1.28 In March 2016 Louise saw her GP as she was feeling “tired all the time”. She denied having a low mood, any anxiety or stress. It was noted that she was on antidepressants and her mood was stable.

3.1.29 Between May and August 2016 Louise was seen by her GP, as she was grieving for the loss of her grandmother. In the middle of this period it was noted that there was a request to increase medication to reduce anxiety. Louise also reported that David had lost his job due to rheumatoid arthritis.

3.1.30 On 16 November 2016 Louise visited her GP. The GP recorded that Louise had been on an antidepressant for 13 months. Louise informed her GP that she had been having delusional thoughts for at least a year. Louise told the GP that she was living in a fantasy world in her head. She was worried that this was affecting her relationship with David, but he was ‘supportive’. She was assessed to have no suicidal thoughts. Louise talked openly and there was no evidence of psychosis. Louise was not keen to change her antidepressants. Options were discussed with her and she was referred to the Community Mental Health Team (CMHT) for further assessment and given a crisis patient information leaflet.

3.1.31 On 21 November 2016 Louise was seen by her GP. It was noted that the referral letter to CMHT was on the practice system. The GP issued a sick certificate until 14 December 2016.

3.1.32 Medical records show that David was certificated as not fit for work from 22 November 2016 through to the 11 May 2017.

3.1.33 On 24 November 2016 South London and Maudsley NHS Trust (SLaM) received the CMHT referral from the GP by post. There was a plan to have a “routine assessment with doctor”. This assessment did not take place, as Louise presented to the ED before it could be scheduled.

3.1.34 On 13 December 2016 Louise attended CUH Emergency Department (ED) with David. According to the medical records, Louise presented with ‘suicidal ideation’ and the notes record that she was planning to take an overdose and had been feeling suicidal for months. The notes record that Louise was assessed in the company of David and there is no record of him being asked to leave the examination. Louise was assessed as being at risk of self-harm. The assessment highlighted no issues of domestic abuse or adult safeguarding concerns.

3.1.35 Louise was seen in the ED by the SLaM Psychiatric Liaison Service. She was referred to the Acute Referral Centre (ARC) for triage and then to the Home Treatment Team (HTT). Louise was discharged home from the ED with a safety plan and was not admitted to hospital.

3.1.36 There was no record of the dynamic between Louise or David and whilst a decision was made to make a MASH referral in respect of the children, the medical records did not record whether any safeguarding adults or domestic abuse concerns were identified. As the Doctor did not know who to send a MASH referral to, they asked the nurse in charge to submit it for them.

3.1.37 On 14 December 2016, as a result of the Hospital visit, the SLaM HTT contacted Louise and started to visit her at home. On many occasions David was also present throughout the consultations.

3.1.38 On 19 December 2016, HTT visited Louise and David and HTT ascertained that David was accusing Louise of having an affair with a man online. Both David and Louise were tearful at the start of the visit and then David left the house with Child B, citing he “cannot deal with this”, however he subsequently returned during the HTT visit. On his return David stated that he felt Louise “needs to be away where she can get proper treatment as HTT input is not sufficient in current circumstances, which are affecting the whole family, including the children”. HTT staff also noted that Louise had recently lost her grandmother and had not had time to grieve.

3.1.39 On 19 December 2016 the HTT received an agitated and confrontational call from David stating that Louise’s problems have gone “way beyond pills” and that he wanted her “put in” and to get her “set on the straight and narrow” because without supervision by HTT she will continue to access dating services and may even meet people from whom she will “be at risk”.

3.1.40 On 20 December 2016 both Louise and David were seen again by the HTT. They were seen together and Louise was assessed as being low in mood with ‘with fleeting

suicidal ideation'. It was noted that David was preoccupied on whether Louise was having intimate relations with another man and that David had taken away Louise's mobile phone from her. There is no evidence that any member of staff attempted to speak to Louise alone.

3.1.41 On 20 December 2016 the HTT weekly review meeting was held and discussed Louise's presentation the preceding week. They discussed the need to explore Louise's use of dating websites to ensure her safety, but the records of the meeting do not rationalise the reason. There is mention of Louise "not interacting well with her child" and a decision that a MASH referral would be completed regarding potential risk to the children. Louise's medication was increased. Louise's presentation was not seen as a response to stress or domestic abuse.

3.1.42 On 21 December 2016, HTT attended the home address but neither Louise nor David were present. David was contacted who stated that he and Louise were on a shopping trip and his phone number was their main contact number.

3.1.43 On 22 December 2016 the HTT visit documented that according to David, Louise had left to stay with her mother in Camberwell. David claimed that he had been finding it difficult to "process" the information relating to the cyber affair and that it was "difficult" for him to be with her.

3.1.44 On 23 December 2016 HTT telephoned Louise's mother who informed HTT that Louise had returned to David having had a "heart to heart" chat in order to spend the holiday period together as a family. This was verified by Louise by calling her on David's mobile phone.

3.1.45 On 26 December 2016, Louise's mother states that Louise separated from David.

3.1.46 On 29 December 2016 the HTT Clinical Review Meeting decided not to pursue the initiation of the MASH referral due to their perception that the relationship/contact between Louise and David had improved.

3.1.47 Later, on 29 December 2016, HTT received a telephone call from Louise to say that she had left home (with the children) as David had "threatened to take the children away and had thrashed the place." She informed HTT that she was going to be staying with her mother, but she was unsure if she would return to her Croydon address. After speaking to Louise, the decision not to pursue the MASH referral was reversed which stated, "although prior to this event, there were no risks associated with her children." The case was transferred to Lambeth HTT who ascertained that Louise had returned to Croydon, so the case reverted back to Croydon HTT.

3.1.48 On 30 December 2016, Croydon HTT visited Louise where she said she felt "great relief" to be separated from David. Louise informed HTT that David had "changed his mind about taking the children away" and that Louise and David had come to a mutual understanding regarding childcare arrangements. HTT discussed the MASH referral

with Louise but she said she did “not need the support as feels supported by her family.” Louise explained that she planned to go to her mother’s to spend New Year’s Eve and David was to care for the children.

3.1.49 On 1 January 2017 Louise called the police regarding the incident on 29 December. She reported that after the separation, David returned to the home of Louise where he assaulted her, smashed a door and a wardrobe, took her sim card from her phone, hacked into her computer and smashed her phone. They commenced an investigation for criminal damage and assault.

3.1.50 On 2 January 2017, David was arrested by the police for the assault and damage. Following an interview of David, the supervisor of the investigation decided that no further action would be taken in respect of David. Besides the complaint statement from Louise and the interview of David there were no other enquiries completed. The Investigating Officer (IO) advised Louise that a referral would be made to the Croydon Family Justice Centre (FJC). The IO stated that a referral to the Multi Agency Risk Assessment Conference (MARAC) had been considered but the case did not meet the criteria for referral, and the closing risk assessment was recorded as Standard. The FJC have no record of a referral being received regarding Louise.

3.1.51 On 3 January 2017, Louise was spoken to on the phone by HTT and she stated she was now back from her mothers and living at her own Croydon address.

3.1.52 On 5 January 2017 HTT held a weekly Clinical Review Meeting (CRM). Louise was assessed at that meeting, and they considered that her mental state was “reasonably okay” and her distress was “proportionate to her social circumstances”. The records also stated that she was of “low risk to self and others” and that Louise was “compliant with medication”, and that “children *[were]* unlikely to have been exposed to domestic abuse”. It was noted that Louise was living with her mother. HTT were visiting on alternate days but the records of the meeting stated she was being visited daily. The conclusion of the CRM was that Louise no longer warranted HTT input.

3.1.53 On 6 January 2017, Children’s Social Care (CSC) received a MERLIN referral from the police in respect of the incidents reported to the police on 1st January 2017 by Louise. The MERLIN detailed a number of incidents that ranged from David preventing Louise from having a relationship with her mother and friends, to David accusing Louise of having affairs. As a result of this, the report detailed that Louise had become depressed, was prescribed anti-depressants, and was under the care of the HTT. It stated Louise had joined a dating website and received messages from two different men and that this had caused arguments when David found out. David had punched a hole in the bedroom door and broke a wardrobe door. Louise further reported that David had pushed her onto a bed, spat in her face, pinned her against a wall and pushed her. The children had also witnessed an incident where David had punched

Louise's mobile phone screen until it smashed. The report also detailed that Louise stated that David was a 'good father and was not violent toward the children'.

3.1.54 On 6 January 2017, HTT conducted a home visit with Louise who stated that David was finding it difficult that their relationship had ended, and that David had access to Louise's email and social media accounts. A MASH referral was completed and sent the same day.

3.1.55 On 11 January 2017 David visited his GP. He reported that he was going through a divorce and his wife had left him. David stated he was tense and anxious and wanted more access to his children. He was prescribed antidepressants.

3.1.56 On 15 January 2017 a further HTT visit documented David to be present in the home with the children, and that Louise was crying. The HTT staff member documented that they were concerned for their own safety but made no mention of risks towards Louise or the children. The records of that meeting show that the children "opted" to live with David.

3.1.57 On 18 January 2017 HTT visited Louise. Louise was in a "brighter mood" and Child B appeared "well cared for". Louise mentioned that David was trying to use the children to "confront her" but Louise stated she was "confident" that she could deal with child issues with David.

3.1.58 On 19 January 2017 HTT held a further Clinical Review Meeting (CRM). The records showed that a discussion took place in respect of the children "opting" to live with David, but there was no documentation as to the decisions made in respect of this or whether discussions or concerns raised on the 15 January 2017 HTT visit were discussed at the CRM.

3.1.59 On 20 January 2017 the HTT team received an email from the MASH stating that the HTT MASH referral "does not meet threshold for children social care" and a "letter was sent to mum directing her to support from family justice centre."

3.1.60 On 23 January 2017 following this decision by the duty senior supervisor within CSC, a social worker within the MASH sent a letter to Louise providing details of the FJC and safeguarding her children.

3.1.61 On 23 January 2017 HTT conducted a visit with Louise. The children were with David and Louise stated that David wanted full custody of the children, but she was hopeful that a shared agreement would occur. Louise stated she was struggling financially and was looking for employment.

3.1.62 On 26 January 2017 there was a further HTT Clinical Review Meeting and a decision was made to delay the discharge of Louise until 1 February 2017.

3.1.63 On 1 February 2017 HTT held a discharge meeting for Louise. Louise was present together with the Assessment and Liaison Team. Louise stated she now had a job as

a receptionist. The records of the meeting do not state whether issues surrounding Louise experiencing domestic abuse, the impact on the children, and Louise having been signposted to the FJC were explored.

3.1.64 On 6 February 2017 Louise presented to her GP with a minor head injury. The records state this was after an assault by a stranger in a pub and the police were notified of the incident. On examination the GP noted tenderness and a bruise over her left eye socket area as well as a misaligned nose. GP requested an x-ray and prescribed pain relief. A self-help advice leaflet for head injury was provided and she was advised to return if symptoms persist or deteriorate. Later the same day, Louise attended the x-ray department. There is no record of this assault having been reported to the police.

3.1.65 On 7 February 2017 London Borough of Croydon Housing Department received an online application in the name of Louise to be placed on the housing register. The application indicated that Louise was living in a privately rented address. There was no information on her medical history. It indicated that her employment status was 'looking for work'. Details of children were not recorded. There was no section on the application prompting information on domestic abuse or signposting services.

3.1.66 On 8 February 2017 SLaM HTT sent an electronic patient record to Louise's GP noting "marital issues" and a brief mention of police involvement due to domestic abuse and in relation to MASH referrals.

3.1.67 On 11 February 2017 David contacted the police to report he had been followed home by a number of different vehicles and he believed Louise's new partner's friends were harassing him. The police conducted enquiries and found David's behaviour to be erratic after they found him hiding on the roof of a public house. The staff of the pub believed he was under the influence of drugs. David explained that one car had beeped its horn and that others had flashed their lights at him as they approached. David could not provide any details of Louise's new partner or how these "friends" could have identified David, so he was taken home by the police and the matter was closed with no further action taken.

3.1.68 On 16 March 2017 Louise was contacted by the HTT to try and arrange an appointment to see her. They had tried previously on 21 February and 14 March 2017 but had received no reply. Louise stated her phone had been broken. She informed she was having "a few problems with David but was doing ok". She also stated she was starting a new job that day and that she was collecting her medication from the GP. Records show that a check was made by HTT with the GP and Louise had missed two appointments and had not collected her medication.

3.1.69 On 29 March 2017 HTT telephoned Louise. She was "feeling well and busy at work". She was working at a Letting Agency and she had arranged childcare whilst she was working. Louise reported that David was being more supportive and that she did not

feel she needed further HTT involvement as “things in her life had improved significantly”. She stated she was maintaining her medication.

3.1.70 In April 2017 GP Medical Records show that David was stated to have met the criteria for Employment Support Allowance.

3.1.71 Papers found after Louise’s death indicate that she drafted an application for divorce on 2 May 2017. The papers indicate that the application was being made as the marriage had irretrievably broken down. Louise’s supporting case briefly stated, “The respondent was controlling and jealous, and I can no longer live with this behaviour and was not allowed to do anything which had a major effect on my mental health”. There is no evidence that any formal application for divorce was made to a court.

3.1.72 On 10 May 2017 David attended GP for a routine appointment. He said that he had a new partner, a new job, and that his children were back with him. He described himself as a ‘Happy Man”.

3.1.73 On 23 June 2017 Louise was seen by the practice nurse. Louise reported to the nurse that she was not sleeping, she had a loss of appetite, and that her mood was fluctuating. She stated that she had good support with childcare and no paid employment. She reported a lack of sexual desire but also informed the nurse that she has been separated from her partner for some time. Depression screening conducted. Louise also mentioned that she stopped taking the mirtazapine in March 2017 because she ran out of tablets and had felt better.

3.1.74 On 1 July 2017, Sussex Police asked the MPS to conduct a welfare check at the home of Louise as David faked injuries to himself. David apparently stated that he and Louise had gone out drinking that evening in Croydon, then Louise went to another pub after David and Louise argued. David called Louise and also called many other people but he could not get a hold of Louise. David was on good terms with Louise’s brother-in-law and asked him to get a hold of Louise. David then got a knife (showing it on facetime), pretended to stab himself, and let the knife drop. Louise’s brother-in-law saw David collapse and saw a red substance on the floor which he thought was blood. On police arrival, David was safe and well and asleep on the sofa. The children were in bed. Louise was not present, and a knife was on the floor next to the sofa, together with tomato ketchup on the floor. The police issued David with a harassment warning but did not complete any welfare checks in trying to locate Louise to ascertain she was safe and well. It is not known whether Louise did actually go out with David that evening or whether he was just looking after the children.

3.1.75 On 2 July 2017 a MERLIN record was sent by the MPS to Children’s Social Care (CSC) by secure email.

3.1.76 On 10 July 2017 the MERLIN report sent by the police was received by CSC. The CSC Supervisor produced a comprehensive action plan.

3.1.77 Between 11 July 2017 and 17 July 2017 CSC made attempts to call both Louise and David. Louise's phone would go to voicemail and David eventually answered his on 17 July 2017, but he was angry that the social worker had called him on his mobile phone.

3.1.78 On 17 July 2017 Louise had a consultation with her GP. She informed the GP she felt slightly better on mirtazapine, but that she was still not sleeping well despite taking mirtazapine at night. She stated she had no suicidal thoughts, and her mood was a bit lifted. Louise was advised to finish her current course of medication and then the dosage would be increased. The GP issued a prescription and informed Louise that she needed a follow-up appointment in 4 weeks' time or sooner if required. She was given Crisis information.

3.1.79 On 22 July 2017 Louise called police to report that she had just been assaulted by David's mother. Louise said that the incident happened at a child's birthday party that she had just left. It was arranged for Officers to see her the following day to take further details. At around the same time a separate report was made on behalf of David's mother, stating that she had been assaulted by Louise. A MERLIN report was submitted as children had been present at the incident. Neither report was recorded as a 'Domestic Incident'.

3.1.80 On 23 July 2017 Louise attended the ED at CUH following the report of assault by David's mother. Safeguarding questions were completed on the hospital records. It recorded that there was no domestic abuse, no substance misuse, no mental health concerns, and no concerns on safeguarding for adults or children. The assault was not recorded as domestic abuse on hospital records.

3.1.81 On 24 July 2017 the CSC Manager reviewed the "knife" incident received by CSC on 10 July 2017 and stated the assessment should continue and that a contingency plan could be discussed if David and Louise declined the assessment.

3.1.82 On 24 July 2017 Louise had a consultation with her GP informing the GP that she had been assaulted during the weekend by David's mother and that she had attended the ED with a suspected head injury. Louise advised the GP that she was separated from David and that the police were involved after the incident and that they were returning to obtain a detailed statement from her. On examination by the GP, Louise reported headaches only. Louise was given a self-help advice leaflet for head injury. The GP advised her to return if symptoms persist or deteriorates.

3.1.83 On 25 July 2017, CSC received the Police MERLIN in relation to the assault on Louise by David's mother on 23 July 2017. The Police MERLIN described the incident and also stated that Louise suffered with bipolar and had been sectioned under the Mental Health Act in the past. This information concerning Louise being 'bipolar' was provided by David's family.

3.1.84 On 31 July 2017, a CSC social worker spoke with Louise and informed her that the police wanted to speak with her about the recent incident involving David's mother.

3.1.85 On 31 July 2017, Louise's GP telephoned her and informed her that they had received a letter from CSC and to remind her that her Child B's immunisation was due. Louise informed the GP that she believed CSC's involvement was instigated by David and not as a result of the assault by David's mother.

3.1.86 An investigation was completed into the cross-allegations of assault at the party, but due to David's mother and other alleged witnesses not co-operating with the police, the case was closed with no further action against either person.

3.1.87 On 31 July 2017 Louise applied for, and was granted, a non-molestation order against David's mother, with a condition that she was not to contact Louise or go to her home. The order was issued at Croydon Family Court and a copy was sent to the police and recorded on intelligence systems.

3.1.88 On 1 August 2017 David requested a letter from his GP for the housing unit, as he was without a home and needed housing. Bromley Housing wrote back to the GP on 11 August 2017.

3.1.89 On 17 August 2017, CSC commenced a Child and Family assessment as a result of the 10 July 2017 referral. Louise and the children partook, but David did not wish to. The social worker concluded that there were "no significant concerns to warrant ongoing safeguarding actions by CSC. Louise was perceived to be a protective factor for her children due to her level of involvement in addressing the presenting concerns and working in partnership with the professional network. Louise knows where to access further support. David is no longer living in the family home. Manager agrees to no further action".

3.1.90 On 22 August 2017 Louise was reviewed by the Practice Nurse and Louise was advised to continue with her medication.

3.1.91 On 20 September 2017 David offered to volunteer at Child A's school. David helped on a number of occasions working in the classroom and he expressed an interest to become a Teaching Assistant. David started to help all day but he was asked to leave the school at lunchtime so that he did not have to be accompanied throughout this period. David was happy to oblige. A Disclosure and Barring Service (DBS) check was applied for and David was not allowed to be left unsupervised with children whilst this was outstanding.

3.1.92 On 21 September 2017 David attended the ED of Princess Royal University Hospital (PRUH) in Orpington. David stated he was depressed, drinking a lot, and taking pain killers along with cocaine and cannabis. He stated that he felt out of control and could be dead within the next week. He was referred to the Psychiatric Liaison Nurse. When the nurse arrived at the ED it was discovered that David had left the hospital.

3.1.93 A Staff Nurse at the PRUH asked the Metropolitan Police to conduct a welfare check on David as he had left the hospital following a mental health assessment and was not answering his phone. The police decision was that it did not meet their criteria to attend as there was insufficient information to suggest that David was at risk of harm and that he appeared to have left hospital of his own volition.

3.1.94 On 22 September 2017 David's GP received a discharge summary concerning his attendance at PRUH the previous day. The same day David visited his GP. David told the GP that he had had a rough nine months after separating from his wife. He sees his children once a week. He stated that he had gone 'cold turkey' and had not used drugs or alcohol for seven days. He said he did not use alcohol and drugs in presence of his children. David told his GP that he had attended Change Grow Live substance misuse services. Enquiries with Change Grow Live have established that they had no record of any of the parties subject to this review being clients of the service.

3.1.95 On 2 October 2017 Louise was reviewed by her GP when she visited for a repeat prescription of mirtazapine. Louise reported that she felt well, was sleeping, eating better, and that her mood was stable. She had no thoughts of deliberate self-harm. She had returned to work and she was coping well with the children. Her GP provided her with details of IAPTs talking therapies for self-referral or online modules.

3.1.96 On 17 October 2017 the DBS result was obtained by the school of Child A in respect of David.

3.1.97 On 4 November 2017 David was arrested after he provided a positive breath test whilst driving.

3.1.98 On 20 November 2017 David was found guilty of driving whilst under the influence. He was fined and disqualified from driving for 12 months.

3.1.99 On 6 December 2017 David collected Child A from school without informing Louise he was going to do so. Louise had booked Child A into an "After School Club".

3.1.100 On 5 January 2018, Louise had a consultation with the GP Practice Nurse. Louise reported 10 days of cold symptoms. Louise also advised the nurse that her mood had dropped markedly 2 days before Christmas having felt very well before but handing in notice at work and spending lots of money before Christmas. She reported that she was not sleeping but she was still taking her medication daily and not missing any doses. The nurse strongly encouraged Louise to contact IAPT.

3.1.101 On or around 1 April 2018 Child A's school noted that David was not proving to be reliable in classroom support. David informed the school he had a job as a Teaching Assistant at another school.

3.1.102 On 4 May 2018 Child A attended the Urgent Care Centre at the PRUH with a minor head injury after he had flipped over the arm of a sofa. He was discharged with advice.

It has not been possible to establish who took Child A to the hospital. This was the last recorded agency contact before Louise's murder later in the month.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

4.1.1 The Chair and Co-Chair were able to interview Louise's mother, sister and friend. They provided a valuable insight into Louise's experience. The accounts have been combined to reflect the chronology of the relationship between Louise and David. In certain areas direct quotes have been used to reflect the feelings of the family.

4.1.2 Louise was raised in South London. She grew up with her mother, step-father and sister (from mother's relationship with step-father)[2]. She left college aged 17 to work in a jewellers. Louise spent some time with boyfriends and started to socialise in the London Borough of Bromley. She left home and rented a room in Bromley around the age of 20.

4.1.3 Louise met David, in her early 20s, when she was in a pub with her sister in Bromley. Her sister recalls Louise and David getting on really well together, but the relationship seemed to progress really quickly. After about three to six months Louise and David moved into a flat together in the same area. David was working for a bank and Louise was working in a high street jeweller's chain. Louise worked to gain qualifications in her profession. Louise's mother recalled seeing David with lots of money and that he showed off with it. This did not appear to fit in with his regular job at a bank.

4.1.4 Louise then got engaged to David. Her mother had doubts about the relationship. Louise then told her mother that she was pregnant. Louise had previously been very career focussed, she had not appeared child oriented and enjoyed her holidays.

4.1.5 Louise's mother saw David as very possessive and trying to control her daughter. Prior to their marriage, David would phone Louise when she was at her mum's and accuse her of being with another man. After they were married this behaviour escalated and became worse. Louise's mother said, 'Once he got that ring on her finger, I felt, he thought he did actually own her.' Louise became noticeably quiet and did not see her family as often.

4.1.6 After their first child was born in 2012 David became the 'doting Dad'. Adult U said that after Louise brought her baby home, he would not let Louise do anything for the child. He would criticise the way that Louise fed the baby, 'he took over and would not let Louise be a mum'. Her mother noticed that her daughter started not to care for her appearance. Her sister noticed a change in Louise after the birth of her first child as well, but she first thought this was due to post-natal depression. She then noticed that

[2] Throughout this report Louise's half-sister will be referred to as her 'sister'.

there were things that Louise couldn't do anymore, such as seeing their mother. Her sister continued to see her every two to three weeks.

4.1.7 It was believed that they would sometimes struggle with finances and were in debt. Before Louise had her second child they lived for a short time with David's mother. They went to the housing department and got temporary accommodation. The council then evicted them, because they could afford a private rent. They then moved to a private rented house in Croydon. Louise was pregnant with her second child at that time.

4.1.8 Shortly before Louise gave birth to her second child she called her mother to her home, packed up and moved in with her mother. Louise said she had enough of the way that David spoke to her and treated her. After staying at her mother's for one night, David phoned Louise and she went back to him.

4.1.9 Louise's mother said that David caused fights between her and her daughter. He made her feel uncomfortable and unwelcome when she was with the couple. Although she did not see Louise that often, Louise's sister maintained contact. Louise was not open with her sister whilst she was with David and did not discuss problems at that time.

4.1.10 After the birth of their second child it was seen that things got worse for Louise. She could not do anything right in David's eyes, 'even down to cleaning the house'.

4.1.11 Louise's mother said that, on a date that she could not remember, Louise and David had a big fight. Louise had gone onto a website that David did not agree with and he belittled her. Louise's mother went to their house. On arrival she was told by David that he had phoned a hospital and he was going to have her committed. She asked Louise if she wanted to come home with her, Louise was curled up on the sofa and said 'No, I just want him gone'. Her sister was also called to the house and David told her that she needed to sort her sister (Louise) out. Louise did go to the hospital and she was prescribed anti-depressants. Louise reported to her family that the hospital told her there was nothing wrong with her; Louise said that she just did not want to be in a relationship with David.

4.1.12 After this her mother was aware that the couple were arguing and parting constantly. David would leave and then come back. The children have since disclosed to Louise's mother that they witnessed domestic abuse.

4.1.13 Louise's mother had not witnessed any incidents but was once caught up in an argument where David initiated a fight between her and Louise, which resulted in Louise hitting her. Following that incident, they did not see each other for some time. In the latter part of 2016 Louise started to tell her sister that she did not want to be with David, she described her as looking 'depressed and just broken'. Louise's sister was with her when she would receive calls from David, screaming down the phone at her

and shouting. He criticised her for not hanging up the washing properly or not washing up.

4.1.14 Louise's sister believed that David was using and selling drugs. Louise did not want this and was concerned as to who would be calling at the family home. She said that David was dealing cocaine and selling little packets from his home. David would get a phone call, grab the drugs, and go and meet someone.

4.1.15 Louise next came to her mother's with David and the children on Christmas Day 2016. They arrived in the morning and did not stay long. The following day Louise left David for good. Louise later told her friend that David had snapped the Christmas tree in half and she just said 'enough'. Louise's mother said David's behaviour 'destroyed everything and her'.

4.1.16 After this, David would not leave Louise alone. He would visit her at home and 'abuse her'. He took her car and told her that he would take the children from her. He would tell the children that he was going to take them with him. He would tell Louise that the children loved him more than her. David would 'hound' Louise constantly, phoning her and yelling at her and calling her an unfit mother. Louise's sister described David as 'constantly being on her (Louise's) case'. She said that David was phoning Louise night and day.

4.1.17 At this time Louise struggled financially. She occasionally cleaned houses and sold skin care products at parties. She was on income support and in debt. She would phone her mother and ask to come and stay if she could not afford food or heating.

4.1.18 During this period Louise developed a friendship with a neighbour, Adult X. Adult X was the mother of a child the same age as Child A and the children went to the same school. Louise disclosed to Adult X that David was violent and that she had money troubles and rent arrears. David would promise to give Louise money, but then did not give it to her. He would also spend money on cocaine binges. Adult X helped Louise with childcare, lending money and sometimes feeding Louise's children.

4.1.19 Louise told her friend that David had been very controlling with her. When she left the house, he would time how long she was away. Louise told Adult X that she would sometimes pour milk away and use it as an excuse to leave the house in order to buy more milk. When Louise was invited to go out with other mothers from the school, she expressed concern that David would 'go ballistic'. Adult X had seen fist imprints in Louise's wardrobe, David told Louise that he was punching that 'rather than her face'. Louise said that David had not hit her, but he had grabbed her by the throat.

4.1.20 Around Christmas 2017 Louise told her friend Adult X that David was having a number of girlfriends and the children would talk about them after they had visited David. Adult X states that David became aware that Louise was talking to her friend and he then started to dislike Adult X.

4.1.21 David had his own flat and Louise would sometimes drop the children there. At one-point David was arrested for drink driving. David made Louise put her car off the road, informing the DVLA that it was not in use, and told her to use his car. He put Louise on his car insurance to use the car but would control her use of his car by taking the keys from her.

4.1.22 Louise had told her mother shortly before her death that David had asked her if he could pay her to have sex with him 'one last time'. She told her sister that David was calling her a 'prostitute'.

4.1.23 After Louise split from David, she started a relationship with a friend that she knew from her childhood. She was considering moving to live with him outside of London.

4.1.24 Leading up to her murder, Louise told her friend Adult X that David had stated he committed a robbery at Christmas and he was going to go to prison for a long time and wanted to see his family one last time. Louise also said that David was constantly phoning her, swearing at her and demanding to see her. She said that Louise was relieved that David would be going to prison and started to make plans to have a holiday with her children.

4.1.25 Around the same time, Adult U explained that Louise had called her asking to babysit the youngest child at the weekend as she was taking her eldest to the theatre. After her mother considered if she could babysit, she called Louise back. Louise then said that there was no need to worry. Louise's mother thought it strange that she had not seen any social media posts from her daughter about the theatre visit. The police arrived at her door at 22:00 hours. As soon as she saw the police Louise's mother said to them, 'He's done it hasn't he.' Because the one thing David always used to say to Louise was "if I can't have you no one can"'.

4.1.26 Louise's mother was asked if her daughter ever considered reporting David. She said that Louise had reported to police when he smashed the panels in her door. She said that Louise and David's relationship was so one sided, he always dominated, and had the last say. 'She was never the free young girl she should have been'.

4.1.27 Louise's mother was asked if anything could have helped Louise at the time. She said, "When she had the break down and went to hospital, if the services had dug deeper, got her on her own and spoke to her. It was her lowest point, she would have cracked and opened up." Louise's sister, independently, expressed similar views that something could have been raised at the hospital, "The hospital knew that Louise was not crazy, just doesn't want to be in a relationship, he is controlling. So could have been raised as a concern. She went with him though so she couldn't have said anything even if she wanted to".

4.1.28 Adult X said that she felt that Louise did not take reports to the police further because she feared losing her children. Adult X was not aware of any other method of reporting domestic abuse apart from calling the police.

4.1.29 When asked to describe her friend Adult X said “She was just a lovely, gentle, caring lady. And it’s sad because she was my friend and I just wanted to help and for her to be happy and I knew that she wasn’t”.

4.1.30 Louise’s sister was asked to describe her, she said ‘She was lovely, we got on great. Our personalities are so different, I’m loud and out there, and she was quite quiet. She got on great with everyone, she had loads of friends and liked to go out, a normal 30-year-old…when they broke up, we saw each other (again). I saw the her from before she met him again.’

4.1.31 When asked to describe her daughter, her mother said she wanted her to be remembered as ‘The person she was, the kind loving girl she was. Even after whatever David said or did to her, she was still the girl we loved. And that’s how we remember her’.

4.1.32 In considering her daughter’s contact with agencies during the period under review Adult U said, “If all women are seen as (Louise) was, then nothing will change”.

4.2 Summary of Information Known to the Agencies and Professionals Involved

4.2.1 **Bromley Children’s Social Care (CSC):** In June 2012 a police referral was received providing information on a household member of the children being convicted of sexual offences towards children in February that year. This required him to register as a sex offender. In October 2012 a routine police visit was made to the uncle’s home and it was discovered that David and Louise were living at the address with Child A. The household member was cautioned, and an initial assessment was undertaken by Bromley CSC in December 2012. It was recorded that Child A’s parents showed insight and took responsibility for ensuring that Child A was protected.

4.2.2 **Bromley CCG:** Information was not initially shared with the panel concerning David’s GP records until the end of March 2020. This after the IMR review meetings. The panel does recognise the sensitivity around disclosure of information on a perpetrator. The submission of this information has been considered in the Overview Report.

4.2.3 David was registered at the same GP Practice as Louise and Child A. He was seen at the practice for a number of medical appointments during the period under review. The most prevalent contacts concerned David’s diagnosis with rheumatoid arthritis. The GP also recorded information concerning David’s mental health.

4.2.4 **Bromley GP Practice:** At the outset of the review period Louise was registered with a GP Practice in Bromley. The practice has over 6,000 persons registered with them.

Louise was registered with the practice from the start of the review period until February 2014. Child A was registered with the practice between shortly after birth at the start of 2012 until February 2014. Child B was not registered with the practice.

4.2.5 The IMR was completed by one of the GP partners. The practice said that they had no independent clinician that could conduct the review with a degree of independence. The chair took the view that the information provided should be considered in the overview report in order to provide a more complete picture of Louise's life throughout the period under review.

4.2.6 Louise was seen by the practice for ante-natal care for her pregnancy with Child A. The practice saw Louise following the traumatic birth of Child A and she was seen for appointments in relation to her mental health. Louise was also seen for routine medical appointments. Louise then received ante-natal care during her pregnancy with her second child before she changed GP practice.

4.2.7 **Bromley Healthcare:** BHC specialises in community health services for adults and children and they worked with the family from 2012 through to 2014 before the family moved to Croydon. BHC also provides Improving Access to Psychological Services (IAPT). BHC had contact with Louise for just over four months from the end of 2013. This contact was as a result of referral from maternity services.

4.2.8 BHC provided HV services to Louise and her children whilst they were living in Bromley. During this time there were eight face to face contacts with Louise; five were home visits and three were at the Child Health Clinic. The Clinic is an NHS community provided resource for parents with children aged five years and under.

4.2.9 During the period under review BHC recorded cross agency communication, in relation to Louise, with the GP, Paediatric Liaison at the local acute NHS Trust, and Social Services.

4.2.10 **Croydon CCG:** The CCG provided an IMR for the GP practice where Louise and her two children were registered from the start of 2014 until her death in May 2018. Louise and her two children were also known to the GP Out of Hour service.

4.2.11 The IMR covered Louise's treatment for low mood and depression. A significant incident was recorded in November 2016 when Louise was seen by her GP reporting delusional thoughts and worries that it was affecting her relationship.

4.2.12 **Croydon Health Services NHS Trust:** CHS provided an IMR covering Louise's attendances at a number of CHS Outpatient departments. These included screening services, dermatology and ultrasound. Louise was also seen at the Emergency Department of Croydon University Hospital. Child A and Child B received services from Heath Visiting and School Nursing. This followed the family's move from Bromley to Croydon in 2014.

4.2.13 The IMR author critically analysed all records of contact with the family. The author identified areas for improving assessment of safeguarding issues and referral processes.

4.2.14 **Kings College Hospital NHS Foundation Trust:** The Trust provides a range of services across South and South East London. The only recorded contact with persons subject of this review was when Louise attended the Emergency Department at Kings College Hospital. The attendance was because Louise had been victim of assault and she left the department before she could be fully assessed or examined. There was no evidence that the GP was informed of this attendance.

4.2.15 **London Borough of Croydon Children's Social Care:** The department were first notified of concerns in January 2017 and had not been known by the department before this date. Notification came from the MPS. Later notifications from police came in July 2017. The record suggests that there was a belief that Louise was engaging with the FJC (Local Domestic Abuse Specialists). The review has shown that was not the case. A Children and Families assessment was conducted.

4.2.16 After the death of Louise, her children became subject of care orders. The London Borough of Croydon are now the corporate parents for Child A and B.

4.2.17 **London Borough of Croydon Housing Services:** Housing services provide advice on council and private housing in Croydon. They manage council housing and property repairs. They had one recorded contact with Louise, when an online application for housing was made in 2017.

4.2.18 **Metropolitan Police Service:** Louise and David have always lived within the Metropolitan Police District area. Police contact with the family started in 2012 when they were living in the London Borough of Bromley. Contact was with the Borough JIGSAW Team when David, Louise and Child A were in the same household as a Registered Sex Offender. Police notified local Children's Social Care. There was no further contact with the family until January 2017, this involved Croydon Borough Police. Police contact involved the investigation of reported domestic abuse. Croydon Police also investigated a reported assault against Louise by her mother-in law. There were further contacts between David and Bromley Police in 2017, this included his arrest for drink driving.

4.2.19 The MPS also conducted the investigation into the homicide of Louise. The case officer and Family Liaison Officer (FLO) supported the DHR.

4.2.20 **Primary School:** Child A attended the Primary School in the London Borough of Croydon joining the school in September 2016. Whilst the school had contact with both parents, David had also helped the school with classroom support in lessons. Child A has remained in the school since and was later joined at the school by their sibling Child B.

4.2.21 The primary school were fully supportive to the review, providing an IMR and attending meetings. However due to concerns on the confidentiality of the children the school will not be named.

4.2.22 **South London and Maudsley NHS Foundation Trust:** SLaM provided Mental Health care services for Louise whilst she was resident in Croydon. The first occasion followed the birth of her second child in 2014 with a referral to the Perinatal service. The second period started in November 2016 when Louise was referred by her GP due to suspected bipolar affective disorder. Louise was then seen by SLaM staff when she presented with David in December 2016 at the Emergency Department of her local hospital, where SLaM supplied psychiatric liaison services. The last contact with Louise was recorded in March 2017.

4.2.23 **Victim Support:** Victim Support were the commissioned service to provide support for victims of crime to the London Boroughs of Bromley and Croydon during the period under review. The only recorded contact between Victim Support and Louise was in January 2017 following the referral from the MPS for the Domestic Assault that took place on 27 December 2016. There are no other records of contact with Louise or David.

4.3 Any other Relevant Facts or Information:

4.3.1 **County Court and divorce proceedings:** The review established that at one point Louise had completed the paperwork for an initial application to commence divorce proceedings. The police panel member was able to provide a copy to the chair and Louise's mother had also seen a copy of the papers. The papers indicate that the application was being made as the marriage had irretrievably broken down. Louise's supporting case briefly stated, "The respondent was controlling and jealous, and I cannot no longer live with this behaviour and was not allowed to do anything which had a major effect on my mental health". The application is dated 2 May 2017.

4.3.2 Standing Together have made enquiries of the local County Court and the central courts office where an initial application would have been made and there are no records in relation to Louise or David.

4.3.3 **Croydon CSP:** There are a number of avenues that victims can take to access support for Domestic Abuse in Croydon. 87% of schools and 83% of GP surgeries have a Domestic Abuse lead who have attended Domestic Abuse and Sexual Violence training, on understanding how to identify signs of Domestic Abuse and understanding the FJC and MARAC referral process. Croydon has three community IDVA's who are based in children centres in the East, North and South of the borough available to see women who visit these centres. The FJC also places IDVA's on a rota to sit in the adult social care team and the children's MASH team to pick up referrals and advise staff.

The FJC itself is a centrally based building which is open for drop ins and appointments. Croydon has also made links with colleges in Croydon to offer IDVA drop-in services for its students. Croydon Council has 40 workplace domestic abuse ambassadors, Domestic Abuse trained to support staff, as well a robust Domestic Abuse HR policy. More recently Croydon has launched a Domestic Abuse 'Safe Space' campaign with 11 large supermarkets in Croydon to support victims during the COVID-19 lockdown. Additionally, community IDVAs now also work with local Anti-Social Behaviour (ASB) teams to directly offer support to victims being approached by the ASB team. They are also setting up drop-in sessions with a number of large, commissioned housing providers who offer single accommodation to vulnerable women as well as supporting staff.

4.3.4 **FJC:** FJC is the locally commissioned Domestic Abuse service in Croydon, providing a skilled and experienced team to provide practical support to persons experiencing domestic abuse. There was no record of Louise being known to the FJC or the National Domestic Abuse Helpline.

4.3.5 **Police:** Checks were conducted on police databases on Louise and David. Louise was not known to the police except in relation to her being a victim of crime. David had previous convictions and cautions for possession of class B drugs, driving a motor vehicle with excess alcohol and theft and fraud.

4.3.6 **Sexual Assault Referral Centres (SARC):** The SARC services for the areas where Louise lived were provided by The Havens. These services are managed by KHC Trust. Given the nature of the information provided to the panel and enquiry was made to see if Louise was known to the service. There was no record of any client using Louise's name.

4.3.7 **Substance Misuse:** It is clear that David had problems with substance misuse and family members of Louise believed he was supplying drugs. Substance Misuse Services were contacted at the outset of the review and it was confirmed that neither party were known to services. The GP records show that David stated he had accessed Bromley Drugs and Alcohol Services - Change Grow Live on 20 September 2017. Further enquiries were made with Change Grow Live and there were no records that David attended the service. After further consultation with the CCG and Change Grow Live it appears that David told his GP that he had used the service, when he had not.

5. Analysis

5.1 Domestic Abuse and Louise

5.1.1 The circumstances of Louise's death and the conviction of David for her murder, clearly show that she was a victim of a Domestic Homicide in line with the definition under the Domestic Violence, Crime and Victims Act 2004.

5.1.2 Evidence of David's coercive and controlling behaviour towards Louise's was clear to this review. This is evident from the disclosures that Louise's family and friends have made as part of this review and from the police murder investigation prior to this review taking place.

5.1.3 Whilst the Panel can look at this case in hindsight in respect of the information obtained from Louise's family it is clear from the information that they provide that David was controlling from an early stage in their relationship and post separation he immediately started to stalk Louise.

5.1.4 It is apparent from interviews with Louise's family and friends that she was subject to economic abuse. It is not apparent that any agency would have been aware of the control David exerted over Louise on financial matters. The panel have not found any information to suggest that agencies were aware of the sometimes dire situation Louise was put in. This included times when Louise had to resort to support from friends and family to feed her children. It appears that David used the loaning of his car to Louise to control her movements. It was established that in the events surrounding Louise's death, David had used her bank card to withdraw cash to pay off his personal debts.

5.1.5 Louise's disclosures to her family show that she was concerned about sexual exploitation by David. Louise said that David had called her a 'prostitute'. David had also offered to pay Louise for sex, after their relationship had ended. Whilst there was no reported sexual violence the panel have been alert to the issue from the outset.

5.1.6 The responsibility for the tragic death of Louise rests solely with David. The following sections outline the reflections of the Review Panel with regard to possible missed opportunities to help and support Louise and her and David's children as well as areas of improvement needed in Bromley and Croydon.

5.2 Analysis of Agency Involvement – Key Issues Arising From the Review

5.2.1 **Bromley GP (Louise and Children)**

5.2.2 An IMR submission was completed by a GP Partner at the practice where Louise and Child A were registered between early 2012 and February 2014. The practice did not

have an independent person available to conduct the IMR. Whilst independence cannot be assured, the IMR was completed by the GP Safeguarding Lead. The panel have considered the information provided as a review of the patient records and will include the learning and the GP's analysis in this section of the report. It should also be noted that this review process has resulted in the GP practice implementing recommendations on the learning.

5.2.3 The start of the period under review began with the traumatic birth of Child A. Louise was initially sent straight to hospital from a GP examination where there were concerns over reduced fetal movements indicating problems with pregnancy. Having undergone an emergency caesarean, Louise's baby was then dropped by the midwife. These events had a significant impact on Louise.

5.2.4 It does appear that the traumatic birth was seen as the cause of Louise's stress. Whilst marital problems were included in the referral for counselling, there was no evidence that the GP asked any direct questions about domestic abuse. The GPs did ask about social situations and assessed the risk of self-harm.

5.2.5 The GP practice was seen as being generally supportive to Louise's needs. They demonstrated effective communication between GP, Specialist Midwife, HV and Pharmacist. The GP also supported Louise's housing concerns by writing to the local housing department. There was no evidence on GP records that the letter was considered by the housing department. The records show good levels of communication with Social Care when there were concerns that Child A was in the same household as a Registered Sex Offender.

5.2.6 **Bromley CCG (GP for David)**

5.2.7 The IMR was completed independently by the CCG and involved interview of the GP who provided the majority of care for David. Most of David's contact with the GP concerned the diagnosis and ongoing treatment for rheumatoid arthritis. In 2016 the GP promptly identified David's low mood and signposted to psychological therapy.

5.2.8 On 11 January 2017 David informed his GP that he was going through a divorce, that he was getting tense and anxious, and that he was concerned about seeing his children. At this stage it was not thought appropriate that any further referrals were made. He was seen four months later, when he was considered to be in a happy mood. He had a new partner and was seeing his children.

5.2.9 On 1 August 2017 there was an opportunity for the GP to make a referral to Adult Social Care, due to David's health and being of No Fixed Abode. The GP did support David with a letter to the housing department and also confirmed that David was staying with friends whilst this was being addressed.

5.2.10 On 21 and 27 September 2017 there were two occasions where the GP missed an opportunity to make a referral to Children's Social Care. This was when David admitted

to taking painkillers, cocaine and cannabis. He was seen at the PRUH Emergency Department and referred to the Psychiatric Liaison Nurse and then discharged himself from hospital. There was a prompt discharge summary sent to the GP by the hospital, and David was seen by the GP shortly after this. The GP did probe David about his drug taking and was informed that he did not take drugs in the presence of his children. There was no referral to Children's Social Care to inform them of long term parental substance abuse. The GP did consider that David was not a risk to himself or others.

5.2.11 It should also be noted that the GP IMR revealed that PRUH referred David to Oxleas NHS Mental Health Trust. Oxleas were asked for details of any contact with David at the outset of the review, and they informed the panel that they had no information on David. The panel established that David had left PRUH before any assessment was completed.

5.2.12 The GP practice did not identify any incidents of domestic abuse within the records of David. The GP Practice has received Identification and Referral to Improve Safety (IRIS) training to support use of an Independent Domestic Violence Advocate (IDVA) when indicated by the patient's presentation to Primary Care. The practice also has organisational policy for managing disclosures of domestic abuse, this is based on the NICE quality standards of 2016.

5.2.13 **Bromley Healthcare (BHC) Universal Health Visiting and School Nurse**

5.2.14 BHC specialises in community health services for adults and children and they worked with the family from 2012 through to 2014 before the family moved to Croydon. During this time there were eight face to face contacts with Louise; five were home visits, and three were at the Child Health Clinic. The Clinic is an NHS community provided resource for parents with children aged five years and under. They are used to discuss any child or parental health issues such as domestic abuse, mental health concerns, housing and financial concerns. These eight face to face contacts were potential opportunities HV's could have used to show professional curiosity in exploring domestic abuse. There is no evidence in the records to show that there was a direct enquiry asking Louise about domestic abuse.

5.2.15 Three visits were completed in the presence of David. It must be recognised that a victim, in a coercive controlling relationship with the perpetrator present, will be highly unlikely to divulge domestic abuse for fear of the consequences that the victim knows will occur after the professional has left unless the victim believes that support from elsewhere is realistic. Enquiries with clients on domestic abuse should be conducted alone, and if a partner insists on being present then this should be seen as a cause for concern. HV training recognises the importance of a mother's safety when asking about domestic abuse. HVs are less likely to ask about domestic abuse when a partner, family member, or friend is present.

5.2.16 **Bromley Healthcare (BHC) IAPT**

5.2.17 BHC IAPT offers a range of free and confidential talking therapies and support for adults over the age of 18, who are registered with a Bromley GP. Ranges of talking therapies are provided for people experiencing problems which include: Low or depressed mood, stress, anxiety, difficulties following traumatic experiences behaviours and, low mood or anxiety in pregnancy or in the first year after giving birth.

5.2.18 Louise was referred to the service, by her GP, in 2013 when she was pregnant with Child B. Her GP referred to Louise as being depressed and tearful, with an irritable Child A. Louise reported that her marriage was falling apart, work was stressful, and she had housing issues. There was no specific reference in the referral concerning domestic abuse.

5.2.19 BHC attempted contact with Louise via mail as she had not requested phone contact. The service wrote to Louise twice, to cover the possibility that one letter had gone missing. BHC then contacted the original referrer and established that Louise had had her baby and moved out of the borough. It should be seen as good practice that this check was made with the referring agency.

5.2.20 It should be considered that this contact was nearly seven years ago. The BHC IAPT service had changed since that time. In the current service referrals received are screened by a Duty Therapist within 24 hours and if suitable patients are moved to the waiting list for initial assessment following the care pathway. The Admin Team will now call the patient twice in one day, and if no response will send the patient an SMS text or email (where permitted) asking them to contact the service, and if not permitted a letter will be sent to the patient asking them to make contact. The current professional referral forms also allow for email addresses (again with consent) and IAPT self-referral forms ask for patients to consent to means of contact. The GP is contacted and notified on the outcome of any contact or whether they have been unable to contact a patient.

5.2.21 All relevant clinical staff now access domestic abuse training in line with mandatory training schedules every three years. There was limited evidence within the notes that staff had reason to believe that Louise was at risk of domestic abuse at the time. Although the referral noted marital problems no further details were given. The second referral does not mention any marital problems and refers to PTSD following a difficult labour. The IMR author stated that BHC policies and procedures have now changed and should a similar referral be received the current procedures would be followed.

5.2.22 **Croydon Clinical Commissioning Group (CCG)**

5.2.23 The Croydon CCG are a membership organisation made up of all GP practices within the London Borough of Croydon. The CCG are responsible for commissioning healthcare services for the residents of Croydon. These include healthcare services members of the public receive at hospitals, in the community and mental health services. The CCG provided an independent IMR on the GP practice where Louise and her children were registered from February 2014 until the date of her death.

5.2.24 The CCG IMR author found no documented evidence of domestic abuse and therefore concluded there were possibly missed opportunities because probing during the consultations may have led to Louise disclosing domestic abuse.

5.2.25 On 18 February 2014 within GP notes there are entries that relate to Louise's low mood becoming worse and affecting the relationship with David. The GP followed guidance for post-natal depression but this could have been an opportunity to discuss whether domestic abuse was present. The low mood could be due to the coercive and controlling behaviour exhibited by David.

5.2.26 On 24 June 2014, Louise self-presented to her GP concerned about weight loss. Louise was concerned about medication being the cause and blood tests were completed. There is no record in the notes as to whether other reasons for weight loss were explored. Weight loss can be a sign of domestic abuse and she continued to lose weight rapidly after the visit which was noted as being abnormal when she returned to the GP on 16 July 2014. Her weight had reduced by a further 3 kg's in 3 weeks. It was noted that she stated she was "still irritable" with David and that her speech was normal but slightly flat. The records do not show whether domestic abuse was explored by the GP having been given this information and was a potential missed opportunity.

5.2.27 On 30 October 2014 during a consultation with the practice nurse, Louise stated that David was supportive in carrying out tasks but he did not understand how or why Louise felt like she did and that she felt unsupported and isolated. It was noted also that Louise's weight had dropped, without any apparent medical cause. Whilst the nurse signposted to MIND the nurse did not discuss domestic abuse. This was a potential missed opportunity. Isolation is a key behaviour perpetrated by the abuser in a coercive controlling relationship.

5.2.28 On 25 August 2015 during a consultation with her GP, Louise reported that she had mood swings which were affecting her relationship with David. The author of the IMR felt this was a further missed opportunity to assess for domestic abuse.

5.2.29 On the 16th November 2016 there was an opportunity for the GP to explore more when Louise reported that she was worried that her delusional thoughts are affecting her relationship with David. Louise informed the GP that she admitted these thoughts to David and that he is supportive. During this consultation her presentation was not unusual for someone who suffers from clinical depression.

5.2.30 On the 24th July 2017 Louise informed the GP that she was assaulted over the weekend by her mother in-law, that she attended the Emergency Department (ED) with a suspected head injury, and that the Police were involved after the incident. She advised the GP that she was separated from David. There was no evidence that the GP considered the fact that Louise was assaulted by David's mother as domestic abuse and this highlight yet another missed opportunity to reference domestic abuse.

5.2.31 Practitioners at the GP practice provided Louise with the contact details for Improving Access to Psychological Therapies (IAPT) to self-refer which is indicative of empowerment, a key principle of adult safeguarding (Care Act, 2014).

5.2.32 **Croydon Health Services NHS Trust**

5.2.33 Croydon Health Services is an integrated National Health Service Trust, which provides care in both acute and community settings. These include Emergency Care, Sexual Health, Inpatient, Outpatient and Community based services. The Croydon University Hospital provides more than 100 specialist services and is home to the borough's only Emergency Department and 24/7 maternity services, including a labour ward, midwifery-led birth centre and the Crocus home birthing team.

5.2.34 On 2 April 2014 Louise attended the Child Health Clinic. The Clinic is an NHS community provided resource for parents with children aged five years and under. They are trained to discussing any child or parental health issues such as domestic abuse, mental health concerns, housing and financial concerns. This would have been an opportunity to discuss any domestic abuse at home but the records do not state whether this occurred.

5.2.35 During a home visit by a HV on 25 April 2014 Louise said that her marriage with David had ended. This would have been an excellent opportunity to ask about separation and ongoing safeguarding concerns following separation which is a high risk time after being in a coercively controlling relationship. From records it does not appear to have been asked. At that point she had high levels of anxiety and a number of areas of stress. Louise was wrongly assessed by the HV for "Universal Needs". Good practice would dictate that Louise should have had an enhanced service under "Universal Plus." The HV should have undertaken follow up home visits, which would help build and establish a relationship with Louise.; and would have allowed the HV to assess and review Louise on more than one occasion and identify her baseline and any deviations from this.

5.2.36 On 11 June 2014, Louise attended the Baby Clinic but the HV focussed on the child's wellbeing rather than the health of Louise who was already experiencing multiple stress factors. Domestic abuse was not explored by the HV as being one of those factors.

5.2.37 Records within Croydon Health Services show that Louise was subject to outpatients appointments. These included Dermatology, Gynaecology, the Breast Clinic and also consisted of two Emergency Department (ED) attendances.

5.2.38 Louise disclosed during the many consultations that she was taking antidepressants for depression, but the records do not demonstrate any further communication between the referrers, GP, or the Outpatient practitioners where external stress factors (such as domestic abuse and coercive control) could be attributed to the unexplained weight

loss and pain. If the “Think Family” approach was implemented then this would have potentially assisted with the required professional curiosity.

5.2.39 On 13 December 2016 David took Louise to Emergency Department to have her “sectioned” (sister reports that she was called by David to the marital home to look after the children because David was going to take Louise to Croydon University Hospital to get her “sectioned” because according to David, Louise was “crazy”).

5.2.40 Louise denied having taken an overdose or self-harming and the Doctor assessed her as looking ‘sad’. As a result of Louise expressing suicidal thoughts, she was considered as a high-risk of self-harm and sent home with David.

5.2.41 There was no consideration that Louise may have been coerced or manipulated. There was no exploration from a domestic abuse point of view as to why she was not sleeping, had significant weight loss and suicidal thoughts. Perpetrators can manipulate victims in order for them to believe that the victims are going ‘Mad’. David took Louise to the hospital, he was present throughout and therefore had Louise wanted to disclose domestic abuse she would have been unable to do so with the perpetrator present. This was a significant missed opportunity and had Louise been able to speak privately then potentially she would have disclosed domestic abuse and this particular aspect of coercive control (taking Louise to the hospital to be “sectioned”) would have become known.

5.2.42 There were no records made of the dynamics between David and Louise and no record of MASH referrals having been made even though the records state they were completed. The Doctor did not know how to make a referral or who to send it to and there is no record as to whether the nurse in charge submitted the referral to Children’s Social Care. Additionally, there were no referrals to the HVs.

5.2.43 Louise attended the Croydon University Hospital x-ray department in February 2017 due to nasal tenderness and suspected misaligned nasal bones. The initial assessment was querying a fracture however, the x-ray found that no bone injury was evident and the lining of the nose was slightly thickened on the right side. It has not been possible to determine who made the referral for this examination, as there is no evidence of the referral in Louise’s health records. There is insufficient information to conclude whether this tenderness was the result of an attack or assault. Although the records say that the tenderness could be the result of a fracture, there is no documented evidence to indicate that a discussion was held between Louise and the referrer, or the radiographer to determine whether she had been assaulted and by whom.

5.2.44 This presentation would have been an apt opportunity to explore whether she was experiencing domestic abuse. Patients always enter imaging rooms unaccompanied (unless in circumstances where they need support from a familiar/trusted person, e.g.

child /parent). None of the Outpatient or Imaging attendances indicate whether she presented alone or was accompanied, and by whom.

5.2.45 23% of high-risk domestic abuse victims attend A&E as a result of their injuries in the year before getting effective help, many multiple times.[3]

5.2.46 Louise presented at Croydon University Hospital Emergency Department again, in July 2017. On this occasion with a head injury following an alleged assault by her mother in law. Louise said that the alleged assault occurred when she was trying to stop her mother in law from holding her child, when her mother in law pushed her and she hit her head on the television cabinet. Safeguarding was considered during this presentation, but the assessing practitioner deemed that there was no domestic violence. This suggests that the health practitioner did not consider an alleged assault by her mother in law to constitute domestic abuse. There is no documented evidence in the health records exploring the relationship between Louise and her mother in law; nor David's responses or reaction to this incident between his mother and Louise. The assessing practitioner also ticked 'no' regarding mental health or vulnerable adult. The records do not show whether the Police had been called or whether Louise had considered calling the Police in response to this incident. The involvement of the Police could have opened a MASH referral to Children's Social Care and explored the family functioning and dynamics with the immediate and extended families; and the rationale why Louise did not want her mother in law to hold her child (grandchild).

5.2.47 The health practitioner was unable to recognise and identify the history and mechanism of the alleged assault as domestic abuse, and both a Safeguarding Children and Adult concern; therefore safeguarding procedures were not adhered to.

5.2.48 When Louise presented to the Emergency Department on both these occasions (Para 5.2.21 and Para 5.2.24), she was known to Croydon Health Visiting services. Both Casualty Cards have been reviewed and there is no evidence to suggest that a notification was sent to the Liaison HV by the Emergency Department. Best practice recommends that a notification is sent to the Liaison HV (who works within the Emergency Department), who in turn notifies the generic HV in the community of the concerns. The Liaison HV was not notified of either of these presentations. Therefore, the generic HV was not aware of these risk factors and concerns. Despite Louise informing the hospital of the assault by her mother in law, there is no record in the Health Visiting records that she disclosed this or her suicidal thoughts to her generic HV.

[3] SafeLives Getting it right first time (2015) https://safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf (accessed 1 September 2020).

5.2.49 Louise and her children were seen by a maximum of four different members of the Health Visiting team on 22 different occasions. This would not assist with any of the health practitioners getting to know Louise very well, nor would it assist with Louise feeling safe and comfortable enough to share sensitive, personal or distressing information with her health care providers. All parents are allocated a named HV, but Louise saw her named HV on five separate occasions, with only one being in the home. The current configuration of HV services would make it unlikely that a mother would see the same HV on each occasion. This lack of continuity brings into focus the need for accurate recording within HV teams.

5.2.50 **Kings College Hospital NHS Foundation Trust**

5.2.51 Louise attended the Emergency Department of Kings College Hospital on 4th February 2014 having been involved in an "altercation" where she had been punched to the head and nose multiple times and thrown to the floor. Louise was bruised and had scratches to her lower right back, her nose was visibly deformed, and she had a bad headache and was visibly shaken.

5.2.52 There was no reference to domestic abuse in clinical notes and it appears the "altercation" was not explored further. Nearly four hours after attending Louise was called over the Tannoy system within the hospital but she did not appear and so she did not receive a full assessment. There was no follow up action recorded on the medical notes and the Emergency Department social work team were not alerted to the fact Louise had attended when they arrived the following morning. Additionally, there was no indication in the notes that a welfare call was made to Louise.

5.2.53 It is the IMR authors belief that this incident was as a result of domestic abuse.

5.2.54 **London Borough of Croydon Children Social Care (CCSC)**

5.2.55 Children's social care services support children with the greatest need – children who are disabled, who have to be protected from harm or who need to be placed in residential or foster care.

5.2.56 The first contact with CCSC was on 6 January 2017 CCSC received a police MERLIN which stated that Louise had reported a series of incidents to the police. She had provided a context to hers and David's relationship in that they had been married for five years and in a relationship for nine years. The MERLIN report included Louise's disclosures to the police regarding David's isolating her from her family, jealous behaviour and assaulting her, and that the children had witnessed arguments.

5.2.57 The CCSC decision was made of no further action with a task to the social worker to write to Louise to include information about the FJC and to inform Louise that if there were any further domestic abuse incidents then this would be reviewed. The records do not show evidence that Louise contacted the FJC.

5.2.58 On 7 July 2017 a further Police MERLIN was received outlining the incident of 1 July 2017, where David was seen holding a knife to his throat in a video call.

5.2.59 The Initial decision made by a senior social worker was to take no further action as no further safeguarding concerns where noted. However, the manager in the MASH team disagreed for the following reasons:

- Young children, lack of voice of the children in this report.
- No information indicating an underlying mental health issue/alcohol use of concern.
- Little current understanding of the care arrangements between parents of the children.
- Case history indicates violence alleged by father in January 2017 – little is known about the relationship dynamic and what the children may be exposed to.

5.2.60 This was an excellent decision by the Manager in the MASH for the correct rationale, also because Louise still had not been seen by any service since the incident on 1 July 2017. A manager subsequently reviewed the decision on 24 July but Louise or the children had still not been seen by CCSC. Records show that the social worker made a number of telephone attempts to contact with David and Louise. Louise was finally spoken to 31 July 2017. It is policy that the family should be seen within five days. The social worker spoke to the children, but the assessment does not include any detail of what direct work was completed to ascertain the children's wishes, feelings, and details of their lived experience. It is also unclear as to whether there was more than one visit to gather information to complete the Child & Family assessment. The Assessment was completed within the 45 day Statutory Time Limit.

5.2.61 The social worker informed the manager that there were no significant safeguarding concerns that warranted ongoing social care involvement and that Louise was perceived as a protective factor for her children. The social worker's records in the Child and Family assessment state, 'Louise is currently engaging with the FJC to address any potential concerns of the domestic violence issue involving her and David'. As a result, on 17 August 2017 the CCSC manager closed the case. However, it has been confirmed with the FJC that Louise had never accessed their services. The records do not indicate what actions were carried out as the result of the manager's request on 7 July 2017 and whether Louise or the children were physically seen after this potentially serious incident with David and the knife. The records show that David did not contribute to the Child and Family assessment and that he was advised by letter from CCSC to seek legal advice in respect of contact arrangements for the children.

5.2.62 The outcome of the Child and Family assessment completed in August 2017, of no further action did not address David's behaviour, rather than taking responsibility to manage this risk. The assessment shows a level of over-optimism and assumes that

because Louise was seeking to divorce David, was making contact arrangements, and was working with the FJC, that these courses of actions meant effective safeguarding for the children. It would have been important for the assessment to be more robust, sceptical, include a thorough risk analysis and hypothesise about what was going on within the family. Inclusion of research about domestic abuse from a control and coercion perspective was also lacking and would have been beneficial in making such an important decision. The police MERLIN dated 22 July 2017 includes a statement that it was apparent that Louise suffered from bipolar and had been sectioned under the Mental Health act in the past. It would have been prudent for this information to be discussed as part of the Child and Family assessment along with further exploration and curiosity to inform risk assessment.

5.2.63 It appears that there was a lack of a thorough risk assessment. This could have drawn on information included in the two police reports sent to the MASH/Assessments teams. The lack of a thorough risk assessment informed the decisions of 'no further action'. There was no referral to FJC or MARAC. Louise, who would be deemed as vulnerable, was left to refer herself to the FJC, something that did not happen. It is possible for CCSC to make a referral in these circumstances, but that would require consent from the client. These decisions left the family at risk of experiencing further domestic abuse, which posed ongoing harm to the children, their development and to Louise. The decision made as part of the Child and Family assessment to close the case, with no further action in August 2017, did not address the risk that David's behaviour presented as a perpetrator of abuse. It left Louise to manage this risk without statutory support or interventions that would have mitigated some of these risks. Additionally, the assessment lacked management oversight as to the decision-making on the case, for instance in the manager's decision section of the assessment states 'no further action agreed' with no rational. The manager provides no analysis as to why there is agreement with the social worker analysis and conclusion. The file is then not updated with information about the conclusion e.g. the case summary was not updated or a case note written.

5.2.64 The Child & Family assessment further relies upon Louise ability to safeguard herself and her children against David, which would have proved difficult in light of what research says about domestic abuse victims. There are several dangerous risk factors identified which includes separation, disputes over contact, David exhibiting harmful behaviours such as holding a knife to his throat in an effort to exert power and control, and his apparent lack of insight and unwillingness to partake in the Child & Family assessment or to have a discussion with the assessing social worker. The Child & Family assessment was not child focused enough and solely relies on Louise as a protective factor, who was vulnerable as a victim of domestic abuse.

5.2.65 The assessing social worker speaks to the impact of domestic abuse upon the children's development but there is no robust risk assessment to discuss the depths

and impact of domestic abuse on Louise and the children. The social worker could have provided a hypothesis about the impact of domestic abuse on Louise or use research to explain its impact in the present and future. There was no consideration of risk to Louise and the children when the first referral came in January 2017 from the police. The report records Louise's narrative about a number of incidents spanning some 5 plus years. There is no evidence of the police or the social worker undertaking a DASH risk assessment which may have informed a referral to MARAC or a discussion with the domestic abuse specialist to undertake safety planning.

5.2.66 The final police MERLIN was received on the 25 July 2017 and records an incident that occurred at a birthday party that Louise took Child A too. This information was included within the timeframe that CCSC were conducting their assessment.

5.2.67 The CSC representative has shared the current MASH process. There are now processes in place to deal with urgent and other referrals. With systems to facilitate strategy discussions, analysis and allocation to appropriate staff. There are clearly defined roles and management oversight.

5.2.68 **London Borough of Croydon Housing Services**

5.2.69 The IMR for Housing Services examines an online application in the name of Louise which was placed on the Croydon Housing register. The submission of the IMR was late and there was no opportunity for the panel to discuss the content with the author or a supervisor. The IMR was very limited and a copy of the online application has been examined by the chair to support the IMR.

5.2.70 The application in the name of Louise was made on 7 February 2017. The application included Louise's mobile phone number and her personal email address. The application states that Louise was living in private rented accommodation in Croydon. She was seeking council accommodation within the borough of Croydon. There were no details supplied for any other person living with Louise. She was seeking a house or maisonette. The application has space to record if there were any medical condition that was made worse by the current living conditions, this part was left blank. There was no section within the application that allows an applicant to highlight concerns on safeguarding or domestic abuse. There is nothing in the form to signpost local or national domestic abuse agencies.

5.2.71 There is no information in the IMR that any further form of correspondence was sent to Louise after the initial application. There is no indication that any acknowledgement of the application was sent to Louise. The IMR author states that the application was rejected, as there was "no housing need" and cancelled in October 2017. There is no evidence that Louise was ever informed that her application had not progressed.

5.2.72 The timing of the application is significant, it followed the report of an assault by Louise to her GP the previous day. Louise had reported to her doctor that she had been

assaulted by a stranger in a pub and she presented with a bruise over her eye. There was no record of this assault ever being reported to the police.

5.2.73 If the online housing application had included a section or a prompt allowing an applicant to report concerns about safety this could have provided Louise with an opportunity to express her concerns in writing. The review has established that Louise had completed her own initial divorce papers three months after the housing application. In that application she cites domestic abuse and that her controlling and jealous husband was having an effect on her mental health. This would indicate that Louise could have the propensity to report her abusive situation, in writing, if prompted or given the opportunity.

5.2.74 The IMR author recognised that there is a need to change processes to include questions on abuse and safety. There is also recognition of the need to improve training for staff in the housing department.

5.2.75 **Metropolitan Police Service**

5.2.76 On 1 January 2017 Louise called police to her home to report that over the previous two days David had caused damage to her front door, smashed her phone, assaulted her and had hacked into her email and messaging apps. Police attended and Louise told them that on 23 December 2016 David discovered that she had been communicating with other males via an online dating site. Although this initially caused an argument, Louise and David agreed to continue in the relationship. However, by 26 December 2016 she decided that she wanted to separate. She stated they remained in the same house together but on 27 December 2016 David checked her phone and discovered she had been in contact with another male. David reacted violently, smashing up a wardrobe. He initially left the address before returning later taking the children to the car, stating he was going to his mother's address. Louise went to the car and took hold of David to try to stop him driving away. He bit her on the hand and she scratched his face. The children were returned later that day.

5.2.77 On the 28 December 2016, David came back to her house to visit the children. David took Louise's phone and removed the SIM card. David later contacted Louise and asked her to meet the following day to discuss their situation.

5.2.78 On 29 December 2016, Louise returned to the house and found David already inside the premises despite the fact she did not believe he had a key. David later left but returned to Louise's home where she agreed to allow him to sleep on the sofa. They later argued over David attempting to access Louise's phone following which he pushed Louise onto the bed. The argument continued ending in a struggle during which David pushed Louise against the wall. David cracked the screen of her phone and left the house, breaking a pane of glass in the door as he did so. The disturbance woke the children who witnessed the assault. After he left, David returned to the house but Louise refused to let him in. She handed him a blanket and told him to sleep in the car.

The following day Louise drove him to his mother's house. David apologised and asked her not to call the police.

5.2.79 Louise told the Initial Investigating Officer (IIO) she discovered that David had hacked into her email and social messaging, changed the passwords and had sent threatening messages to the people she had been in contact with. The IIO correctly completed a Domestic Abuse, Stalking and Harassment (DASH) Risk Identification Checklist and assessed the risk as MEDIUM. The rationale was because Louise had indicated David had isolated her from friends and family and had previously threatened suicide if she left him. It is not clear whether the IIO also considered the separation as a further risk factor.

5.2.80 The IIO consulted with a detective within the Community Safety Unit (CSU) and completed a MERLIN report with respect to the children. Appropriate intelligence checks were completed. The IIO ensured a CAD was created to request David was wanted for questioning in relation to the incident and commented that no neighbourhood enquiries were conducted due to the lateness of the hour. The Merlin was shared with Croydon Children's Services (CCS) on 2 January 2017. It was also noted that David still had keys to the property. Safety planning was discussed with Louise and she stated she would go to her mother's house with the children and said she did not think David would go there. Louise was advised that a referral would be made to the Croydon FJC.

5.2.81 On the morning of 2 January 2017 the investigation was allocated to an Investigating Officer (IO) in the CSU. During that morning, David called the police stating he wanted to know where Louise and his children were. David had gone to Louise's home and found the support services advice notice given to Louise by the IIO which bore the IIO's name. He said he had called Louise's mother who told him they were not with her. The call handler noted David was wanted for interview (as a result of the IIO's actions) and did not disclose Louise's whereabouts. Police were despatched to Louise's address, but David was not present. The officers phoned him and he said he was at his mother's address where officers arrested him on suspicion of assault and causing criminal damage. Correct positive action was taken by the police but no house to house enquiries were conducted with neighbours. Whilst it is appreciated that they were not conducted by the IIO due to lateness of the hour they should have been conducted prior to interview of the suspect as this may have provided valuable evidence that could have corroborated with Louise's version of events or David's. In essence the interview is therefore conducted of "one word against the other". There also appears to have been no consideration as to why David was so keen to trace Louise and whether or not this heightened the risk to Louise and the children bearing in mind they had been separated since 26 December 2016, various offences had been committed, and he knew there was police involvement.

5.2.82 David was interviewed and admitted causing damage to property and assaulting Louise but claimed his actions were in self-defence. David had injuries to his head which he said were caused when Louise grabbed him when he was sitting in the car with the children. David admitted biting Louise's hand to stop her digging her nails into his skin. He admitted grabbing her by the arms but stated this was in an effort to stop her hitting him. Potentially this could have been proved or disproved by completing house to house enquiries. It appears that the investigating officers were looking at the investigation as two separate substantive offences of assault and criminal damage. They did not consider the coercive control legislation or stalking legislation. Additionally, it appears they did not consider what has occurred previously in light of coercive control. Research by the national domestic abuse charity SafeLives shows that on average there will have been 50 previous incidents or coercive controlling behaviours before a victim of domestic abuse contacts the police.[4] These of course do not need to be violent behaviours or substantive offences and had this information been obtained from Louise or other family members and friends then it would assist the investigation. Police guidance on domestic abuse investigation is to ascertain who the Primary Aggressor is in relation to the "whole" of the domestic abuse investigation and not to investigate just what is obvious to see.

5.2.83 Further, Louise and David had separated on 26 December 2016 and these incidents and behaviours had occurred since the separation. Therefore, the controlling behaviours displayed e.g. pushing Louise onto the bed, against the wall, smashing her phone, hacking into her email accounts, taking her SIM card, entering her home without permission and smashing the door should have been considered as a stalking crime as there was a course of conduct, Louise would have been in fear of violence or she was having to change her life as it was having a substantial adverse effect on her. Stalking legislation allows previous coercive controlling behaviours to be considered after December 2015 or prior to that as "bad character" evidence but this does not seem to have been explored by the IO or their supervisor.

5.2.84 David stated in interview that the broken mobile phone belonged to him under contract although admitted Louise paid the bills. The damage caused to property was jointly owned and he claimed that some of the damage to the wardrobe was caused by Louise. He admitted changing Louise's passwords but stated he had not done this to stop her accessing the messages but because he wanted to see them. This was not recognised by the IO or their supervisor as controlling behaviour. The police report also stated that David claimed to be distraught because Louise had been in contact with

[4] SaveLives *Insights Idva national dataset 2013-14* (2015) https://safelives.org.uk/sites/default/files/resources/Insights%20Idva%20national%20dataset%202013-2014.pdf (accessed 1 September 2020) and Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office.

other men and that the IO noted that David was very contrite and upset throughout the interview. Showing remorse during an interview is not a reason to close an investigation with no further action being taken. It does not appear the IO considered the admission made by David in relation to accessing Louise's email and messaging applications. The IO could have sought additional evidence to assess if offences under the Computer Misuse, Malicious Communications Act or stalking offences as they show the continuum and course of conduct and is covered by the stalking legislation.

5.2.85 The IO discussed the case with their supervisor and concluded that as David stated he was acting in self-defence, had sustained worse injuries than Louise, and because the damage was caused to his own property that the matter should be concluded with no further action. It does not appear that the supervisor considered during their decision making evidence that had not been investigated, the full history of the relationship, the fact that David and Louise were separated and the fact that David had entered Louise's home after the separation.

5.2.86 Before the police can decide whether a decision to take no further action can take place they can only do so if;

- The evidential stage of the Full Code Test OR Threshold Test are not met and
- The case cannot be strengthened by further investigation or other means
- The decision does not require the assessment of complex evidence or legal issues.

This means that a police decision to take no further action only applies to those cases that clearly cannot and will not be able to meet the appropriate evidential standard (the Full Code Test or the Threshold Test) because all reasonable lines of enquiry have been exhausted, there is no prospect of further evidence / enquiries strengthening the case and the evidence is still insufficient for the case to eventually meet either of the Tests.

5.2.87 The IO noted David and Louise had not previously reported any domestic incidents and that David had provided a plausible account of the incidents and was of previous good character. As mentioned in (para 5.2.53) many victims of domestic abuse will not call the police which is why it is important that when they do then the full history of the relationship and enquires with others must be conducted. If this had occurred, then potentially further information would have been gleaned that could have resulted in a thorough and detailed investigation which in turn would inform the risk and the necessary safety planning that should have been put into place.

5.2.88 The IO contacted Louise to inform her of what David had said in interview and to inform her of the decision to close the case. Louise confirmed the phone was David's and agreed that she had caused some of the damage to the wardrobe. She said she did not want to see David again but would not stop him seeing the children. She stated

there had been no previous violence in the relationship. The IO advised her they would make a referral to the Croydon FJC which provided support services to victims of domestic abuse.

5.2.89 The IO closed the report stating that a referral to the Multi Agency Risk Assessment Conference (MARAC) had been considered but did not meet the criteria for referral and stated the closing risk assessment was STANDARD. The DASH score was 7/14. The IO did not add an updated DASH to the CRIS and the reason for reducing the risk grading from MEDIUM to STANDARD is not recorded. There does not appear to have been a further DASH completed with Louise to determine why the risk was reduced to STANDARD or what crime prevention and safeguarding advice and measures were put in place to safeguard Louise and the children. The answers in Louise's initial DASH RIC would have justified the risk level remaining as MEDIUM. Following the investigation the Risk Management plan for Louise should have been reviewed. It is not clear whether a Risk Management Plan was completed. Additionally, had the officers correctly identified that this was a stalking case then an S-DASH should also have been completed.

5.2.90 Whilst positive action was taken the following day in relation to David's arrest it does not appear that a Domestic Violence Protection Notice (DVPN) was considered.

5.2.91 On 1 July 2017 the MPS received a call from Sussex Police as they had been contacted by a family member of Louise who informed Sussex Police that David had been speaking to him via a video Facebook chat and David was holding a knife to his neck. Prior to that the family member had received thirteen voice messages from David who was angry that he did not know where Louise was. David stated that he thought Louise had gone to meet another male and he wanted to know if Louise was ok. Louise and David were still separated. David ended the call and so the family member called David back and it appeared that David had collapsed and so he called Sussex police. Sussex police ascertained the address of David and the enquiry to trace David was sent to the MPS. MPS attended Louise's address (Louise was not present) and David was found fit and well, asleep on the sofa. David stated his children were asleep upstairs and told police that he was trying to work things out with Louise and had moved back into the house but was sleeping on the sofa. The IIO noted the earlier domestic incident and believed that David had acted as described by the family friend in an attempt to elicit information about Louise's whereabouts.

5.2.92 David apologised to the police and became emotional as he had been left by Louise and was caring for the children by himself. Officers checked the children and they appeared to be asleep and were not woken by the police. The primary responsibility of the police is to protect life and best practice is for the children to be woken to ensure they are not harmed in anyway.

5.2.93 The IIO questioned David about his intentions and David stated he wanted to scare the family friend into telling him where Louise was. David said he regretted his actions and was not and has never been suicidal. David was given a first instance harassment warning and the matter was closed with no further action by a CSU supervisor.

5.2.94 Although the IIO recognised that David's intent was to manipulate the family friend into providing information about Louise it does not appear that Louise was spoken to by the police in relation to the "knife" incident, bearing in mind the previous history recorded by the police of 1 January 2017 and the fact David was making such threats whilst Louise's children were in the house with David. It also appears that neither the IIO nor the CSU supervisor considered speaking to Louise to check on her welfare considering the serious way that David had tried to track Louise down (knife to the throat) or make her aware of the incident and ascertain if this was part of a wider campaign of stalking by David. It is also unclear whether the family friend was asked to provide a statement to the police in the context of further serious stalking behaviours which if linked to the police investigation on 1 January 2017 would have potentially influenced how Louise was safeguarded using professional judgement and escalation. Although this may not have altered the outcome of the investigation, it may have influenced how the risk to Louise was considered and a further DASH and S-DASH could have been completed with her to ascertain the current level of risk and a potential referral to MARAC. Children's Social Care became aware of this incident on 10 July 2017.

5.2.95 On 22 July 2017 Louise called police to report she had just been assaulted by David's mother. A counter allegation was subsequently made by David's mother. The police obtained a statement from David's mother and the IIO completed a MERLIN report with respect to the children. This is classified as a domestic abuse incident but whilst two CRIS reports were correctly created to record the separate allegations of assault neither contained a DASH risk assessment. Both were assessed as STANDARD risk as Louise and her ex-mother in law were not in a relationship and did not live together and therefore were not considered to present an ongoing risk to each other.

5.2.96 Louise attended the police station to be interviewed and she recounted that, since her separation from David, she had ongoing issues with David and his family. David had invited Louise to attend a family BBQ with the children. When Louise arrived, she discovered that she was not welcome by the host and David had only asked her as another way of trying to resume their relationship. There was a disagreement with David's mother and as a result the children became frightened of David's mother. In relation to the assault, this occurred at a children's birthday party. David's mother was also there, which Louise had been unaware of. David's mother tried to pick up Louise's child, but they became upset so Louise intervened. David's mother pushed Louise away, causing Louise to hit her head on the television set. Louise told David's mother to leave her child alone but stated she was then slapped across the face by David's mother. Louise said she defended herself by lashing out at David's mother. Louise was

then threatened by the rest of the family so Louise picked up her children and left. Louise had no contact with any of the family since the incident.

5.2.97 The IO attempted to gather further witness statements and obtain photographs of David's mother's injury however none of the witnesses responded to attempts to contact them. The decision was made to take no further action against either Louise or David's mother as a prosecution would not succeed without independent medical or witness evidence.

5.2.98 The MERLIN report was completed following the initial conversation with David's mother and presented a similar version of the events described by Louise. However, the MERLIN referred to Louise suffering from bipolar Disorder and alleged she had been sectioned under the Mental Health Act in the past. The CSU IO who interviewed Louise made no reference to any past or current mental health concerns. The MERLIN was shared with CCS and it was noted the children were an open case with an allocated social worker.

5.2.99 It is interesting to note the reference to bipolar and the allegation of having been sectioned. Neither of these aspects were enquired upon and seemed to have been taken as the truth by the police. The information has come from the other suspected party (David's mother or her family) and yet this is now recorded on the police system without either being verified or checked with Louise to ensure she did not need any additional support. Regardless of this, just because victims may suffer with a medical issue, mental health or otherwise it does not make the victim any less of a victim. The correct use of language and the rationale as to why such language is used needs to be documented and sourced otherwise dangerous assumptions can be made which have historically wrongly influenced the course of investigations.

5.2.100 In total there were three contacts with the police that involved Louise and David. It does not appear that any links were made between the investigations of 1 January 2017, 1 July 2017 and the 22 July 2017. Had professional curiosity based on interrogation of the police systems and the links been made between the investigations (which could have been more thorough in relation to 1 January and 1 July), further questions asked, and enquiries made with other services, then potentially better safeguarding would have been put in place based on DASH and S-DASH assessment. By considering the evidence gleaned not only from the investigations but also the risk assessments, professional judgement concerning the escalation of three police incidents within 12 months then the assessment of risk could have increased to high risk and therefore have been subject of the MARAC forum. It should be noted that the local mandatory protocol for a 'potential escalation' MARAC referral is set at four incidents in a 12 month period.

5.2.101 A comprehensive risk identification should be completed by the IIO and recorded for all domestic abuse incidents, whether crime or non-crime, to assess current and future

risks to the victim and any children, to enable that risk to be effectively managed and the required intervention and safety strategies to be implemented. The management of the risk remains with the IIO until the risk is removed or formally handed over to the incoming response shift or member of the CSU. The model states the victim should be informed of the risk assessment and options for safety planning discussed with them.

5.2.102 Secondary supervisors and investigators within the CSU, Sapphire or other investigating unit are then responsible for conducting a secondary risk assessment for all medium and high-risk cases. The risk assessment remains dynamic and should be reviewed as circumstances change.

5.2.103 There are many risk factors linked to domestic abuse that might indicate future risk to victims and none of these should be overlooked or discounted. However, research and analysis of domestic murder, serious domestic abuse offences and academic research has highlighted a prevalence of certain factors that indicate a higher risk to the victim of domestic violence and indicators to serious violence and murder. Those factors should be included in any risk assessment to identify and manage risk.

5.2.104 The mnemonic SPECSS+ features throughout the MPS policy in order to remind officers of the risk assessment model and associated risk factors.

5.2.105 The Policy is clear of what the heightened risk factors in cases of domestic abuse are the relevant risk factors that are listed that are present in the Louise case include: separation/child contact issues, pregnancy/new birth, escalation, isolation, and stalking.

5.2.106 Additionally, the following factors should be considered when conducting a risk assessment: child abuse, use of weapons, strangulation, suicide, controlling jealous behaviour, abuse of alcohol/drugs, mental health and victim's fear.

5.2.107 There is no mention that the SPECCS+ model was considered or referenced. Had it been considered then a more thorough investigation and safeguarding measures are likely to have been put into place.

5.2.108 Positive action was taken against David after Louise reported the crimes which resulted in the MPS deciding that the case would be "No further actioned". The MPS need to take a wider view of the potential offences committed including coercive control and stalking and conduct the necessary investigation and safeguarding in order to do so by following the MPS SPECSS+ Policy.

5.2.109 Officers could have considered pursuing a coercive control investigation linked into a stalking investigation as Louise was the victim of the offences she alleged after she and David had separated. Coercive control behaviours can be included as part of the evidence when conducting a stalking investigation. Neither Coercive control nor stalking offences were considered either in the recording of the offences or in their investigation.

5.2.110 **Primary School**

5.2.111 During the period under review Child A started primary education at a school in the London Borough of Croydon. The school provided education for the child from September 2016 to the present date. Child B later joined the school with their sibling but was not in full time education before the death of Louise.

5.2.112 Child A was seen as a happy outgoing child when they started at the school. Child A achieved an appropriate level of development at the end of reception. The school established good relations with both parents. Louise was considered quieter but would often acknowledge the Head Teacher at the start of the day. Louise had expressed an interest in working at the school but she did not progress this when a suitable job was advertised.

5.2.113 David also offered to support in the classroom from the reception year. At the time it was not considered Regulated Activity in need of a Disclosure and Barring Service (DBS) certificate. As David's support continued into Year 1 a DBS certificate was obtained for David in October 2017. It appears that during this period David used the opportunity to 'put down' Louise to teachers. As the school became aware that Louise and David had separated, it was felt by staff that David's put downs were his way of dealing with the breakup. On other occasions David was seen as complimentary towards Louise.

5.2.114 Issues came to the fore when Louise attended to collect Child A from an after school club and discovered that David had already collected the child at the end of school lessons. This was around December 2017. This resulted in a meeting between Louise and the Head Teacher where she explained that she had split up from David. She said that David would often do his own thing. She described him as being 'not well' but did not want to be 'bad mouthing' him.

5.2.115 In reviewing the interaction with the school, the IMR author suggests that David appeared to be controlling the situation with Louise, appearing to be reasonable and caring. It is now considered that David could have been trying to manipulate the situation and to present himself to the school as a positive factor in Child A's life.

5.2.116 The school staff involved had all undertaken appropriate safeguarding training. There were no disclosures of any safeguarding issues that would have led the staff to suspect that Louise was experiencing domestic abuse.

5.2.117 The school has demonstrated good practice and has a "worried about something" button on the school website to enable children to report concerns about safety at home. There are a number of other supportive safeguarding measures in place and yearly support from the NSPCC. This work should be considered as good practice.

5.2.118 **South London and Maudsley NHS Foundation Trust (SLaM)**

5.2.119 The Trust provides mental health and substance misuse services to the people of Lambeth, Southwark, Lewisham and Croydon, as well as substance misuse services for people in Bexley, Greenwich and Bromley and some more specialist services to people from across the UK.

5.2.120 The Trust works closely with patients and carers and local partners in health and social care. Services are primarily focused on people with severe and enduring mental illness. However, the Trust also promotes good mental health, early intervention to prevent more serious problems and provides support to primary care in dealing with people with less severe problems. The Trust has a strong community focus and services are provided in a wide range of settings including people's own homes, GP practices, day services, residential and nursing homes, prisons and hospitals.

5.2.121 Louise was first referred to SLaM Perinatal Service in July 2014 by her GP. This was because Louise was experiencing secondary depression following the birth of her second child. The referral from the GP was assessed as evidence of good practice. Louise was seen for one scheduled appointment in August 2014. She was seen to have presented with significant improvement and was discharged back to her GP. There were no concerns on safeguarding and all interagency communication was appropriate.

5.2.122 Louise's second referral to SLaM Mental Health services came from her GP on 24 November 2016. The referral was made to the Mood, Affective and Personality Disorders (MAP) services due to "suspected bipolar affective disorder and social stressors". The referral was discussed by the MAP team and a 'routine assessment appointment with the doctor' was planned. An appointment with a doctor would normally be offered for more complex cases and would normally be within two to three weeks. A letter was sent to Louise with a Crisis leaflet and telephone contact details on the same day. There was no evidence of an appointment being made for Louise to see a doctor. The IMR author stated that this could have been appropriate, but they had not been able to discuss the matter further with the original member of staff, as they had left the trust. Louise presented in crisis 20 days later at the Emergency Department of CUH on 13 December 2016 having been taken there by David.

5.2.123 Following that presentation at CUH Emergency Department, SLaM had 34 recorded interactions with Louise directly or as part of a Clinical review meetings between 13 December 2016 and 29 March 2017 where domestic abuse, coercion and control, and subsequently stalking behaviours were exhibited by David but were not effectively acted upon.

5.2.124 Following on from when David took Louise to the Emergency Department, SLaM Home Treatment Team (HTT) visited Louise at home to conduct an HTT assessment. Home Treatment is a service providing an alternative to hospital admission via intensive home support. It was a quick response following the hospital visit the previous day but it is

not recorded as to whether David was present for this HTT visit or not. Best practice for ascertaining whether domestic abuse was present would be for the partner not to be present.

5.2.125 On 18 December 2016 at the next HTT visit David was present. Carer's support was suggested to David but he declined access to this. Offering carer support is considered by the IMR author as good practice. One could now consider that David's refusal to access carer support demonstrates his controlling behaviour and the involvement of a carer could further expose his abuse. In this visit, the records describe Louise's home environment, her relationship with David and acknowledgment and consideration of the children in the household. SLaM recognise this as good practice, as 'crisis episodes can be caused and/or exacerbated by the family environment and equally importantly, how Louise's mental state can affect her relationship with David and the children'.

5.2.126 What was gleaned at this particular visit was that David and Louise had argued for five hours allegedly as a result of David finding out about Louise's use of dating websites. There was lack of documented exploration as to the extent of the argument, e.g. raised voices, physical harm and such, and also whether the children were exposed to this. The staff visiting documented that Louise "feels that David has always gone though all her messages and is paranoid about her seeing other people… and that she came off social media because of him." Such behaviour by David shows clear coercive control but there was no recognition by the HTT professionals that this was abusive behaviour by David.

5.2.127 The HTT visit on 19 December 2016 noted high expressed emotions between Louise and David around the revelation that SC had been exchanging email communications with a male under a pseudonym, and that she had allegedly sent naked/explicit pictures of herself. From the notes, David left the house as he was unable to deal with the situation and took Child B with him. The IMR author believes that it is clear at this stage that Louise and the children were exposed to domestic abuse however this is not documented in the records and no form of Risk Assessment was completed in order to formulate a plan to keep Louise and the children safe from harm.

5.2.128 Also, on 19 December 2016, the team consultant received a telephone call from David. He was documented as being "quite agitated and a bit confrontational" in the discussion. During the conversation, David demanded for Louise to be admitted to the hospital as he said he does not feel that the current treatment is working and wanted her "set on the straight and narrow." It would appear that David was finding it difficult to accept that Louise had been engaging in alleged online relationships without his knowledge and David attributed this to a Mental Health illness. Again, this is a clear demonstration of controlling behaviour by David with regard to Louise's mental health needs and treatment, and pathologizing of her decision-making and choices, again potentially as a means of control. David was also concerned that 'without his supervision', Louise would continue to access dating sites and 'put herself at risk.'

However, it appears that the HTT staff did not consider the domestic abuse aspect and viewed it as caring and protective behaviour from David. The only safeguarding advice from the HTT was a suggestion that Louise and David spend some time apart.

5.2.129 A similar occurrence happened on the HTT visit on 20 December 2016 to the same staff, where Louise mentioned that she "doesn't have her mobile phone anymore and that David has taken it from her." This can be considered as controlling and isolating behaviour by David, it does not seem to have been explored further by the HTT.

5.2.130 The HTT visit on 20 December 2016 also noted that David remained pre-occupied with Louise's online behaviour and was unwilling to go to RELATE (relationship counselling service) until he was satisfied with the "absolute truth" that she did not engage in sexual relations outside of their marriage. His behaviour around this had allegedly also caused Louise to be low in mood and she had verbalised suicidal ideations with no clear intent. The impact of David's behaviour on Louise's already fragile mental health was not considered in the notes.

5.2.131 The HTT weekly review meeting on 20 December 2016 discussed Louise's presentation the preceding week. HTT discussed the need to explore Louise's use of dating websites to ensure her safety but nothing was mentioned in terms of the perpetrator of the domestic abuse. There is no clear rationale for exploration and whilst it believed that that this may have had something to do with Louise's risk to herself there were no safeguarding adult referral made to the Local Authority to accompany the concern highlighted. There was no documentation of risk change on the risk assessment form in relation to the controlling behaviour clearly exhibited by David.

5.2.132 The HTT visit on 22 December 2016 documented that according to David, Louise had left to stay with her mother in Camberwell. David claimed that he had been finding it difficult to "process" the information relating to the cyber affair and that it was "difficult" for him to be with her. From this entry, it appears that David was more concerned with prioritising his own needs over that of Louise, her mental health crisis and, the effect on the children. This decision appeared to be in consonance with the earlier suggestion from the HTT consultant that physical separation might aid in reducing tension between them. The behaviour displayed by David could be seen as behaviour of a perpetrator of domestic abuse where it is "all about me" as opposed to the actual victim. It is also potentially a high risk time as the victim has left the abusive relationship.

5.2.133 Louise returned to the marital home on the 23 December 2016 but this could only be verified by calling David and then speaking to Louise on David's mobile phone as David had taken Louise's phone from her. This together with the evidence of previous visits could have led the HTT to realise that domestic abuse was present and therefore further safeguarding, risk assessment, risk management, potential MARAC referral, and liaison with other agencies should be completed in order to keep Louise and the children safe.

5.2.134 On 29 December 2016 during the HTT Clinical Review Meeting, the team decided not to pursue initiation of the MASH referral due to their perception that the relationship/contact between Louise and David had improved. The review has noted that this was as a result of limited awareness as to what constitutes domestic abuse due to lack of experience and insufficient training. SLaM mandatory training does not provide DASH training to staff.

5.2.135 On the same day HTT received a telephone call from Louise to say that she had left home (with the children) as David had "threatened to take the children away and had thrashed the place." She stayed at her mother's in Camberwell and at the time, was unsure if she would return to Croydon. Following that disclosure and after further discussion amongst the HTT, a decision was made to continue with a MASH referral but the MASH referral stated, "there were no risks associated with her [Louise] children." This is another clear indication that previous domestic abuse events were not considered a risk to Louise's children.

5.2.136 Louise's care was transferred to Lambeth HTT on the same day (29 December), where they requested that Croydon HTT refer Louise's children to CSC/MASH and a safeguarding referral made. Furthermore, they believed that the controlling behaviour David presented should constitute an "alert to the Children's Social Services." Lambeth HTT did not manage to see her as she again returned to her Croydon address. David agreed to leave the property to stay with his mother and allow Louise to live in the Croydon home with the children, as the property was in her name. The recorded term that David would 'allow' Louise to live in Croydon, indicates controlling behaviour. Looking through the electronic patient records, there was no indication that Croydon HTT completed the requests made by Lambeth HTT. Whilst Lambeth HHT have shown good practice in recognising the safeguarding need, this was then not followed up by the Croydon HTT.

5.2.137 Croydon HTT visited Louise on 30 December 2016, where Louise claimed she felt "great relief" to be separated from David. She further stated that he "changed his mind about taking the children away" and they had come to a mutual understanding regarding childcare arrangements. Staff discussed the MASH referral with Louise but she claimed to "not need the support as feels supported by her family." Louise planned to go to her mother's to spend New Year's Eve and David was to care for the children. In light of the recent events of domestic violence and abuse, there was a lack of exploration regarding Louise's views on possible safety issues around leaving her children with David. There was also no consideration as to how concerning and threatening to Louise a referral to CSC may have been, with regard to their involvement. We now know from Louise's family that David had already been questioning her competence as a mother, and this can now be seen as a controlling behaviour.

5.2.138 Throughout the interaction that HTT had with Louise and David there were many indicators of abuse, which could have prompted professional curiosity to enquire around domestic abuse. Beyond the completion of the MASH referral, there had been no other indication of formal documentation or updating of Louise's patient records with regard to risks and possible abuse towards her and the children. Whilst the MASH referral was completed, this review has now been able to identify a range of concerning behaviours by David and a pattern of escalating behaviour.

5.2.139 On 5 December 2017, SLaM held a Clinical Review Meeting and concluded that Louise no longer warranted HTT input.

5.2.140 Language used in organisations records to describe domestic abuse has to be appropriate and must not minimise. Expressions such as "volatile relationship" recorded on 15 January 2017 and "Marital discord" on 1 February 2017 does not portray what a victim of domestic abuse and coercive control is going through. It is far more than marital discord and the expression "volatile relationship" would suggest that both parties are to blame. Some victims will fight back and resist either physically or verbally. Both fighting back and attempting (and failing) to appease the perpetrator can reinforce the perception that they (the victim) are to blame.

5.2.141 **Victim Support**

5.2.142 Victim Support (VS) is an independent charity, working towards a world where people affected by crime or traumatic events get the support they need and the respect they deserve. VS support victims and witnesses to feel safer and find the strength to move beyond crime; support is free, confidential and tailored to individual needs. VS services are available to London resident victims and witnesses regardless of whether the crime has been reported to the police or no matter how long ago it happened. VS specialist teams deliver tailored support to help people recover from the effects of crime and traumatic events. They also speak up for victims' rights, ensuring their needs are met in the criminal justice system.

5.2.143 On 3 January 2017 an Automated Data Transfer was received from the police in respect of the MPS attendance to see Louise on 1 January 2017. The referral was flagged as domestic abuse and there was a brief precis of the call from Louise to the police.

5.2.144 Before contact was made with Louise the risk level on the VS case management system was automatically changed to 'high' by the Victim Contact Officer (VCO) from the standard classification as the referral came through from the police. This is an internal practice with all domestic abuse and sexual violence cases so they are clearly flagged on the case management system and so the correct and safe contact methodology can be adopted. The changing of the risk level to high is not indicative of the actual risk level as in order to assess this a DASH RIC must be completed with the

victim. The changing of the risk level to high on the case management system can therefore be misleading as it is not necessarily reflective of the actual risk level.

5.2.145 An initial telephone call was made to the victim on 6 January 2017; successful contact was made with Louise and an explanation of VS services was provided as well as confidentiality of service provision and the boundaries of this. The call was made by a Victim Contact Officer working as part of the South London Victim Assessment and Referral Service (VARS). The role of the VCO was one which provided initial needs and risk assessments to incoming referrals. For VCO's to undertake assessments with domestic abuse cases they needed to have Victim Support multi-crime, DV and safeguarding training.

5.2.146 During the call Louise stated she had regular visits from the Croydon Home Treatment Team who visited her every two days. The VCO did not enquire as to the reason for support from this agency or what type and level of support she was receiving. Louise asked for information about obtaining a restraining order so after the call the VCO sent Louise information via an SMS text about the National Centre for Domestic Violence and the contact details for VS should she require further support.

5.2.147 The VS case management system details support provision to Louise as being:

Immediate signposting, immediate support and intervention and Introduction of other agencies.

5.2.148 The actual risk score for Louise is not recorded on the case file and there is no evidence of a DASH RIC being completed despite successful contact being made with Louise.

5.2.149 After the initial call to Louise and the follow up SMS text message with agency contact information the case was closed and no further contact was had with the victim.

5.2.150 Contact methodology was in line with VS operating procedures for the initial contact with victims of domestic abuse. This outlines contact should be made within 72 hours of receipt of the referral and contact should always be by phone from a withheld number in order to try and establish safe contact with the victim and to ensure they are not put at further risk by the contact attempts.

5.2.151 The VCO who spoke with Louise confirmed the risk level on the case management system was changed to 'high' before contact was established with Louise. This ensured a pre-call SMS text was not sent to Louise before an initial call to her was made as this happens for non-DV enhanced priority cases. The staff member said they did not ask Louise about whether she would complete the risk assessment over the phone; however best practice would have been to ask about risk assessment completion and still attempt to undertake this. This would have ensured an actual risk level was identified and an immediate safety and support plan could then have been put in place. Had the risk assessment been carried out and any high risk factors identified, a referral could then have been made to MARAC and an IDVA service. The VCO's lack of further

enquiries with Louise is attributed to the volume of cases being received via ADT on a daily basis. The VCO confirmed that had Louise said she required support from VS, the worker would have completed a DASH risk assessment and undertaken necessary follow up work if the risk level had of been assessed as high (referral to MARAC and an IDVA service), and Louise had needs she required VS to support with.

5.2.152 The panel believe this was a missed opportunity to help identify risks Louise was facing from David and a missed opportunity to undertake safety planning with her. Dependant on the risk level there may have been a missed opportunity to refer to MARAC and an IDVA services.

5.3 Equality and Diversity

5.3.1 The Review Panel identified the following protected characteristics of Louise as requiring specific consideration for this case; Sex, Marriage, Pregnancy and Maternity and Disability.

5.3.2 **Sex*:*** Domestic abuse is a gendered crime and most victims are female. Whether a crime is Interpersonal Violence (IPV) or Adult Family Violence (AFV) perpetrators are most commonly male. That was the case with this DHR. The panel considered how this protected characteristic of Louise affected the services provided to her. Most support services accessed by Louise are well established and consider the fact that the majority of victims of domestic abuse are female.

5.3.3 **Marriage:** The parties in this case got married early in the period under review and the breakup of that relationship was a key factor in the review. It was established that Louise had drafted an application for divorce, but there was no evidence that she had submitted the application to a court or sought legal advice. Consideration was given to how the combination of Louise status as a woman attempting to end a relationship would have impacted on her.

5.3.4 **Pregnancy and Maternity:** This review started from a point when Louise was pregnant and expressing concerns about mental ill health. Louise's second pregnancy was a particularly vulnerable time for Louise as the birth of Child A had been traumatic. The panel have been mindful of the recognised risks of domestic abuse that can arise during pregnancy. The panel has included expertise in safeguarding around maternity and child health and the contact with healthcare professionals has featured in much of the analysis.

5.3.5 **Disability:** The panel did consider disability in relation to the perpetrator and information on arthritis. The analysis of information provided did not reveal this to be a significant factor when considering David's position. David has declined to cooperate with the review and the issue of disability was not raised by him during criminal proceedings. David's medical condition does not appear to have brought additional caring responsibilities to Louise.

5.3.6 The protected characteristics should not only be considered in isolation. The combination of those areas can increase the levels of vulnerability for victims. It appears that Louise's position as a married woman was exploited by David. Her family noted that his controlling behaviour increased after they married. David also used Louise's status as a mother as a way of undermining her and controlling her. He portrayed himself as a caring father to his children's school, working as a helper in school and then criticising Louise in conversations with staff. It is also known that even after they had separated David continued to exert control over Louise as a single parent.

6. Conclusions and Lessons to be Learnt

6.1.1 The murder of Louise resulted in the loss of a kind and loving daughter, sister, mother and friend, and is devastating. David is the person responsible for this act.

6.1.2 David demonstrated controlling behaviour towards Louise. Friends and family have provided clear information to the panel on the way in which David would undermine Louise and exert control on her. The agencies have seen how David interposed himself on Louise's contact with agencies and how he was often present. He tried to influence mental health professionals, taking control and undermining Louise as a mother. When Louise had started to forge a new life for herself and move forward, David lured her to his home by emotionally exploiting her. He lied that he was going to be sent to prison and wanted to see his children one last time. He then killed Louise.

6.1.3 David controlled Louise economically. She was often left unable to feed her children and relied on her mother and friend to help. He controlled her use of her car and he controlled her finances. He ensured that Louise's access to a car for transport had to be through him, by retaining control of the keys. Louise was left in debt. Towards the end of her life David tried to sexually exploit Louise by offering money for sex. David's economic abuse was clearly evidenced in his accessing her finances to pay his debts when he killed her.

6.1.4 For situations where there is known domestic abuse, or indications of it, referral pathways and the relevant processes must be scrutinised, and inconsistencies and inadequacies must be prioritised and addressed. To ensure a coordinated community response to domestic abuse, these systems must be audited, discussed, and inadequacies must be addressed, or survivors of abuse will continue to fall through these gaps. Unfortunately, it appears that some front-line staff and their supervisors had limited understanding of domestic abuse.

6.1.5 Domestic abuse can be a complex matter and may not always be apparent to practitioners when engaging with clients. If it is recognised then practitioners must complete the necessary risk assessments, create safety plans within their own organisations for the victims, and have knowledge of and use the relevant referral pathways so that the information is shared with other agencies. This is important because many agencies may have different information on a survivor or perpetrator, each holding parts of the jigsaw but unless the information is being shared and organisations liaise with each other the jigsaw will not be complete, and victims of domestic abuse and stalking will continue to be seriously harmed.

6.1.6 As with many reviews, there must be continued momentum to train and provide tools and policies to ensure that professional curiosity and identification of domestic abuse is fostered in all settings. This is particularly true in relation to healthcare settings where there is opportunity to engage with both the victim, the perpetrator, and the wider family.

This could be the place of earliest intervention. If these tools are available, then they must be effectively marketed so that practitioners are fully aware of them and supervisors must ensure they are being complied with.

6.1.7 The use of language is important both when speaking to victims and survivors, and in relation to how reports are written. Reports must be clear and give their rationale on why a practitioner has made a particular decision and explain it in detail. In this case Mental Health services did not identify domestic abuse and mislabelled coercive control as a "volatile relationship" or "marital discord". The Police recorded comments from a family member of David, that Louise was bipolar and had been sectioned because of mental health issues. Such language can negatively influence others who assess or oversee a case later and therefore human nature can dictate (if they have little knowledge or understanding of the complexities of domestic abuse) their attitudes and/or distort their understanding, which then causes incorrect decisions to be made going forward.

6.1.8 Importantly, it is not only professionals who require support and information about domestic abuse. Louise was isolated by David from friends and family who understood what was going on with their daughter and sister, would try to support her. On many occasions, family and friends know much more accurately the situation and feelings of victims and survivors. However, more needs to be done to ensure that family and friends know pathways to support and when to encourage engagement with services, particularly during a recent separation.

6.1.9 **Lessons to Be Learnt:**

6.1.10 This case shows that there needs to be a strong multi-agency partnership focus on tackling and preventing domestic abuse. It should also be recognised that the DHR process and homicide investigation have resulted in some immediate changes in the protocols and procedures. This demonstrates a willingness to implement change and improvements across the Boroughs.

6.1.11 **Lesson 1. Risk Assessment and Safeguarding.** This review highlights the need for agencies to work in partnership and make possible use of information available from all sources to produce dynamic risk assessments to ensure the safety of victims in the future. It has shown that persons managing reports of abuse and investigations should make sure that they make best use of information held within their own agency and understand how the evidence presented to them by a victim or perpetrator could reflect domestic abuse.

6.1.12 Bromley Healthcare HVs that delivered the service to Louise and her children graded her at the Universal Level (low health visiting intervention) when they should have been assessed with the evidence presented to them as Universal Plus. This meant that Louise received a lower level of intervention. Universal Plus identifies additional parental or child health needs; social care needs or needs in relation to domestic abuse

and gives additional support from partner agencies. HVs need to ensure they are aware of what the thresholds are.

6.1.13 Croydon Children Social Care (CCSC) noted that it was evident that there was a lack of a thorough risk assessment being completed.

6.1.14 Victim Support (VS) have identified that practitioners need to be more rigorous with attempts to engage the victim with the risk assessment process. In this case particularly after Louise stated she required information about a Restraining Order. The implication being Louise was aware of risks to herself from the perpetrator and for the practitioner not to pursue a line of enquiry was not effective practice.

6.1.15 This lesson is reflected in Recommendations: F, V, W, X and AL.

6.1.16 **Lesson 2. Training**. The review showed that many practitioners do not understand the complexities of domestic abuse and as a result they are not always professionally curious and do not conduct routine explorations of domestic abuse and stalking with the person or family they are dealing with. By receiving such training practitioners will better understand domestic abuse within the context of their normal role and how therefore a victim and perpetrator may present. Previous reviews have shown that for the training to be effective it needs to be face to face as opposed to a short online eLearning package. Whilst it is recognised that for some agencies there is a shortage of staff and therefore a reliance on temporary bank and agency staff it is incumbent for agencies to ensure that there is a thorough induction to organisational systems, processes and domestic abuse training.

6.1.17 Bromley Healthcare have identified that Health Visitors need to have further training in respect of domestic abuse in order to understand its complexities. They also identified that they must make enquiries about domestic abuse with the families separately and in a safe setting.

6.1.18 Kings College Hospital (KCH) NHS Foundation Trust found that there were no clear guidelines for the Emergency Department in particular to routinely exploring issues of domestic abuse with all patients and that there is no consistency in approach to domestic abuse victims across the 24 hour period within the Emergency Department even when IDVA's or social workers are on site.

6.1.19 The South London and Maudsley NHS Foundation Trust (SLaM) have recognised that due to a lack of understanding of Domestic Abuse staff missed opportunities to signpost Louise to local domestic abuse services, they did not conduct proper risk assessments when domestic abuse is identified (SLaM staff are not DASH trained) and therefore did not consider a Safety Plan thereafter.

6.1.20 The Metropolitan Police Service need to take a wider view of the potential offences committed including coercive control and stalking and conduct the necessary investigation and safeguarding. This will only occur if officers and staff receive domestic

abuse and stalking training. Officers should have considered pursuing a coercive control investigation linked into a stalking investigation as Louise was the victim of the offences she alleged after she and David had separated. Coercive control behaviours can be included as part of the evidence when conducting a stalking investigation. Neither coercive control nor stalking offences were considered either in the recording of the offences or in their investigation. Had these offences been investigated then a more thorough investigation and therefore a better of the risks the victim and the children were enduring would have been realised.

6.1.21 This lesson is reflected in Recommendations: Two, Three, F, M, Q, R, T, Y, AB, AC, AD and AJ

6.1.22 **Lesson 3. Record Keeping.** The review has shown that whilst records are generally kept of meetings with organisations clients/patients/service-users they are not detailed enough in terms of the areas that were covered with the victim, the decisions made and the rationale for those decisions. This therefore means that proper safeguarding is unable to take place due to not enough information being collected to formulate a robust safety plan/risk management plan. Additionally, other practitioners (including supervisors) who continue to work with the victim are ill-prepared, meaning the victim has to constantly repeat themselves to different practitioners (a common complaint amongst survivors of domestic abuse) or incorrect safeguarding decisions are taken.

6.1.23 CCCG note that documentation of some consultations with the GP highlight some missed opportunities when the GP could have explored the reasons for Louise becoming irritable with David and how Louise felt about David working 7 days a week.

6.1.24 Croydon Health Services identified that there needs to be clear documentation of the submission of the MASH referral and notification to the Liaison HV regarding attendance as this can alter the outcome of the attendance and other services can be initiated.

6.1.25 Croydon Children Social Care (CCSC) identified that there was is no evidence of discussions held with Child A and Child B about their lived experience although it was known that they had witnessed domestic abuse incidents and whilst it is accepted that the allocating manager may have made an initial decision based on their not being a long standing history of referrals to children's social care and this may have informed their analysis and judgment, what was not fully considered was the historical information shared with the police and the increased trajectory of risk contained in the second referral or safeguarding in respect of the Louise also.

6.1.26 This lesson is reflected in Recommendations: E, H, I, J, K, P, Z, AE, AG and AM

6.1.27 **Lesson 4 Information Sharing.** The review shows that organisations held information on Louise, David and Child A and B which, if shared, could have assisted in understanding that domestic abuse and stalking were present. This would have

allowed a better understanding of what was happening within Louise's life and as a result informed actions and safeguarding measures could have been taken. Even within the same organisation information has not always been shared or systems interrogated to ascertain such information. The MARAC process generally works well to protect victims of domestic abuse and stalking because there is a multi-agency response to it. Whilst the MARAC process is for those victims that are assessed as High Risk the basis of sharing information is key and therefore it is incumbent on organisations to make enquiries not just within their own organisations but others equally within the Information Sharing Agreements they should hold. As a result of the review CCCG recognise that Partnership working between practitioners in primary care, health visitor, Police (MAPPA) and social care needs to be evidenced fully.

6.1.28 Croydon Health Services noted that whilst Louise was able to share and disclose her past medical and mental health history with some professionals. There needs to be improved communication pathways so as to assist with earlier identification; and information sharing of issues and concerns.

6.1.29 This lesson is reflected in Recommendations: A, B, L, N, O, W, AI and AK

6.1.30 **Lesson 5 Separation**: It is known that the issue of separation can lead to increased risks in the area of domestic abuse. The division of one household into two will normally bring about the need for housing, Louise raised housing as an issue with her GP as a being a cause of stress in 2013. In 2017 she made an application for housing from Croydon Housing Services. There was no section within the application to prompt the applicant to record any concerns on domestic abuse. Within three months of that application the review established that Louise had drafted, but not submitted, a divorce application citing David's domestic abuse. It is hard not to conclude that if she were given the opportunity to outline abuse from David in her housing request she would have used it.

6.1.31 The chair spent time trying to establish a link between the divorce application process coming into civil courts and the opportunity for referral to local domestic abuse services, when appropriate. The chair was informed initial applications for divorce are not always handled in local courts.

6.1.32 This lesson is reflected in Recommendation: One.

7. Recommendations:

7.1 Single agency recommendations

7.1.1 **Bromley CCG**

7.1.2 **Recommendation A:** To enable a learning event for GPs on parenting capacity to give further skills in both assessing this and how to refer to early intervention services.

7.1.3 **Recommendation B:** To encourage use of the social prescriber within a Primary Care Network to facilitate onward referrals to aid patients who are suffering from social deprivation factors. Social prescribing allows GPs to refer patients to non-clinical services, with the aim of helping then to take greater control of their own health. Social prescribing came into place after these events this is an 'actioned' learning point.

7.1.4 **Bromley GP Practice**

7.1.5 **Recommendation C:** GPs to ask direct question about domestic abuse if a woman has depression in the perinatal period.

7.1.6 **Recommendations D:** Practice to maintain IRIS accreditation

7.1.7 **Bromley Healthcare (BHC) Universal Health Visiting and School Nurse**

7.1.8 Bromley Healthcare has not been commissioned to provide a Health Visiting Service in the Borough of Bromley since October 2017. Therefore, these recommendations will be applied to the 0-19 Children's Public Health Service which is provided by Bromley Healthcare.

7.1.9 **Recommendation E**: To identify current Health Visiting practice around enquiry of domestic abuse and how this is documented in records.

7.1.10 **Recommendation F:** To update level 3 safeguarding children training and provide additional research/evidence from DHR's/SCR's which highlight the importance of asking about domestic abuse and the 'hidden' signs.

7.1.11 **Bromley Healthcare (BHC) IAPT**

7.1.12 **Recommendation G:** IAPT to ensure that GP's are sent a list of alternative services that the patient can be signposted to that relates to the issues identified in the referral if the patient no longer wishes to engage or take up the service.

7.1.13 **Recommendation H:** Supervisors within IAPT to have access to the EMIS (electronic clinical records used by other BHC services). To ensure that all information can be accessed and reviewed when reviewing a referral and before discharge.

7.1.14 **Croydon CCG**

7.1.15 **Recommendation I:** Recordkeeping to capture follow-up discussions practitioners in primary care are having with other statutory partners and this could be incorporated in audit programme at GP practices

7.1.16 **Recommendation J:** Apply good recordkeeping standards by making records at the time the events happen, or as soon as possible afterwards

7.1.17 **Recommendation K:** GPs to exercise professional curiosity to ensure that reasons for injuries sustained by young children do correspond with the actual injury

7.1.18 **Recommendation L:** All GP practices to ensure the DASV lead attend and fully engage at the safeguarding leads forums facilitated by the safeguarding team in the CCG

7.1.19 **Recommendation M:** All staff in primary care to receive on-going basic training on domestic abuse as part of the safeguarding training

7.1.20 **Recommendation N:** Adopt the IRIS model to improve the GPs' response to domestic violence and abuse (DVA)

7.1.21 **Croydon Health Services**

7.1.22 **Recommendation O:** Develop, implement and embed a Family Health Needs Assessment (FHNA) model or tool that is used in CUS into all services provided by CHS, regardless of how brief the involvement, so as to assist with earlier identification and information sharing of issues and concerns.

7.1.23 **Recommendation P:** Undertake a recordkeeping audit 12 months after implementation of the FHNA to review and monitor success.

7.1.24 **Recommendation Q:** Review all safeguarding training to ensure that a Think Family approach is embedded into service delivery.

7.1.25 **Recommendation R:** Review safeguarding training to encourage professionals to develop deeper critical thinking and to display professional curiosity, to assist with earlier identification of issues and concerns.

7.1.26 **Recommendation S:** Implementation of a group supervision model across all adult services within CHS.

Update: Croydon University Hospital Emergency Department now have a toolkit that was ratified in 2019 by the Governance Committee and the Named Nurse for Safeguarding Children has presented the toolkit to medical practitioners working within

the Emergency Department. It will be kept under review by the Safeguarding Adult and Children's teams.

7.1.27 **Kings College Hospital NHS Foundation Trust (KCH)**

7.1.28 **Recommendation T:** Continued work within the Trust to raise awareness with regards to domestic abuse. The Safeguarding service will address this by providing weekly core skills training for trust employees, Domestic Abuse awareness days, the first of which was held in September 2019.

7.1.29 **Recommendation U:** The Safeguarding service has had discussions with the Emergency Department (ED) consultant who is the lead for Adult Safeguarding as to how to discuss how routine questioning around domestic abuse when a patient is triaged can take place but particularly within emergency departments. (It is already in place in maternity) The consultant will be speaking with the ED lead to discuss this further and will report back to the Safeguarding service.

7.1.30 **London Borough of Croydon Children Social Care (CCSC)**

7.1.31 **Recommendation V:** Social workers and team managers in assessment service to access DASH Risk Assessment training through the Croydon Safeguarding Children Partnership.

7.1.32 **Recommendation W:** Social workers to check with Police if a 124D risk assessment was completed when receiving referrals in respect of domestic abuse/ violence

7.1.33 **Recommendation X:** Social workers will be encouraged to speak to the domestic abuse specialist about cases where they are unsure about process or completing risk assessments. (Specialist workers to attend Team Meetings – By November 2019)

7.1.34 **Recommendation Y:** Social workers attend the current training offered on different aspects of domestic abuse, facilitated by the domestic abuse specialist. This training will enhance social worker's knowledge and understanding about domestic abuse and its impact on the victim and children. (Service managers and Team managers to identify and action)

7.1.35 **Recommendation Z:** Training support and development on what makes a good and thorough C&F assessment aimed at social workers and managers.

7.1.36 **London Borough of Croydon Housing Services**

7.1.37 **Recommendation AA:** That the online application for Housing Register cases is reviewed and question added to ask the applicant if they are experiencing any kind of abuse. That a question is added to ask if the applicant feels safe in their home environment**.** That a section is added for other information to be taken into account.

7.1.38 **Recommendation AB:** Housing Staff to complete DVAS training via the FJC.

7.1.39 **Metropolitan Police Service (MPS)**

7.1.40 **Recommendation AC:** That the South BCU Senior Leadership Team debrief the staff involved in the initial response, primary and secondary investigation of the incident dated 01 January 2017.

7.1.41 **Recommendation AD:** That the South BCU Senior Leadership Team dip sample the initial response, primary and secondary investigation of a sample of similar incidents/allegations within the BCU to establish what, if any further work is required to assist staff.

7.1.42 **Primary School**

7.1.43 **Recommendation AE:** Significant conversations with parents to be recorded on the schools online 'Class log book'. This will be passed up to each teacher to ensure that any concerns raised in previous years can be considered.

7.1.44 **South London and Maudsley NHS Foundation Trust (SLaM)**

7.1.45 **Recommendation AF:** The Croydon Home Treatment Team to implement a clear system of task assignment and oversight arising from Clinical Review meetings to ensure that there are no delays in the completion of tasks

7.1.46 **Recommendation AG:** The Croydon Home Treatment team to revise the current system of updating care plans and risk assessment documentation to reflect risk levels and change in care needs so that these are completed at the time of identified risk changes

7.1.47 **Recommendation AH:** HTT Service Lead in collaboration with borough safeguarding lead to appraise current system of identifying events that meet the threshold for safeguarding referrals and a more robust system of discussing concerns within the team. To be outlined in operational policy

7.1.48 **Recommendation AI:** The Croydon Home Treatment Team to provide training/support in the completion of MASH referrals to ensure that concerns are appropriately documented. This will be reinforced with a request for a training session at a Croydon Borough Safeguarding meeting, to be led by a member of staff from CSC.

7.1.49 **Recommendation AJ:** The Trust to review current training provision relating to all domestic violence and abuse, including content in other safeguarding mandatory training, delivered trust-wide. This should include routine enquiry and consideration of safety planning and MARAC referrals

7.1.50 **Recommendation AK**: The Trust to build on its' current progress in raising awareness around DVA approaches to gathering additional information and pathways to follow once DV identified.

7.1.51 **Victim Support (VS)**

7.1.52 **Recommendation AL:** All front line staff to have Domestic Abuse risk assessment training to ensure confidence of usage and quality of completion.

7.1.53 **Recommendation AM:** Heads of Service have agreed to explore an alternative way to flag Domestic Abuse cases to ensure that automatic SMS text message is not sent out rather than the current practice of changing Domestic Abuse and Sexual Violence cases to 'high' risk upon receipt of referral. VS need to adopt accurate recording of risk levels, including notification of when a risk assessment has been refused and why. The Head of Service for domestic abuse services in London to work with the wider London Management Team to ensure this recommendation is considered.

7.2 Panel Overview Report Recommendations

7.2.1 **Overview Report Recommendations**

7.2.2 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Croydon Community Safety Partnership within six months of the review being approved by the partnership.

7.2.3 **National Recommendations**

7.2.4 **Recommendation One:** The Home Office to review the processes in place for County Courts and Matrimonial Hearings to ensure that information is provided to both parties on the availability of domestic abuse services. If appropriate provide guidance through the appropriate legal office.

7.2.5 **Recommendation Two:** NHS England to review guidance for NHS professionals working in Mental Health Services to consider cases where an abusive partner could attempt to exert control through the manipulation and threat of using the Mental Health Act framework. Consideration should be given to the provision of mandatory training on Domestic Abuse for NHS Staff that is separate to the current Safeguarding Adult and Safeguarding Children training.

7.2.6 **Local Recommendations**

7.2.7 **Recommendation Three:** The Safer Croydon Partnership to ensure that there is a commitment at a senior level within Croydon Housing Services to the DHR process. This should also include a training needs analysis for members of staff completing IMRs.

Appendix 1: Terms of Reference

Domestic Homicide Review Terms of Reference: Case of Louise

This Domestic Homicide Review is being completed to consider agency involvement with Louise and David following the death of Louise in May 2018 the Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Louise and David during the relevant period of time March 2012 to May 2018 (inclusive). To summarise agency involvement prior to March 2012.
2. 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.
3. To 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.
4. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
5. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
6. To contribute to a better understanding of the nature of domestic violence and abuse.
7. To highlight good practice.

Definitions: Domestic Violence and Coercive Control

8. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross government definition states that 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."

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

9. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Louise and David (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child). There were no local area characteristics identified.
10. The Review Panel identified the following protected characteristics of Louise and of David as requiring specific consideration for this case; Sex, Pregnancy and Maternity and Disability.
11. The following issues have also been identified as particularly pertinent to this homicide: - Substance Misuse, Mental Health, Economic Abuse, Separation, and Stalking (including Cyber stalking).
12. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' Definition in Section 42 the Care Act 2014: "An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over, who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

    Abuse is defined widely and includes domestic and financial abuse. These duties apply regardless of whether the adult lacks mental capacity.

    The conclusion by the panel is neither party is an "Adult at Risk".
13. *Expertise:* The Review Panel will therefore invite representatives for agencies dealing with, substance misuse, economic abuse, and cyber stalking to the panel as an expert/advisory panel

member to the chair to ensure they are providing appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide. Consideration on agencies dealing with disabilities will be considered on review of evidence supplied by health representatives on panel.

14. If Louise and David have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with those communities.
15. The CSP/Chair of Review/other panel member will make the link with relevant interested parties outside the main statutory agencies.
16. The Review Panel agrees it is important to have an intersectional framework to review Louise and David life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Collating evidence

17. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
18. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Louise and David and their children during the relevant time period:
    a. Croydon Clinical Commissioning Group (CCG)
    b. Croydon Health Services
    c. Croydon Housing
    d. MPS
    e. South London and Maudsley NHS Trust
    f. Victim Support Croydon
    g. Bromley CCG
    h. Kings College NHS Foundation Trust - Bromley Princess Royal Hospital
    i. Oxleas NHS Foundation Trust – Mental Health Services Bromley

19. 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 Louise, David and their children in contact with their agency.

Key Lines of Inquiry

20. In order to critically analyse the incident and the agencies' responses to Louise and/or David, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Louise / David 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 policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Analysis should pay particular attention to the following issues: - Substance Misuse, Separation, Financial Abuse, Stalking and use of technology, and Self-Harm.

    As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

21. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to the Community Safety Partnership on their action plans within six months of the Review being completed.
22. Community Safety Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

Media handling

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

Confidentiality

25. 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.
26. 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.

Appendix 2: Action Plan

No	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
Bromley CCG (7.1.1)							
A	To enable a learning event for GPs on parenting capacity to give further skills in both assessing this and how to refer to early intervention services.	Plan a learning event. Signpost to Peri-Natal Mental health team	Learning Event conducted on 24.03.2020	Interactive training event delivered by the Perinatal Midwife Mental Health team Referral pathway for GPs highlighted	Named Safeguarding GPs	24.03.2020	Learning Event conducted 24.03.2020 and Referral Pathways for GPs on the Perinatal Mental Health pathway in the annual safeguarding agreement to Primary Care.
B	To encourage use of the social prescriber within a Primary Care Network to facilitate onward referrals to aid patients who are suffering from social deprivation factors. Social prescribing allows GPs to refer patients to non-clinical services, with the aim of helping then to take greater control of their own health.	This has been actioned	Social Prescriber now available via Primary Care Networks	Improved mental health and physical wellbeing for patients Connect more patients to existing community groups	Primary Care SELCCG-Bromley	completed	Social Prescribing is now embedded in GP practices in Bromley and there is a referral form accessible electronically on the Referrals Optimisation Protocol. This process is now available to all Bromley GPs.

	Social prescribing came into place after these events this is an 'actioned' learning point.						
Bromley GP Practice (7.1.4)		Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
C	GPs to ask direct question about domestic abuse if a woman has depression in the perinatal period.	Safeguarding lead at practice to discuss learning points at Practice Education Meeting in February 2020.	Actioned	Increased safety for pregnant women and more opportunity for them to disclose. GP's are in regular contact with their AE for IRIS and continue to ask questions around mental health and pregnancy in patients.		Completed.	This is also covered in the risk indicators training covered by IRIS: SPECSSS (Separation, Pregnancy, Escalation, Cultural Issues, Stalking, Strangulation, Sexual assault) This learning outcome is specific to the affected GP Practice. The IRIS programme covers this area for Bromley GPs as part of a standardised training package.
D	Practice to maintain IRIS accreditation	Practice Manager to book update to IRIS, last	March 2020-21 there were 100 IRIS referrals for the Bromley area	Practice continues to be accredited to IRIS.		Update training received 2020.	Completed. This is a Local Recommendation relevant to the GP Practice involved.

		update at March 2020.	and 5 referrals from the affected GP Practice				IRIS training update included training on the importance of seeing patients on their own, not using family members as interpreters, not acting as a mediator between patients, and not relaying information to family members/community members. They also do a section within their training on supporting perpetrators and how best to respond to them/where to refer them.
Bromley Healthcare (BHC) Universal Health Visiting and School Nurse (7.1.7)		Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
E	To identify current Health Visiting practice around enquiry of domestic abuse and how this is documented in records.	To complete a health visiting audit		The HV audit highlighting a small study of 20 mothers with young children was completed in June 2020.	Sandra Anto-Awuakye Safeguarding Children Advisor	Audit feedback to Health Visiting Team Dec 2020/Jan 2021	Actions/Outcomes that were completed after the DHR. An audit was completed addressing Health Visitors clinical practice on asking and documenting about Domestic Abuse to Mother's in pregnancy until Infant's first birthday. The audit was completed in July 2020: Feedback to Health Visiting Staff: There have been 3 feedback sessions to Health Visiting Teams on the outcomes of the audit was undertaken within the Health Visiting teams. An outcome of the audit was to develop SoC presentation as 'Charlotte's Story'

							which summarised events and circumstances leading to death of SoC. ➢ The presentation of Charlotte's story was delivered virtually on MST Health Visiting teams 2020/2021. ➢ Overview of the outcomes from the Audit indicating a strong response of question's being asked from pregnancy to first year of a child. ➢ The data from 20 records/documentation indicated over 50% asked/documented Q's/responses about domestic ➢ The reason why this was not a higher percentage HV's did not ask when family members/partner's were present at the first opportunity. ➢ Debate raised; research evidence advises Women must be asked in a private/confidential space.

							➢ Discussion around COVID-19 Pandemic 'Hidden Harm' reduced acess face-face with parents. Discussed about family safety whilst partner is present – An opportunistic time to ask about DA. ➢ Other areas highlighted in training: DA triggers and warning signs addressed at feedback. Talking through symptoms/triggers. ➢ Professional curiosity required to unmask Hidden Harm ➢ Recognition and importance of sharing information with GP's/Allied Health Professionals/Adult Nursing etc
F	To update level 3 safeguarding children training and provide additional research/evidence from DHR's/SCR's which highlight the importance of asking		 DHR Soc Presentation 2020.p				Bromley Healthcare will continue to discuss the impact of domestic abuse and the effects on mental health and emotional wellbeing of children in our Level 3 safeguarding training and at safeguarding supervision as per our Safeguarding policy and safeguarding supervision policy.

	about domestic abuse and the 'hidden' signs.						➢ BHC will continue to use our supervision templates to highlight the risks for the families with clear actions plans to support families and children. ➢ We will continue to keep a "Think Family Approach" (Think child, think parent, think family" Social Care Institute for Excellence, SCIE, 2012) ➢ BHC Safeguarding Team have a Bi-monthly news update and the highlight for January 2020 was on domestic abuse, coercive controlling behaviours, routine enquires,. ➢ Support for families and reminding BHC staff of the Domestic Abuse Policy. BHC to continue to encourage staff to be professionally curious. This is part of BHC Level 3
Bromley Healthcare (BHC) IAPT (7.1.17)							

G	IAPT to ensure that GP's are sent a list of alternative services that the patient can be signposted to that relates to the issues identified in the referral if the patient no longer wishes to engage or take up the service.	Discharge summary shared with patient and GP which includes the service the patient has been signposted to as stated in the TtB Sign posting resource.	Discharge Template Individual patient's record	Pts and GP are informed of alternative services	Sarah Medford	Dec 2020	When patients are discharged from the service, either through completion on treatment, dropping out of treatment, or not engaging with the service – the discharge letter will signpost patients to other relevant services for support. In the case of domestic violence, where known about, the service would not include this in the letter as it may escalate risk for the patient.
H	Supervisors within IAPT to have access to the EMIS (electronic clinical records used by other BHC services). To ensure that all information can be accessed and reviewed when reviewing a referral and before discharge.	EMIS accounts to be set up and training to be provided by the EMIS team	EMIS cards and access for all IAPT supervisors	All IAPT supervisors have the provision and training to access clinical records on EMIS	Sarah Medford	Feb 2021	The Clinical Supervisors are yet to be provided with access to EMIS. This has been escalated.
Croydon CCG (7.1.20) Recommendation		Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
I	Recordkeeping to capture follow-up discussions practitioners in primary care are having with other statutory partners and this could be incorporated	Recordkeeping audits	Multidisciplinary discussions through the huddles are evidence of collaborative	Strong leadership and accountability at huddles discussions	Safeguarding lead and Practice Manager		In 2017 the Clinical Commissioning Group (CCG) in Croydon has done some significant work with colleagues in primary care and ensured that there are DASV leads across GP practices. FJC and the

	in audit programme at GP practices		working with key statutory partners. Quality alert system allows GPs to raise issues about secondary care with the CCG	Feedback about the engagement by the Practice from statutory partners.			safeguarding teams in the CCG disseminate all information related to domestic abuse to these leads in GP practices across Croydon. DASV leads share learning at team meetings and peer supervision within the practice.
K	GPs to exercise professional curiosity to ensure that reasons for injuries sustained by young children do correspond with the actual injury	The practice will continue to learn about the effects of physical on mental health and vice versa. We will ensure that we follow up on requests for physical health check requests	Ongoing NICE guidance is saved onto the shared drive for access by everyone in the practice. As well as discussion at clinical meetings of any new learning	The practice ensures it follows NICE guidance and safeguarding toolkits available via the Royal College of GPs	Safeguarding lead Dr Debbie Berry and Dr Mary Onianwa DASV lead Dr Debbie Berry	10/12/2020	The practice contacts SLAM via a secure email address or if urgent via a telephone number. The practice agrees that if there is a possibility of safeguarding then the practice will contact the named leads for advice and follow their guidance. Safeguarding leads ensure that they are up to date with any changes to guidance. Safeguarding is also discussed at clinical meetings were appropriate. Huddles are also used as a form of support We have tried to obtain speakers on MH for patient talks which are both useful to staff and patients alike. This has proved difficult.
Croydon CCG (7.1.20) Recommendation		Key Action	Evidence	Key Outcomes	Named Officer	Date	Update

L	All GP practices to ensure the DASV lead attends and fully engage at the safeguarding leads forums facilitated by the safeguarding team in the CCG	The practice continues to attend safeguarding forums and training provided by CCG and FJC, Croydon domestic abuse service.	Individuals training records	Continue to maintain up to date safeguarding training	Safeguarding lead in post since 2018	10/12/2020	All clinicians have undertaken adult and children safeguarding online training and when provided physical training. Training flyer for staff to access safeguarding training is available to all staff. New safeguarding dates have been issued by Croydon. These have been passed to the clinicians whose safeguarding training will expire in 2021 Staff access training offered by local safeguarding boards via the practice manager who receives these dates and forwards on
M	All staff in primary care to receive on-going basic training on domestic abuse as part of the safeguarding training	The practice continues to attend safeguarding forums and training provided by CCG and FJC. GPs also access training offered via the Royal College of GPs.	Individuals training records	Risk assessment Referrals to FJC Flagging of clinical records	Safeguarding lead and Practice Manager	Ongoing	The RCGP learning sessions include training about domestic abuse. NICE guidelines such as Domestic violence and abuse Quality standard [QS116] is available to GPs
N	Adopt the IRIS model to improve the GPs'	MOPAC/IRISi introduce 7B	To date over 30 surgeries have	There have been 46 referrals to	DASV Coordinator	Ongoing	Funding has now been extended to March 2022.

	response to domestic violence and abuse (DVA)	IRIS model in Croydon September 2020	signed up for IRIS training of which 17 are fully trained.	date to AE's and 10 MARAC referrals. This is meeting the KPI's set by IRISi.			The CCG in partnership with the FJC, Croydon domestic abuse service and Bromley and Croydon's Women Aid will approach SW CCG to commit to further funding to ensure sustainability.
Croydon Health Services (7.1.30)		Key action	Evidence	Key outcomes	Named Officer	Date	Update
O	Develop, implement and embed a Family Health Needs Assessment (FHNA) model or tool that is used in CUS into all services provided by CHS, regardless of how brief the involvement, so as to assist with earlier identification and information sharing of issues and concerns.	To develop a safeguarding Think family toolkit	 Safeguarding Toolkit_CHS.pdf Notes taken to capture discussion at daily huddles Data collection to feed into safeguarding governance process Patient's clinical records	The toolkit is well embedded and that all staff are applying it in practice, able to identify risk and vulnerabilities and take action to safeguard individuals and families and ensure appropriate support is in place.	Associate Director Safeguarding	March 2020 due for review 2023	Croydon University Hospital Emergency Department now have a toolkit that was ratified in 2019 by the Governance Committee and the Named Nurse for Safeguarding Children has presented the toolkit to medical practitioners working within the Emergency Department. It will be kept under review by the Safeguarding Adult and Children's teams. Since October 2020 daily safeguarding huddles are established, and the safeguarding team has regular discussions with staff to improve outcomes for patients

			Safeguarding supervision notes held on the shared drive Data collection about the concerns, demographics, categories of abuse raised at the huddles				
		Key Action	Evidence	Key Outcomes	Named Officer	Date	Outcome
P	Undertake a recordkeeping audit 12 months after implementation of the FHNA to review and monitor success. Compliance with a Think Family approach.	Recordkeeping audit to be completed across adults and children safeguarding	Outcome of the audit in a form of a report and shared via the CHIST governance process.	The toolkit is well embedded and that all staff are applying it in practice, able to identify risk and vulnerabilities and take action to safeguard individuals and families and ensure appropriate support is in place.	Associate Director Safeguarding	Completed	This has not been completed but will be included in next cycle of audit activity. 1. Clinical records are reviewed by safeguarding professionals as part of the daily huddles 2. Recordkeeping audit is pending 05.10.21. Domestic abuse audit undertaken by Public health nursing team and outcome shared with safeguarding team. The audit shows

							the need for improvements. Routine enquiry introduced in maternity.
		Key Action	Evidence	Key Outcomes	Named officer	Date	Outcome
Q	Review all safeguarding training to ensure that a Think Family approach is embedded into service delivery	Training compliance captured on a quarterly quality assurance framework Copies of the toolkit disseminated to all staff across acute and community	Completed multi-agency referral form (MARF) saved on the shared drive. How is this evidence – please include an explanation. MARAC paperwork uploaded onto the electronic patient records and saved on shared drive. Safeguarding professionals did a presentation at Croydon Cares to raise awareness about the toolkit.	There is representation by safeguarding adults and children at the daily safeguarding huddles All practitioners should include a think family approach to all assessments and consider any member of the family who is affected by the presenting issue or ability to provide safe parenting to ensure they are safe and receive	Associate Director Safeguarding	Ongoing	As part of ongoing workplans reviewing of the training delivery is an ongoing process. The safeguarding professionals incorporate the learning from statutory reviews into training delivery 5.10.21: As part of ongoing work plans reviewing of the training delivery is an ongoing process. The safeguarding professionals incorporate the learning from statutory reviews into training delivery There is representation by safeguarding adults and children at the daily safeguarding huddles All practitioners should include a think family approach to all assessments and consider any member of the family who is

			November 2019 the Head of Safeguarding presented and introduced the toolkit to members of the safeguarding steering groups which are attended by heads of service across acute and community	appropriate support.			affected by the presenting issue or ability to provide safe parenting to ensure they are safe and receive appropriate support.
		Key Actions	Evidence	Key Outcomes	Named Officer	Date	Outcome
R	Review safeguarding training to encourage professionals to develop deeper critical thinking and to display professional curiosity, to assist with earlier identification of issues and concerns.	Reviewing all learning opportunities to improve the quality of training on induction, update training and safeguarding supervision.	DA training delivered by hospital based Independent Domestic Violence Advocate (IDVA) Learning from statutory reviews such as Safeguarding	Training packages for Induction, bespoke training and update training contain information relating to domestic abuse Case reflection model developed and embedded in	Associate Director Safeguarding IDVA	Ongoing	Forms part of the workplans for safeguarding professionals and the IDVA 10.05.21 Training packages for Induction, bespoke training and update training contain information relating to domestic abuse.

		Safeguarding teams to continue reviewing the evaluations/ reflections staff complete after training.	Adult Reviews (SARs). Visibility and leadership of the safeguarding professionals.	order to support staff understanding of domestic abuse and the impact on individuals and families and improve practice. Development of an effective safeguarding duty desk which allows the opportunity to explore issues and promote liaison with other key services (homeless health, Mental Health, LD, Redtread and Dementia). The named nurse, Children and Adolescent liaison HV and the designated nurse for SGC facilitate a forum where			Case reflection model developed and embedded in order to support staff understanding of domestic abuse and the impact on individuals and families and improve practice. Development of an effective safeguarding duty desk which allows the opportunity to explore issues and promote liaison with other key services (homeless health, Mental Health, LD, Redthread and Dementia). The named nurse, Children and Adolescent liaison HV and the designated nurse for SGC facilitate a forum where clinical staff undertake safeguarding case reviews. The Children and Adolescent liaison Health Visitor provides supervision to clinicians on a monthly basis to strengthen reflective practice and improve service delivery.

				clinical staff undertake safeguarding case reviews. The Children and Adolescent liaison Health Visitor provides supervision to clinicians on a monthly basis to strengthen reflective practice and improve service delivery			
S	Implementation of a group supervision model across all adult services within CHS.	Safeguarding professionals are applying the Toni Morrison 4x4 model to approach the supervision sessions	Record of the ad hoc supervision sessions are stored on the shared drive. Safeguarding professionals meet with the community	Improvements in the knowledge and skills of staff across acute and community setting. Safeguarding professionals raise awareness about other support services such as	Associate Director Safeguarding	Ongoing	10.05.21: The work of safeguarding supervision is expanding. Improvements in the knowledge and skills of staff across acute and community setting. Safeguarding professionals raise awareness about other support

				Redthread which ensure better outcomes for			services such as Redthread which ensure better outcomes for.
KCH NHS Foundation Trust (7.1.37)		Key Actions	Evidence	Key Outcomes	Named Officer	Date	Outcomes
T	Continued work within the Trust to raise awareness with regards to domestic abuse. Domestic Abuse awareness days, the first of which was held in September 2019.	The Safeguarding service will address this by providing weekly core skills training for trust employees,					Email sent for update on the 4th, 17th and 25th of November. No response. To date.
		Domestic Abuse awareness days will be organised		This was held in September 2019			What was the outcome? How many attended? Has there been any more?

U	The Safeguarding service has had discussions with the Emergency Department (ED) consultant who is the lead for Adult Safeguarding as to how to discuss how routine questioning around domestic abuse when a patient is triaged can take place but particularly within emergency departments. (It is already in place in maternity) The consultant will be speaking with the ED lead to discuss this further and will report back to the Safeguarding service.						This need to be made in a SMART action please.
London Borough of Croydon Children Social Care (CCSC)1.41 (o7. 7.1.41)		Key Evidence	Evidence	Key Outcomes	Named Officer	Date	Outcomes
V	Social workers and team managers in assessment service to access DASH Risk Assessment training through LSCB. (Head of	Introduce mandatory training for all social workers at Croydon Council	Mandatory training is now in place across the council	Social Workers will be able to explore and understand further:	Jo George	Ongoing	Overview of those social workers and managers who have received DASH training to be provided quarterly (data to be run in January 2022 and then ongoing)

	Service to action with Service Managers)			• the evidence base that informed the DASH (2009); • the risk identification process and the high risk factors for serious harm and homicide; • how this relates to the risk management including MARAC/MAPPA • how the model fits into the wider public protection framework; • the profile of the domestic violence perpetrator and nature of serial offending, and;			Training continues to be provided on a regular basis and staff are expected to attend as this is core training

				• lessons learned from homicide reviews using case studies.			
W	Social Workers to check with Police if a DASH risk assessment was completed when receiving referrals in respect of domestic abuse/ violence		Practice guidance is in place and embedded (evidenced in audits)		Julie Daley Charles Donkoh		SPOC staff are aware they need to request this information when a MERLIN is received and a reminder was sent out to the service in November 2021 An agreed process or practice guidance for when a DASH risk assessment should be completed by a social worker to be developed by March 2022
		Key Actions	Evidence	Key outcomes	Named Officer	Date	Outcomes
X	Social workers will be encouraged to speak to the domestic abuse specialist about cases where they are unsure about process or completing risk assessments.		Social workers and managers report they are confident about how they can get support and advice	Increased awareness of the role of the FJC for social workers. Further understanding of RIC and internal process for	Charles Donkoh Jo George	January 2022	Social workers and team managers liaise with FJC for advice and guidance The domestic abuse specialist role no longer exists Practice guidance about working with families where domestic abuse

		FJC to provide Quarterly DASV Newsletter to the Director to of Social Care to share.	DASV Bulletin October 2021FINAL.	referring to MARAC Quarterly newsletter provides up to date information about MARAC and the FJC in every issue.	Ciara Goodwin	4 times a year.	is a factor will be reviewed in January 2022 Development of service 'champions' and recruitment of practice improvement officers underway Training on risk assessments and safety planning to be delivered from January 2022
Y	Social workers attend the current training offered on different aspects of domestic abuse, facilitated by the domestic abuse specialist. This training will enhance Social Worker's knowledge and understanding about domestic abuse and its impact on the victim and children. (Service managers and Team managers to identify and action)	SW must attend mandatory training which is facilitated by the children safeguarding board and delivered by the FJC.	Numbers to be provided by CSCP.	• Understand what domestic abuse is • Increased awareness and signs of domestic abuse • Assessment of risk • The role of the Family Justice Centre • Understanding the risk and impact on babies,	Donna Kinsley Jo George	December 2021	Domestic abuse specialist post has been deleted. An on line course is offered via the FJC. This is new so numbers won't be relevant yet and won't identify what role the attendee is The partnership's Learning Improvement Group is being resumed from January 2022 and learning regarding domestic abuse is one of their priorities See action V

				children and Young people • Brief overview of Risk Identification Checklist and the MARAC			
Z	Training support and development on what makes a good and thorough C&F assessment aimed at Social Worker's and managers. The C& F assessment completed with the Adult T family, whilst providing some information there is a lack of analysis and a lack of thorough robust risk assessment.	SW must attend mandatory training		Increased understanding of systemic practice	Jo George		See action V All social workers and managers are required to complete the foundation course in systemic practice which supports the development of the assessment and relational skills (includes professional curiosity, understanding of the GRACES and second order change)
London Borough of Croydon Housing Services (7.1.50)		Key Action	Evidence	Key Outcomes	Named Officer	Date	Outcome
AA	That the online application for Housing Register cases is reviewed and question added to ask						Update please including actions, outcomes and evidence

	the applicant if they are experiencing any kind of abuse. That a question is added to ask if the applicant feels safe in their home environment.						
AB	Housing Staff to complete DVAS training via the FJC.	Housing Operations Managers to arrange dates to complete training.		• Understand what domestic abuse is • Increased awareness and signs of domestic abuse • Assessment of risk • The role of the Family Justice Centre • Understanding the risk and impact on babies, children and Young people • Brief overview of Risk Identification	Jo Jonnanue	March 2021	Dates are in discussion for training to take place early next year.

				Checklist and the MARAC			
Metropolitan Police Service (MPS) (7.1.55)		Key Action	Evidence	Key Outcomes	Named Officer	Date	Outcome
AC	That the South BCU Senior Leadership Team debrief the staff involved in the initial response, primary and secondary investigation of the incident dated 01 January 2017.	Debrief of staff	Debrief completed and recorded in the Specialist Crime Review Group Recommendations Grid for attention of MPS Commander for Safeguarding	Debrief completed and officers knowledge gap identified	A/DCI Ben Cockburn SN BCU	Outcome finalised on 01/02/21	Officers reminded of Golden hour principles and consideration to arrest for DA offences under positive action the importance of early identification of investigative actions, and documentation in regards to the voice of the child who would appear to have been present at the time. Officers advised that further consideration should be given to identification to implied offences such as Coercive and Controlling Behaviour, crimes identified under Computer Misuse Act, Protection from Harassment and Stalking. The officers are no longer in a response or secondary investigative roles but were reminded to ensure training in this area is refreshed. Officers were reminded of the requirement to ensure continual risk assessment throughout any investigation and

							documentation of these regular risk reviews to be made on the systems
		Key Action	Evidence	Key Outcome	Named Officer	Date	Outcome
AD	That the South BCU Senior Leadership Team dip sample the initial response, primary and secondary investigation of a sample of similar incidents/allegations within the BCU to establish what, if any further work is required to assist staff.	Dip sampling to assess performance	South BCU has created a department of officers tasked with analytical and intrusive review of all aspects of policing. This department is called the Dedicated Inspection Team (DIT) and the Public Protection side is staffed by two experienced Detectives. Their role is to dip sample and review on a monthly basis all investigations that sit within the Public Protection Portfolio and	Ongoing performance analysis reports to BCU Senior Leadership Team on monthly basis	A/DCI Ben Cockburn	Outcome finalised on 01/02/21	South BCU are fully aware that training is vital to all officers and we are especially aware that approximately 55% of our current front line officers on the Emergency Response Policing Team (ERPT) are in their probation. Domestic Abuse awareness training was given to all ERPTs including a presentation from an Independent Domestic Violence Advocate (IDVA). As a result of this review the review a Police Sergeant on each ERPT has been identified as a dedicated DA expert so that learning can be fed into the team and standards of expectation maintained. In addition to this each team has a dedicated Detective Sergeant to guide on criminal investigations. These Detective Sergeants have experience in public protection investigations. All officers have central guidance on the intranet regarding domestic violence policy and operating

			report to the strand leads with results and recommendations for further training and best practice that are identified.				procedures, subject to regular review. In recent years all officers no are deployed with laptops or computer tablets which allow them to access this guidance when they are away police stations. If officers need further guidance they can contact a Public Protection Detective Constable based in the Operation Room for the BCU who can offer guidance. If further specialist guidance is required then there are CSU officers on duty twenty-four hours a day. The CSU Teams deal with domestic abuse crimes for the BCU and we have had a number of officers on attachment over the last year from ERPT. The aim was to expose officers at an early stage of their career to experience investigating DA and have confidence in working alongside twelve experienced Detective Sergeants and our Risk Management Team who are responsible for DA crimes. Those officers on attachment will then return to the ERPT with an understanding of DA investigation

							that they can share with their colleagues. We are fully committed to training our CSU officers support them to attend the Metropolitan Police's Advanced Safeguarding Course, which is held at Hendon Training School and lasts three weeks. This courses covers assessing risk using the DASH method. DA Matters training has been scheduled for all frontline officers MPS-wide as part of their 2021 Professional Development Days
	This action was highlighted in the MPS IMR and completed in the period prior to end of the review						The panel were pleased to see that the SIO for the Adult T murder investigation launched a video campaign in December 2018 to raise awareness of domestic abuse and to encourage victims to seek help and support. The two short videos featured scenarios which illustrate typical behaviours of both victims and abusers in relation to physical abuse and coercive control. The purpose was to convey the message to victims that "you are not alone" and to encourage them to "tell someone." The videos highlight

							other medical professionals and partner agencies who can offer support alongside the police. The videos were supported by Women's Aid, Refuge, NHS England and the London Association of Directors of Adult Social Services, with the aim of being played in GP surgeries across London. This is great although it doesn't answer the two recommendations – can we have a link to the video to add to the action plan? but also actions taken, evidence and outcomes of the two recommendations please.
Primary School (7.1.600)							
AE	Significant conversations with parents to be recorded on the schools online 'Class log book'. This will be passed up to each teacher to ensure that any concerns raised in previous years can be considered						Implemented September 2019
South London and Maudsley NHS Foundation Trust (SLaM) (7.1.63)							
AF	The Croydon Home Treatment Team to implement a clear system						This is now done in the twice daily team handovers; a staff member is allocated to each task and this is

	of task assignment and oversight arising from Clinical Review meetings to ensure that there are no delays in the completion of tasks						listed on the electronic board. There is also a once weekly Clinical Review Meeting which is documented and allocates any outstanding tasks to staff with a timeframe for completion.
AG	The Croydon Home Treatment team to revise the current system of updating care plans and risk assessment documentation to reflect risk levels and change in care needs so that these are completed at the time of identified risk changes						Risk assessments and Care Plans are expected to be updated by the staff member who has reviewed the patient whenever a new risk factor/change in need is identified. This is verified and checked at each handover meeting. Risk assessments and Care Plans are also reviewed ay the clinical review meeting to ensure they are up to date.
AH	HTT Service Lead in collaboration with borough safeguarding lead to appraise current system of identifying events that meet the threshold for safeguarding referrals and a more d robust system of discussing concerns within the team. To be outlined in operational policy						HTT is now offered regular meetings with the new Safeguarding Lead. This permits the team to reflect on live cases and action plan. This has improved the education of staff. Staff are much more confident in now raising concerns with senior team members to get a steer as to whether a Safeguarding referral is required. The Safeguarding Lead is also able to reach in and provide

							support on particularly complex cases. Unfortunately, the Operational policy for Home Treatment Teams is a cross trust policy and therefore more challenging to change quickly. The change to policy has been requested via the Clinical Service Lead and the Trust Safeguarding Leads sit on the Clinical Practice Review Group meeting for Policy and will flag this up as a necessary change.
AI	The Croydon Home Treatment Team to provide training/support in the completion of MASH referrals to ensure that concerns are appropriately documented. This will be reinforced with a request for a training session at a Croydon Borough Safeguarding meeting, to be led by a member of staff from CSC.						

AJ	The Trust to review current training provision relating to all domestic violence and abuse, including content in other safeguarding mandatory training, delivered trust-wide. This should include routine enquiry and consideration of safety planning and MARAC referrals						This is covered in the trust wide training. Both Adult and Children's safeguarding training has been recently re-vamped. The trust also plans to hold another DVA conference in 2022.
AK	The Trust to build on its' current progress in raising awareness around DVA approaches to gathering additional information and pathways to follow once DV identified.						A Trust-wide inaugural DVA conference which was held in November 2019, the theme of which was Thinking Family and DVA. The conference strongly focused on lived experience (including two speakers), practice expectations, research and lessons learned from DHR's across the trust. SafeLives presented, and there were opportunities for staff to network with local DVA services. Going forward, it is hoped that future conferences will take place, and staff will be encouraged to consider possible themes in the feedback from the November 2019

							conference. This was positively attended with 145 delegates. There are plans to hold another virtual conference on 24th November 2022. There has been a trust-wide audit around DVA undertaken in 2018, focusing on practitioner's awareness and documentation. There is a new audit planned for 2022 now there is further recording systems implemented with regards to DVA within the trust
Victim Support (VS) (7.1.79)							
AL	All front line staff to have Domestic Abuse risk assessment training to ensure confidence of usage and quality of completion.	DA risk assessment training arranged through SafeLives	Triage and Complex Case Independent Witness Advocates to receive this training to ensure they are able to complete accurate risk assessments with service users presenting as service users	Front line staff to be comprehensively trained in risk assessing DA service users and be able to assess high risk factors when making professional judgements about escalation to	Rachel Nicholas Head of London Services for Domestic Abuse		Training completed in 2020 but will be ongoing as and when new starters come on board

			experiencing domestic abuse.	MARAC and IDVA services.			
AM	Heads of Service have agreed to explore an alternative way to flag Domestic Abuse cases to ensure that automatic SMS text message is not sent out rather than the current practice of changing Domestic Abuse and Sexual Violence cases to 'high' risk upon receipt of referral. VS need to adopt accurate recording of risk levels, including notification of when a risk assessment has been refused and why. The Head of Service for domestic abuse services in London to work with the wider London Management Team to ensure this recommendation is considered.				Rachel Nicholas Head of London Services for Domestic Abuse		Victim Support will be developing and implementing a new case management system in 2022. The new system will take account of recording actual risk levels after a DASH RIC has been completed.
Overview Report Recommendations (7.2.1)							
National Recommendations (7.2.3)		Key Actions	Evidence	Key Outcomes	Lead Officer	Date	Outcome

1	That the Home Office review the processes in place for County Courts and Matrimonial Hearings to ensure that information is provided to both parties on the availability of domestic abuse services. If appropriate provide guidance through the appropriate legal office.	DASV Coordinator will email HO for an update			Home Office		Email sent on the 29th June 2021 Follow up email sent on the 25th November 2021
2	That NHS England review guidance for NHS professionals dealing working in Mental Health Services to consider cases where an abusive partner could attempt to exert control through the manipulation of mental health orders.						
Local Recommendations (7.2.6)		Key Action	Evidence	Key Outcomes	Lead officer	Date	Outcomes
3	That the Safer Croydon Partnership ensure that there is a commitment at a senior level within Croydon Housing Services to the DHR process. This	DASV Coordinator to email head of Tenancy and Caretaking to	Email sent June 2021	Head of service has agreed to attend future meetings with the current housing SPOC for DHR's to	Ciara Goodwin/Sharon Murphy	June 2021	Sharon will attend future meetings. Sharon has now left the organisation. SCP have emailed the Director of housing services to

	should also include a training needs analysis for members of staff completing IMRs.	commit as a senior level		facilitate a more robust housing response to DHR's.			request representation. Email sent November 2021.
		Housing SPOC for DHR's to work with an outside agency for support around IMR's	DASV Coordinator will facilitate the partnership.	IMR's from housing will be more robust and more detailed information.	Ciara Goodwin/Jo Jonnau.	July 2021	Ongoing

Appendix 3: Glossary of terms

124D	Metropolitan Police Form for recording Domestic Incidents and Risk Assessment
AAFDA	Advocacy After Fatal Domestic Abuse
A&E	Accident and Emergency department (NHS)
ASC	Adult Social Care
C.A.D.	Computer Aided Dispatch
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CHS	Croydon Health Services
CMHT	Community Mental Health Team
CNS	Clinical Nurse Specialist
CRIS	Crime Reporting Information System – Metropolitan Police Service
CPS	Crown Prosecution Service
CRIMINT	Criminal Intelligence System – Metropolitan Police Service
CSC	Childrens' Social Care
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DA	Domestic Abuse
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model
DHR	Domestic Homicide Review
DNA	Did Not Attend – Sued by NHS for appointments
DV	Domestic Violence
ED	Emergency Department (NHS)
FLO	Family Liaison Officer
FJC	Family Justice Centre
GP	General Practitioner
HSCA	Health and Social Care Act 2008

HV	Health Visitor
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IIO	Initial Investigating Officer
IO	Investigating Officer
ISVA	Independent Sexual Violence Advisor
KCH	Kings College Hospital NHS Foundation Trust
LA	Local Authority
LAS	London Ambulance Service
LCJB	Local Criminal Justice Board
MAPPA	Multi-Agency Public Protection Agreements
MARAC	Multi-Agency Risk Assessment Conferences
MASH	Multi-Agency Safeguarding Hub
MERLIN/ACN	Metropolitan Police Service Notification of adult come to notice
MERLIN/PAC	Metropolitan Police Service Notification of child come to notice
MERLIN/MIS	Missing Person report
MHA	Mental Health Act 1983
MISPER	Missing Persons
MPS	Metropolitan Police Service
NFA	No Further Action
NHS	National Health Service
NPCC	National Police Chiefs Council (Formally ACPO)
NSPCC	National Society for the Prevention of Cruelty to Children
PNC	Police National Computer
PND	Police National Database
SARC	Sexual Assault Referral Centre
SCO	Specialist Crime and Operations (MPS)
s. 136 MHA	Section 136 of the Mental Health Act
s. 47 CA	Section 47 of the Children's Act
SIO	Senior Investigating Officer
SN	School Nurse

SLaM	South London and Maudsley NHS Foundation Trust
VCO	Victim Contact Officer
VS	Victim Support

Home Office

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20 December 2021

Dear Ciara,

Thank you for resubmitting the Domestic Homicide Review (DHR) report (Louise) for Croydon Community Safety Partnership to the Home Office. The report was reassessed in December 2021

The QA Panel felt the DHR was easy to read, well-written and sensitive, featuring involvement of family and friends which produces a good background to the case. It is clear in the report that the author has established a relationship with the friends and family of the victim. The Panel also noted the attempt to engage the perpetrator as good practice.

The report features a good exploration around the independence of the Individual Management Reviews (IMR), and the decisions made to include the information. This combined with the chronology of events make the report detailed and comprehensive. The review also features a well-considered terms of reference (ToR) with specific key questions relating to the individual cases, making the purpose of the DHR clear to the reader.

There is good learning in the review, especially through the exploration of economic abuse as a key line of enquiry and a number of appropriate recommendations for a number of agencies. The equality and diversity section is also strong, considering sex, maternity, disability and marriage.

The Home Office noted that the issues raised in the previous feedback letter following the first submission have now been addressed.

The view of the Home Office is that the DHR may now be published.

We would be grateful if you could provide us with a finalised digital copy of the report with attachments and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

Please also send a digital copy to the Domestic Abuse Commissioner DHR@domesticabusecommissioner.independent.gov.uk.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel