DOMESTIC HOMICIDE REVIEW

Bromley

“Susan”

Author: Anthony Wills

January 2015

Contents

1. INTRODUCTION

1.1 Details of the incident

1.1.1 In November 2013 Susan (the victim)[1] was found unconscious at an address in Croydon, not her home address. She had obvious head, arms and facial injuries and was unresponsive. She was transferred to Croydon University Hospital where her life was pronounced extinct. Her partner Alex was subsequently arrested and charged with her murder. He has accepted responsibility for her death and a new trial date was fixed for 2015. He has now been found guilty of murder, and was sentenced to life imprisonment with a minimum term of 20 years.

1.1.2 The immediate circumstances leading up to this death are that one morning in early November police were called by the London Ambulance Service (LAS) to attend the Croydon address mentioned above. The LAS had received a call to an unresponsive female at that location. When they arrived, Susan was found on a bed in the ground floor bedroom. She was covered by clothing and a duvet. The LAS crew noted she had obvious bruising to her head, face and arms. Alex was also present, but as they commenced caring for Susan he left the premises.

1.1.3 It appears Susan and Alex visited the address on the morning prior to the incident, left and then returned in the small hours of the next day. There was concern that they had had an argument before their initial departure. Susan looked visibly unwell and some time later the LAS were called by someone in the household.

1.1.4 On the day after the incident a Special Post Mortem was conducted at Princess Royal Hospital Mortuary. Susan's cause of death was recorded as a 'Head Injury.' The pathologist noted other injuries and it is believed that the injury was consistent with an accelerated fall as well as an assault.

1.2 The review

1.2.1 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Bromley Community Safety Partnership (CSP), Susan having lived in Bromley for all her life. The initial meeting was held on 24th March 2014 to consider the circumstances leading up to this death. The delay between the death and the first panel meeting is due to the very limited contact between those involved in this case. There were doubts within the local

[1] Pseudonyms have been used throughout this document for reasons of confidentiality. The name for the victim was chosen by the family

partnerships about the benefits of a DHR but it was finally agreed that every opportunity to learn lessons should be taken. The DHR process was then commenced.

1.2.2 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with the Home Office revised guidance.

1.2.3 From the outset it may be helpful to make it clear that Susan and Alex were not known at all, **as a couple**, to any agencies, voluntary or statutory. This review has discovered significant features in both their individual lives which are described below. These features resulted in much contact with many agencies, and it is their separate paths which has formed the most illuminating aspect of the review. The circumstances of their lives have provided an opportunity to gain an insight into the process whereby vulnerable individuals are victimised and perpetrators serially abuse their partners.

1.2.4 The panel believes that this case should have an impact beyond Bromley because of the nature of the circumstances. The reality of the risk posed by a perpetrator and the opportunities for violence by that individual towards a young woman who has had a difficult life are truths which do not belong to local boundaries.

1.2.5 To enable this learning process to take place, the information relating to previous victimisation by Alex has been mentioned. The detail of this has not been included as the panel decided that this would put the confidentiality of other victims at risk. What was also agreed was that the previous history of Alex established that he was a serial perpetrator and a very violent and dangerous man; although, all the characteristics of his violence have not been outlined in the interests of those he abused.

1.3 Terms of Reference

1.3.1 The full terms of reference are included in Appendix 1. The purpose of these reviews is to:

a. 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.

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

1.4 Parallel and related processes

1.4.1 At this stage there are no other reviews being conducted into the circumstances leading up to this death.

1.5 Panel membership

1.5.1 The Panel consisted of representatives from the following agencies:

a. London Borough of Bromley (LBB) – Domestic Abuse and VAWG Commissioner

b. LBB – Education, Care and Health Services (including children's services

c. Metropolitan Police – Critical Incident Advisory Team &Serious Crime Review Group

d. Metropolitan Police – Bromley Police (local)

e. Victim Support

f. London Ambulance Service

g. Kings College Hospital NHS Foundation Trust

h. Probation Service (subsequently the National Probation Service and Community Rehabilitation Company)

i. Bromley Healthcare

j. Oxleas NHS Foundation Trust

k. Bromley Clinical Commissioning Group

l. Croydon Clinical Commissioning Group

m. Affinity Sutton – housing provider

n. Bromley Women's Aid

o. Kent Police

p. Bromley Y

q. Glebe School, Bromley.

1.6 Independent chair

1.6.1 Following Bromley CSP's decision to undertake a Domestic Homicide Review into the death of Susan, the CSP appointed Anthony Wills, an associate of Standing

Together Against Domestic Violence as the independent chair. Standing Together is an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. Anthony has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on domestic abuse partnerships, 'In Search of Excellence'. He was also Chief Executive of Standing Together from 2006 to 2013. He has undertaken the Home Office accredited training for DHR Chairs and also worked as a police officer for thirty years, concluding his service as a Chief Superintendent. He has no connection with the Bromley Community Safety Partnership or the agencies involved in this review.

1.7 Methodology

1.7.1 The process adopted was to seek information, and where necessary Individual Management Reviews (IMRs) from all agencies who had had recent contact (i.e. from January 2012) with Susan or Alex. Additionally, where contact with those involved had relevance beyond this period, they were asked to include any information that they possessed which could assist this review. Largely this was the police (Kent and Metropolitan) and Bromley Education, Care and Health Services.

1.7.2 All agencies were asked to provide IMRs in relation to their contact or confirmation that they had not had any contact. When subsequent agencies were found to have known Susan or Alex, they were asked to provide information in the form of an IMR or letter detailing their knowledge of any interaction.

1.7.3 This then led to an iterative process of a review of all the information by the panel over the course of three meetings. Subsequently, further information was then sought and a draft overview report was then further considered by the panel. There were a total of five meetings of the panel. This report is a product of that process and agreed by the panel.

1.8 Contact with family and friends

1.8.1 Initial attempts to contact family and friends of Susan were unsuccessful; although, they were informed verbally and in writing of the fact that the review was underway. Following Alex's acceptance of responsibility for the death, further attempts were made to speak to the family and a meeting was held with Susan's mother, two of her brothers and a partner to one of the brothers. At this meeting, a very close friend of Susan was named and she also agreed to speak with the

chair. These conversations took place on the 2nd October and the 14th October respectively. The views emanating from these discussions are referred to within the report.

1.8.2 Five of Susan's family were introduced to the report on the 16th January 2015. Its contents were explained at length in the presence of the police family liaison officer. They were satisfied that the perpetrator had been found guilty and received a life sentence. They made no comment about the report and were given an opportunity to consider it and contact the report writer if necessary at a later date. No contact was made.

1.8.3 Any opportunities to discuss this review with Alex will not be progressed until after the prosecution is complete in January 2015. He has been informed by letter that this review is underway. (Following his conviction Alex has been contacted in prison but he has yet to agree to participate in this review. Should he do so an additional report will be attached to this review.)

1.9 Equalities

1.9.1 The nine protected characteristics of the Equality Act, 2010 are:

a. age
b. disability
c. gender reassignment
d. marriage and civil partnership
e. pregnancy and maternity
f. race
g. religion and belief
h. sex
i. sexual orientation

1.9.2 These were all considered by the panel. Both Susan and Alex are described as being of white European background. Susan did have learning difficulties but the panel do not believe this amounted to a disability as defined by the act. No other characteristic was regarded as relevant with the exception of possibly sex and age. It is accepted that women are more likely to suffer domestic abuse than men, and this review seeks to deliver recommendations with that reality in mind.

1.9.3 Susan was 20 years old at the time of her death and Alex was 33 years old. This age gap was considered by the panel, but it was the specific characteristics of

Susan and Alex (vulnerability and dangerousness) that were significant rather than their respective ages.

1.9.4 Alex was recognised as having psychological issues from a very early age and interventions took place during his childhood. He was not diagnosed in his later life as having any mental health issues which would amount to a disability as defined by the act.

2. THE FACTS

2.1 Introduction to the following facts

2.1.1 Susan's relationship with Alex lasted approximately nine months, and they lived in a multi-occupation house in Bromley where they had met originally. At the time of Susan's death, she was 20 years old and Alex was 33 years old. There is no record of any contact with any agencies that identified any concerns about the relationship. There were no reports to the police or other agencies about domestic abuse or related issues that involved this couple.

2.1.2 Susan had no children. Alex is now known to be the father to three children with women described below as V2 (two children) and V3 (one child).

2.1.3 For this reason, much of the below deals with Susan and Alex separately and attempts to describe their development and issues from an earlier age to assess whether different approaches could have altered the outcome of cases of this type (i.e. where a serial perpetrator meets a vulnerable individual).

2.1.4 Following much debate, it was agreed that the history of both Alex and Susan was relevant to the manner in which perpetrators and victims are approached and managed and how agencies can benefit from the facts of this case. What is evident in this review is that a vulnerable individual and a very dangerous male did come into contact and, had different practice and policies been instituted, the outcome may have been different. It is vital to learn from these circumstances so that future action in such cases, which are not atypical, can be modified where possible to improve the response to domestic abuse.

2.1.5 In the following sections Alex is discussed first as he is the perpetrator and bears responsibility for Susan's death. The facts relating to him are largely set out in relation to those agencies with whom he had contact. The description of Susan's life is more complex as she had more contact with agencies and this was known in some detail. It is split generally into her earlier years and then her later life.

2.2 The perpetrator - Alex and contact with police

2.2.1 Alex has a history of involvement with the police. He has twelve criminal convictions and four cautions for twenty-one offences. He was first convicted of robbery in 1995 when he was 15 years old. Apart from the prosecution in relation to Susan and domestic related cases described below, Alex was convicted of other offences including assaults, criminal damage, burglary and possession of

drugs. Prior to his contact with Susan, there are records of four previous partners (and their relatives) whom Alex is alleged or proven to have assaulted. The victims are numbered below for clarity.

2.2.2 Alex has been identified or investigated for domestic abuse related issues in one of the Home Counties and three London Boroughs. This review is based in Bromley as both Alex and the victim of the homicide, Susan, lived in the London Borough of Bromley at the time of her death. There is one report by Susan to Bromley police of domestic abuse but this was a different partner and is discussed below.

2.2.3 In 1999, Alex assaulted his girlfriend of the time (V1) and a relative using considerable violence and causing significant injury. He was sentenced to one month's imprisonment for the assault on his girlfriend and nine months for the assault on the relative.

2.2.4 In 2007 Alex assaulted another girlfriend (V2) with a weapon and was sentenced to eight months imprisonment consecutive to another sentence. This offence was only reported in 2009 when a later report of abuse was also made (see para graph 2.2.6).

2.2.5 In 2008, Alex was alleged by a victim (V1 again) to have assaulted her and, previously, a relative. Alex was arrested but the case was not proceeded with as the victim withdrew support for the investigation.

2.2.6 In 2009, Alex was arrested and charged with assault and harassment against an ex-girlfriend (V2). He was also charged with the assault mentioned above in para 2.2.5. For these offences he was sentenced to twelve months imprisonment (and the eight months mentioned above to run consecutively). A restraining order was also imposed

2.2.7 Again in 2009, (but reported after the previous offences) another ex-partner (V3) stated to police that Alex had assaulted her. This was a sustained and violent attack but due to a level of unwillingness by the victim to pursue the case and a lack of witnesses, this offence could not proceed to prosecution.

2.2.8 As Alex's release from prison approached in 2009, it became clear that one of the earlier victims was concerned for her safety. She was living outside of London and the county force took considerable efforts to establish the background to the case and provide a safe environment for the victim.

2.2.9 In 2010, Alex alleged an ex-partner (V3) had assaulted him and he had bitten her in self-defence. He subsequently admitted this was a false allegation.

2.2.10 In 2011, this same female (V3) had allegedly been assaulted by Alex. The physical violence was again significant. Despite Alex leaving the country, he was eventually brought before a Crown Court and the victim gave evidence against him. She then declined to be cross-examined and Alex was found not guilty. (Special measures had been requested and were in place for this case.)

2.2.11 It is notable that the police were so concerned about the level of violence and the threat that Alex posed on the night of this assault, that when the victim could not be found alternative accommodation, a police officer was posted outside her address in case Alex returned. The case was pursued thoroughly for the same reasons.

2.2.12 In 2012, a further victim (V4) who had been in a relationship with Alex made a statement to the police to the effect that Alex had assaulted her. She subsequently withdrew this statement indicating it had been a malicious allegation, having previously said she was worried about the repercussions from Alex and his family. She refused all further help.

2.2.13 Later in 2012, the same victim as in the preceding paragraph (V4) was present after an unidentified caller had sought police presence. She was apparently the subject about which the call had been made but wanted no action taken, saying it was a verbal argument. The police were so concerned about Alex's behaviour that they arrested him for breach of the peace.[2]

2.2.14 In 2013, this same victim was reported to police as arguing with Alex. Police could not trace her (V4) but spoke to her on the phone. She declined to answer questions for the risk assessment process and the risk was judged on the basis of the available information at the time and assessed as standard. There is no evidence of checks on Alex's previous behaviour, with regard to this victim or his previous assaults against other women.

2.2.15 In 2013, V4 attended a police station asking for support to allow Alex to collect his property from his address as she had "thrown him out". There were no allegations made, but a risk assessment was completed and the risk assessed as standard.

[2] This is a common law power which allows the police to remove those individuals likely to cause a breach of the peace but it is not a criminal offence and can only result in an "undertaking" not to continue that behaviour at court. Most often such arrested people are released after a period of detention sufficient to allow an individual to no longer to be a threat to the peace.

2.2.16 The final contact police had with this person (V4) was when she attended a police station stating Alex had assaulted her six weeks previously at a public house. She did not wish to pursue any allegations and she and Alex were advised “to have no further contact”. A risk assessment again assessed the risk as standard despite a supervisor noting that “the suspect’s (Alex’s) previous gives cause for concern over repeat offending of this victim or a new partner”.

2.2.17 There appears to have been one MARAC case throughout the period that Alex was known to police. This was in February 2012 when information known to the Metropolitan Police was passed to a county force as Alex had been arrested for the offence relating to V3, and they referred the matter to their MARAC. The MARAC actions sought to safeguard V3 and her home. Alex did not apparently have any further contact with her.

2.2.18 Throughout the cases involving Alex, there is evidence of referrals for other victims to specialist services. For reasons of confidentiality, the referral processes and subsequent actions by specialist services are not known nor can these be explored; although, the scale and degree of violence amply demonstrates the need for specialist services and an effective means of referral to those services.

2.2.19 Within the Metropolitan Police IMR, there are a number of errors in procedure and practice which are worthy of note and relate to more than one police area. (These relate back to 2008 and processes have changed during the intervening period but are included to demonstrate concerns about process completion in a general sense and the effectiveness of supervision).

a. At least one victim was risk assessed on the basis of inaccurate intelligence checks (this issue is now specifically covered in the MPS Domestic Abuse Toolkit).

b. A significant witness was not sought after being mentioned in the preliminary investigation of the same case.

c. No contact was made with an alleged assailant to ascertain her role or wellbeing.

d. Risk assessment processes lacked completion on a number of occasions and may have resulted in an incorrect risk grading.

e. On one occasion there was a failure to refer to the MARAC.

2.2.20 It is important to quote directly and at some length from the MPS IMR which describes the fear women felt in their relationships with Alex and their response to that fear. The following paragraph is taken from that IMR:

a. “It is clear that (Alex) is an individual that presented a significant risk to women throughout his previous relationships. There were DA (domestic abuse) incidents involving four previous partners within the MPS, these included five incidents of violence and four Non Crime Book Domestic Incidents. There were similarities throughout all these cases. (Alex) indicated controlling and coercive behaviour throughout with a vicious temper. In all of the cases the victims withdrew their allegations or were reluctant to give evidence at various stages of the investigations. This was despite significant reassurances from police. Each victim was emphatic that if they were compelled to attend court they would say that they had lied. One victim got as far as court, but refused to be cross examined. It is clear that all of these victims were intimidated and vulnerable because of (Alex’s) behaviour.”

2.2.21 Reference was also made within the MPS IMR about The Grip and Pace Centre (GPC) which is intended to be “a robust, dynamic and flexible mechanism for managing an MPS Borough on a daily basis” This was introduced in 2012 and looks 'internally' to ensure it can meet demand. It also looks 'outwards' to ensure the Borough is delivering policing which, amongst other things, investigates every crime thoroughly. 'Grip' is defined as meaning that the Borough senior leadership team will have an accurate, up to-date picture of crime and other issues at all times with no important elements overlooked. Consequently it is intended that “the most dangerous, harmful or persistent criminals will be on the Borough 'radar' at all times - as will victims, particularly those who are vulnerable or repeat victims”. 'Pace' means prompt police reaction to events or, proactively, to emerging crime threats.

2.2.22 Operation Dauntless has also been introduced within the MPS and is their new Continuous Improvement Plan for Domestic Violence. This is essentially a system connected to a tactical plan ensuring they are monitoring activity in relation to domestic abuse with a "whole Borough" approach. The three strands around which the response is expected to be assessed and improved are: Total Victim Care (Enduring Risk), Offender Management, Emerging Risk. This operation will lead to more focus on the perpetrator and the use of other tactics against these violent individuals.

2.3 Alex and contact with Probation

2.3.1 During the period of this review the Probation Service has changed to the National Probation Service alongside a privatised organisation providing local services, known for the time being as the Community Rehabilitation Company. Alex's contact with Probation was prior to this reorganisation, and this review reflects that position.

2.3.2 Probation managed Alex after his release on licence in October 2009 until April 2010. He had been imprisoned for offences relating to domestic violence. He undertook no courses in Prison; although, Healthy Relationships programmes were run in prisons at that time. He completed his licence with no further offending and appears to have been compliant and motivated to address his offending.

2.3.3 The Probation IMR shows that Alex was managed as a MAPPA offender and that they were the lead agency who had the responsibility for managing him as a Level 1 (ordinary agency management) offender. It is not apparent that his previous convictions for domestic abuse in 1999 (including a custodial sentence) were considered. When assessed (under Offender Assessment System (OASys)) he was considered medium risk but again it appears the assessment did not identify previous convictions for violence as domestic abuse convictions.

2.3.4 It is unclear from the records (now unavailable) if the details of his previous conviction for domestic abuse were identified by the police who supply them. It does appear that domestic abuse is not always identified on lists of previous convictions within a violence (or other) conviction. Had this been considered, Alex's risk may have been raised to high by probation; although, this would not have necessarily led to him becoming a Level 2 offender for joint agency management.[3]

2.3.5 The Spousal Assault Risk Assessment (SARA) was started but not fully completed, but with limited information about the previous domestic violence may still have only been of limited value. The SARA will be triggered by an OASys assessment and should be carried out by Probation staff in all cases where offending is linked to domestic abuse. The IMR from Probation identifies some improvements to the processes around fuller risk assessments, including

[3] Level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. Other agencies can be involved, but it is not considered necessary to refer the case to a level 2 or 3 MAPPA meeting where agencies devise a multi-agency risk management plan.

consideration of the possibility of domestic abuse towards his mother where he was living, and a contingency planning post release. There has been considerable focus on improving risk management planning within the Probation Service, and it continues to be a focus within the new arrangements for the delivery of Probation Services.

2.3.6 Alex was recognised as being suitable for placement on an Integrated Domestic Abuse Programme (IDAP), but his licence period was too short to complete the course at this time. There are now opportunities to offer shorter structured individual interventions which have become available since Alex was supervised by Probation.

2.4 Alex and contact with Health agencies

2.4.1 Alex first began to come to the attention of Health agencies when he was very young. At 2 years old, he is believed to have started a fire in a friend's house and was statemented in 1989.There are also separate reports of possible sexual abuse by a step-father, being assaulted and suffering alcohol intoxication at 15 years old. The relationship with his mother's partner was consistently cited as problematic for a number of reasons. He is believed to have placed himself in voluntary care from 1995. In 1996, Alex's mother felt he was suffering from attention deficit disorder (ADD) stating he was hyperactive, had problems sleeping and had been expelled from school. The ADD is a consistent theme throughout his childhood but this is an issue for Bexley who were not part of the panel (but see recommendations regarding their use of this review as a learning tool).

2.4.2 Psychological interventions when Alex was 16 years old demonstrate a troubled young person becoming very challenging who had experienced domestic abuse within the family. At this time, he was becoming increasingly well known to the police for his offending behaviour.

2.4.3 In December 2012, Alex told his GP he had used steroids after an accident in Spain and subsequently bought them through the internet in the UK. There is no further information about this issue despite the known concerns about its overuse.

2.4.4 In September 2013, Alex sought treatment for leg swelling, diagnosed as thrombophlebitis, which resulted in him being taken to hospital by ambulance where the diagnosis of phlebitis was confirmed (verified from the GP records).

2.4.5 The contrast between Susan's history of engagement with Health and other agencies and Alex has been noted by the panel. Her history allows for considerably more analysis. In terms of Alex's contact with Health agencies, it appears Alex was a largely healthy boy and young man with very limited contact with his GP. The records tend to be more limited and factual than Susan's and open to less interpretation.

2.5 Susan and her early years

2.5.1 Apart from minor childhood ailments, Susan did not come to the notice of the NHS for anything of significance until 1997 when the first note of a urinary tract infection (UTI) was recorded. Susan was four years old at this time. In the same year she fractured her arm after a fall from a kitchen cabinet.

2.5.2 From 1997 until her death in November 2013, there are records of Susan seeking medical assistance for UTI (largely recorded in GP's notes) on a total of eleven occasions. Apart from the prescription of antibiotics, these repeated presentations do not result in any recorded consideration of any potential causes.

2.5.3 In 1999, the Community Paediatrician noted significant learning difficulties, sleeping problems and high activity levels. It was also reported that she did not attend for appointments with the Clinical Psychologist. The GPs notes record that her problems had not changed in 2003 and she again failed to attend appointments with the Psychologist. Of course her attendance at medical appointments would not have been an area where she had total agency and her family, particularly her mother, would have been responsible for her attendance or otherwise at such appointments when Susan was younger.

2.5.4 From 1996, when she was two years old, Susan was known to Children's Services. This first contact was a result of an assessment for assisted playgroup fees. The reasons given were:

a. To assist delayed speech and language development
b. Integration with peer group
c. To receive adequate stimulation not received at home
d. Parental illness and tension within home environment.

2.5.5 Whilst the funding was agreed it was withdrawn as Susan had stopped attending. The family's health visitor was contacted at the time and spoke to the family but

was advised that they were unlikely to return her to the playgroup so the case was closed.

2.5.6 By 1999, a special educational needs statement suggested that Susan was identified as having moderate learning difficulties. She had difficulties completing tasks involving forethought, planning, verbal reasoning and visual spatial skills.

2.5.7 In January 2007 when Susan was 13 years old, Children's Services in Bromley allocated a social worker to Susan following a core assessment. Her school (Glebe School) reported serious concerns about her behaviour. When examined, it became clear that a number of issues were affecting Susan at this time:

a. Father was chronically ill

b. Mother had left the home and she was a key figure in Susan's life

c. Her brothers (she had four older brothers) were attracting attention locally for poor behaviour

d. Susan was struggling to manage herself and had to care, to an extent, for her father.

2.5.8 It is notable that Susan was regarded as a child in need and was not a "looked after" child. Susan was never on the Child Protection Register, nor did she have a Child Protection Plan subsequent to the register's abolition. Her case was reviewed regularly, but there is little evidence from the file record that Susan ever developed a trusting engagement with her allocated social worker. This engagement was therefore relatively unproductive.

2.5.9 Susan's position worsened as her father's illness proved terminal and he died in 2008. Her mother then returned home temporarily, returning finally after Susan had left school. Following a visit by Children's Services in early November 2008 which they felt was useful, the family appeared to be coping well. There was no further contact between them and Susan or her family and the case was closed in December 2008.

2.5.10 There is a report from Princess Royal University Hospital (now part of part of King's College Hospital NHS Foundation Trust) in March 2009 that Susan was found sleeping in the street having been drinking. This resulted in a referral to social services who responded with a "duty call to mother". Susan's mother reassured the social worker that the family were dealing with Susan appropriately and the case was not reopened.

2.5.11 The panel was very fortunate to be able to speak to a teaching assistant who worked very closely with Susan at Glebe School and a school counsellor who had conducted sessions with Susan. They were able to describe the context of Susan's life, especially the challenges within the home. It would be unnecessarily intrusive to outline all the details of this time in Susan's life but it is clear that:

a. Whilst Susan had learning difficulties they were moderate. She had first been statemented at nursery. All of Susan's four older brothers experienced problems at school.

b. Home life was very challenging with very significant male role models and limited female input which worsened dramatically when her mother left under very distressing circumstances.

c. Susan's mother was in contact by phone (she lived a considerable distance away when she was separated from the family) and her mother was a supportive factor.

d. The family were resistant to outside support and rejected any offer of support from a social worker. They clearly loved Susan but may not have managed her needs effectively.

e. School was a refuge for Susan. The support given there was extraordinarily powerful and helpful and she could also mix with other females. Exclusion was seen not to help and Susan was allowed to stay when, in normal circumstances, she may have been asked to leave.

f. There is also a question mark over the extent of the mother's capacity to help Susan when she returned and how regularly she was actually in the home. There is a suggestion that Susan had to act as her "bodyguard" and that the mother had attempted suicide.

2.5.12 Whilst Susan was at school, a process (which now no longer exists) called a Vulnerable Pupil Panel was asked to consider her case on two occasions in 2007. This was in connection with the possibility of Susan bullying a younger pupil, "social issues" and engagement during school holidays. Her teaching support was increased and she was referred to a Youth Involvement Support Package, but no records can be found as to the outcome of this later referral.

2.5.13 At a late stage in the review process, some documentation from the school became available that details another meeting about Susan's disruptive behaviour in 2007 when Susan was 13 years old. This makes clear the issues and the scale of Susan's problems and recommends that additional teaching assistant support be provided. Some of the concerns highlighted are the engagement of the mother since she left the family home, Susan's refusal to take the bus home and her

aggressive behaviour towards other children. The meeting attendees included teaching staff, two social workers and an individual from the Behaviour Service.

2.6 Susan and her later years

2.6.1 The police have records of a significant number of interactions with Susan. In 2008, when Susan was approximately 15 years old, she came to the notice of police on twenty-one occasions. These interactions concerned her drinking and simply as being seen on the street at a young age.

2.6.2 A child in need meeting was held at Orpington Family Centre in January 2008 and the police, children's services and Hyde Housing were in attendance (and probably others). The meeting was called as there were concerns about the family circumstances and Susan being exposed to criminal activity. A Section 47 (Child Protection) investigation was recommended. However, a social services manager concluded that "although there are complex family support issues it is not felt at this time that the case had reached the Child Protection Threshold"

2.6.3 In 2009, Susan came to the attention of the police on a further four occasions when "loitering" with a group and as a suspect for a bullying case, but this did not result in further action and only one case was referred to CSC.

2.6.4 In 2010 in Bromley, Susan reported that her boyfriend at the time (not Alex) had threatened her and strangled her. She did not want any further action taken and was unwilling to attend court. The suspect was "given strong words of advice around behaviour". The police IMR notes that Susan was 16 years old at the time and she did not then fall within the definition of domestic violence due to her age. There appears to be no MERLIN report or any referral, or offer of a referral, to any other agency, with the exception of Victim Support (see following paragraphs).

2.6.5 Again in Bromley in August 2012, Susan reported a male who was unknown to her for harassment in August 2012. He was dealt with appropriately (harassment warning) and there is no record of a referral or offer of specialist support for Susan apart from that offered by Victim Support after their receipt of the referral. (See below).

2.6.6 Victim Support received five referrals from the police relating to Susan. The first of these was flagged as domestic abuse (not Alex) and relates to the case mentioned above. Susan declined support and no further action was taken.

2.6.7 The other four cases were not flagged as domestic violence but contact was still attempted as per their policy.

a. May 2011 – assault by acquaintance. No contact made with Susan and letter sent.

b. October 2011 - assault by acquaintance. No contact made and letter sent.

c. August 2012 – harassment. No contact made and letter sent.

d. August 2012 – assault by acquaintance. No contact made and letter sent.

2.6.8 It is notable that many attempts were made to contact Susan before the letter was sent on these four occasions. She did not seek support on any occasion.

2.6.9 Other records for Susan show that she was drinking alcohol in the street and having unprotected sex on a regular basis. There were also other occasions which demonstrate a potentially problematic lifestyle.

2.6.10 Susan attended A&E in 2010 with an injury to a finger after being involved in a fight.

2.6.11 From 2009, Susan's GP records show that she had trouble sleeping, abdominal pains (2011) and possible panic attacks (also 2011). A referral to CAMHS resulted in them suggesting she attends Bromley Y[4] in the first instance; although, Susan did not attend.

2.6.12 These problems continued into 2012 when there are records describing Susan having blackouts, being stressed and upset. Susan stated she does nothing all day but cries at home. She denied being suicidal, but the GP felt SSRIs (selective serotonin re-uptake inhibitors, a category of anti-depressant) should be avoided because of the "unexplained blackouts". This problem again came to the attention of the GP later that year. Susan was again advised to attend Bromley Y but "says she cannot talk to people she doesn't know" and the GP recommended that she take a family member.

2.6.13 Also in 2012, there are reports on separate occasions of Susan suffering a dog bite and injury caused by a glass with a query of whether she was drunk. Also in that year she attended Princess Royal University Hospital alleging assault by a friend of her boyfriend. She was discharged with no apparent referral or consideration of domestic violence.

[4] Bromley Y is a long established local agency offering free therapeutic support to young people between the ages of 0 -18 years.

2.6.14 In October 2012, Susan called the emergency doctor at Princess Royal University Hospital describing pains in her ribs and stomach. When she did not attend for examination she was given advice over the phone.

2.6.15 At the time of the eviction (see paras 2.6.18 and 2.6.19 below) from their home, Susan again contacted the GP with sleep worries

2.6.16 Finally in June 2013, Susan had discussions with her GP about wishing to conceive (the records state she was living with her partner and the assumption is that this is Alex). She also reported some months later (August and October) a lesion[5] on her nipple which the panel felt was highly unusual for a woman of this age.

2.6.17 As described above Susan was a child in need (not a looked after child) for two years (January 2007 to January 2009) but engagement had been limited. The case had been closed but Susan did come back to the attention of Children's Services when found drunk in the street (March 2009) and when the mother reported Susan as having unprotected sex (April 2009). Other notifications in 2011 about a possible eviction, Susan not attending college and taking sleeping pills were also reported.

2.6.18 The last occasion Susan came to the notice of police was when they assisted with the eviction of Susan and her family in 2013, when Susan was an adult, from the address that had been their home throughout their father's illness. Susan and her mother then rented rooms in the address where Susan met Alex.

2.6.19 The eviction was sought on the basis of rent arrears; although, the issue of anti-social behaviour was mentioned within the process. The problems with payment of the rent were of very long standing, at least three years, and there is much evidence of efforts to resolve this situation without eviction. It is also relevant to note that other agencies were involved (police, social services, mental health team). The outcome of this involvement, largely concerned with Susan's mother who had apparently threatened suicide in the past, is unclear.

2.6.20 There is no evidence of any follow-up by any agency after the eviction took place.

[5] A lesion is any abnormality in the tissue of an organism (in layman's terms, "damage"), usually caused by disease or trauma.

2.7 Contact/Relationship with family/friends

2.7.1 The family (mother, two brothers and brother's partner) were very helpful in the review process and were able to provide much useful information which has been used within this report. The following is a précised version of the meeting where Susan and the circumstances surrounding her life were discussed.

2.7.2 The family first discussed their impressions of Alex:

a. They felt that Alex was quite charming and generous. There was a slight concern about the age gap but Alex did not appear to act as a much older person than Susan, and these fears tended to dissipate over time. The mother initially kept this relationship private for this reason, but gradually it became obvious to all that they were behaving as a couple. Alex apparently "boasted" about being in prison, but the family did not think generally he was "that clever". Alex gave Susan many gifts and appeared to treat her well. It was only a few days before Susan's death that Susan mentioned to any of the family that she may need to gradually move some of her property out of Alex's address so that it was not obvious. There was no sign or discussion about abuse of any form, and before any action was taken Susan was killed.

2.7.3 Susan's life was then discussed and the facts as known to the review were described to the family.

2.7.4 These were discovered to be largely correct. Susan did struggle at school; although, the Glebe School was praised for its efforts with her. She was hugely attached to her father and did "everything" for him. As the only girl in the family, Susan was a little "spoilt" and enjoyed being treated (which made Alex's generosity attractive). There was a complete acceptance of the fact that it was a very "male" household.

2.8 Additional Factors

2.8.1 There are also a number of issues which did throw further light on this review as outlined below.

2.8.2 *The eviction*

a. This was for rent arrears and allegations of difficult behaviour. In their own words they felt they were "dumped on the street and had nowhere to go". They were given no support and Susan and her mother found rooms through one of their sons (not present) who knew of a man with accommodation. This

was the property where Susan met Alex. They still feel that the eviction was unwarranted and that they were then abandoned to their fate. There was no offer of alternative accommodation. The eviction was led by Hyde Housing with other agencies, particularly the police, in attendance in some numbers.

2.8.3 *Relations with police*

a. They were very clear that one police officer treated the family in a prejudicial and unfair way. They feel that this one individual harassed them and behaved in a way that was not justified. They admit to being a difficult family and having regular contact with the police and other agencies. They do not accept that the behaviour of this one police officer was in any way appropriate even bearing in mind their challenging behaviour. They feel that he may have had a role in stopping the mother's benefits which led to the rent arrears and subsequent eviction. They also suspect that Susan's contact with police (as discovered in the review during her teenage years) was related to this one officer.[6]

2.8.4 *Relations with the statutory sector*

a. When asked what affect this had on them it became clear that their dislike of agencies in the statutory sector was exacerbated by their experience with the police. They agreed that they were resistant to any agency involving themselves in their family's life. This is particularly relevant when asked about their attitude to any intervention by social services. Their deeply held belief is that the context of the family would mean that, if given the opportunity, Susan would be taken into care or "taken away" by the social services.

b. The next elements of the process were explained to the family and they asked to see the report before it is submitted to the Home Office. When asked what they would like to see change in terms of the response to domestic abuse, bearing in mind what they knew of the context of Susan's life and the information they had discovered at this meeting they made the following points:

- That agencies and individuals from those agencies who may come into contact with victims of domestic abuse should have a greater awareness of this issue and how to respond
- Clare's Law should be much better publicised (see para 3.2.11)

[6] A search of police records does not show that this officer was regularly involved with the family

- More should be done about perpetrators, especially when well known to the police and other agencies
- There should be a register for perpetrators of domestic violence and abuse
- Education in schools about these issues is essential

2.8.5 Susan's friend (Jane) also made herself available for a discussion about Susan's life. The following is an abbreviated form of that discussion:

a. She had known Susan for over nine years and regarded herself as Susan's best friend. Her mother was also described as like a second mother to Susan. Whenever there were difficulties in Susan's life, she would see her and her mother for comfort, support and advice. This was apparently particularly important at the time of Susan's father's death.

b. She was "like a sister" to Susan and talked about things that affected them as girls. She felt that Susan began to engage in risky behaviour (the things that have become evident in the review) at the time of her father's death. She was extremely close to her father and struggled to deal with his passing.

c. She was quick to form attachments to others and had a number of boyfriends which were described as normal relationships, with one exception prior to Alex where she does think a boyfriend was abusive.

2.8.6 *The relationship with Alex*

a. Jane did not actually meet Alex but saw a photograph and spoke to Susan at length about him and formed the opinion that he was "dodgy" and warned Susan to be careful. There was some vague talk about Alex being wanted in Spain and having a wife and children. Susan knew he had a criminal record, but it is unclear if she knew what offences he had committed.

b. Just before Susan's death, it was evident that she was unhappy. There was an incident where Alex was abusive when he found Susan talking to another male on Facebook. Jane is sure he hit Susan once and suspects it was more than one isolated occasion.

c. Susan was scared of Alex, and this was the biggest factor in her not speaking about the relationship or going to the police. It did not help that she was concerned about her brother's reactions if they had found out and she did not trust the police.

d. When asked what could have made a difference Jane's response was: She feels that Susan was scared of Alex, had little trust of the police especially, and other statutory sector organisations generally. She would not have known who to go to seek safety or good advice about domestic violence but may have responded positively if a caring agency had asked her if she was safe.

e. When asked directly if Susan lacked support in her earlier years, Jane felt that she and her mother were able to provide that support.

3. Analysis

3.1 Relationship between Susan and Alex

3.1.1 The relationship between Susan and the man who killed her had lasted for approximately nine months. The possibility of abuse was only known to Susan's friend and her family, and they did not share their suspicions with any agency. There is no evidence of this relationship coming to the attention of any agencies that might have been able to support Susan had the existence of domestic abuse become known.

3.1.2 In 2013, Susan did discuss with her GP a wish to conceive and it can be assumed that the potential father was Alex. This was an opportunity to explore the relationship, bearing in mind Susan's troubled background, but that opportunity was not realised.

3.1.3 This may have been a very limited chance to discover the circumstances of Susan's position and any threats to her. It is an example of the need to grasp such chances, especially when the circumstances of Susan and Alex's previous histories are considered.

3.1.4 The lack of opportunities to change the outcome of Susan and Alex's relationship has led to a broader approach to the following analysis. Where wider issues are relevant, these are also addressed using this case as an example of the ongoing issues and problems within this area of crime and social ill.

3.2 Alex's dangerousness and the response

3.2.1 There is no doubt that Alex was serially violent towards his partners. The level of continuing threat was such that on many occasions they declined to support an investigation or prosecution and many were extremely fearful of him.

3.2.2 It is also true that he was prosecuted successfully a number of times and served time in prison for his crimes against women. On occasions, these prosecutions were impressive for the diligence with which they were pursued.

3.2.3 These terms of imprisonment seem to have had no impact on Alex's offending behaviour.

3.2.4 The prison service are responsible for sentence planning for low and medium risk offenders, and Probation lead on this when an individual is a high risk offender. The prison can also raise the risk level should they think this is justified which would then lead to Probation taking on sentence planning. There was an opportunity to enrol Alex on a healthy relationships course whilst in prison, but this was not realised. It appears that healthy relationship courses are over-subscribed and places are prioritised for the most serious offenders serving longer sentences.

3.2.5 This leads to two questions: Should the prison service have ensured Alex was involved on a relevant course and should Alex, bearing in mind his actions, have been considered high risk leading to Probation involvement in his sentence planning while in custody? This may have increased the chances of him accessing the Healthy Relationships Programme, but given the length of time spent in custody, this is by no means certain. The possibility of changing his behaviour through an Integrated Domestic Abuse Programme (IDAP) was not available when released on licence as the IDAP period would have extended beyond the term of his licence. Individualised interventions for those with a history of domestic abuse had not been introduced at that time.

3.2.6 Regardless of procedural considerations which are discussed below, the history of Alex continuously begs the question as to what should or could have been done differently to safeguard existing and future victims of domestic abuse. Alex is not a lone example and the panel heard from the lead police officer in the Community Safety Unit at Bromley that Alex's past was not as serious as many of their other known domestic abuse offenders. The availability of voluntary perpetrator programmes (although one exists in Bromley) is very limited and it is unclear if Alex would have accepted one if offered. There is also concern within the statutory sector that voluntary perpetrator programmes are not seen as a panacea, and that further research on the effectiveness of range interventions is required. Such programmes also need to be run in conjunction with services that focus on intervention and safety planning for those at risk. It is also worth noting

that from what is now known about Alex's background, that he is likely to have needed some form of specialised intervention.

3.2.7 Prosecutions where victims are reluctant to support a case, but which still proceed (sometimes called victimless prosecutions), were considered in this case but were not pursued because the victim wishes were so clearly against such an approach or because the chances of success were so limited. It is the policy of both the Crown Prosecution Service (CPS) and the police to prosecute more of these, cases but from the evidence in this review there seems to be little sign of a significant increase being achieved.

3.2.8 Specialist support for victims (e.g. independent domestic violence advisers (IDVAs) are intended to support a victim through the prosecution process and access to these is discussed below. Additionally, Specialist Domestic Violence Courts are specifically designed to address issues of expertise around domestic abuse, specialist support and flagging of cases to ensure that the domestic abuse is identified – all issues within this review. These courts have been reducing in number and clarity of purpose for some years now.

3.2.9 MARACs are another means of reducing the risk to victims and are victim focused. A tool of the MARAC can be a focus on the offender. There is at least one occasion where a referral to a MARAC in relation to one of Alex's victims could have been made and was not.

3.2.10 Referrals to MARAC are based on three different processes: a high risk grading after a risk assessment has been completed, after repeated Police attendances or from individual professional judgement in particular cases where the individual worker has serious concerns about the safety of the victim (and where the other criteria may not be fulfilled). It is very debatable whether the assessment of the women Alex assaulted were graded correctly. The simple fact of his previously violent behaviour towards his partners does not seem to have carried sufficient weight (and in at least one case it was not known through a failure to consult available databases) and towards 2013, including 2011 and 2012, any woman who came into contact with him as a partner was undoubtedly at more than standard risk of violence.

3.2.11 Additionally, what appears to be lacking is a process where all the different police commands examined his behaviour in the round. Each case was dealt with largely separately, and some of these were dealt with effectively, but Alex was a continuing and massive threat to any partner. This review has been able to

identify this position through a joint examination of the cases in which he is involved. This does not seem to have happened as a matter of practice or policy, and such an approach may have made a difference. For example, it could have led to warnings to future or existing partners about the threat they may be under.

3.2.12 Clare's Law (a scheme allowing police to disclose to individuals details of their partners' abusive pasts) was introduced in 2014 and was considered by Susan's family and the panel to have potential value in this type of case. It is also important to note that one of Alex's previous victims has resumed contact with him since Susan's death. She has been fully informed of Alex's behaviour and she has chosen to remain in contact.

3.2.13 Probation's involvement in this case is limited, but if their processes had been fully implemented effectively it is possible that a different level of management would have been deployed while he was on licence. However, as Alex did not come to notice for re-offending during the course of his licence, it is unlikely that a different outcome could have been achieved. The lack of detail in the information they possessed is undoubtedly a factor here, and this reinforces the need for a full picture of previous domestic violence behaviour to be available to Probation as a matter of routine.

3.2.14 The MAPPA arrangements are in place to manage the risks that have been identified and are not generally used to conduct a form of offender profiling. High risk domestic violence offenders are not necessarily managed as level 2 MAPPA cases unless there is a particular complexity about the case which suggests the need for additional oversight. (Of course a MAPPA level 2 status should not be required in any event for effective partnership working.) It is possible that had the full domestic abuse history been known and factored into the risk assessment as it should have been in this case, a decision may have been taken to manage Alex at level 2. However, that MAPPA response would have focussed on steps to manage the immediate risks and would not have drawn in additional resource for intervention, so it is unlikely it would have made a long term difference to Alex's behaviour.

3.3 **Police Policies and procedures**

3.3.1 There was a failure on a number of occasions by the MPS to follow its own procedures; although, it must be accepted that of these some were in the distant past and before Operation Dauntless was introduced. It is possibly too early to

evidence improvement as a result of Dauntless, but issues of process completion and supervision remain a key element of good performance. As has been discussed above, an improved risk assessment process may have resulted in a higher grading which may have led to a MARAC referral (although the one occasion the risk was assessed as high within the MPS the referral did not take place). In the home counties force when they were apprised of the dangerousness of Alex to a victim within their boundaries, they took considerable efforts to manage the risk to the individual.

3.3.2 What is true is that some form of supervision took place in all these cases but this supervision failed to alter the outcomes or discover any failings in procedure. Supervision is the means of assuring the best possible approach has been taken, and if this does not take place the risk to individuals increases.

3.3.3 The MPS approach to “grip and pace” is designed to react quickly to significant problems or threats. Had the victim from Bexley (V4) and her full circumstances, and Alex’s offending behaviour become known to senior managers it seems likely, according to their own definitions, that an action plan would have been implemented. It remains to be seen whether Operation Dauntless will impact successfully on the management of domestic violence, particularly their response to perpetrators.

3.3.4 It is important to re-emphasise that Susan’s relationship with Alex was never risk assessed as that relationship did not come to the attention of police or other agencies. It remains reasonable to ask the question: had the policies of the MPS and Probation been followed correctly in other cases would Alex have been dealt with differently (and earlier) leading to different outcomes in this case?

3.4 Susan and the context of her life

3.4.1 It was identified early in her life that Susan had learning difficulties, and Children’s Services funded a nursery place for her. This place was withdrawn when Susan stopped attending for reasons which cannot now be ascertained. The role of the parent is obviously crucial and this is an example of the belief that the care provided by the mother was competent and this reduced the level of intervention by Children’s Services. This concept of “competence” of the family to deal with the complex challenges in their family situation remained an issue throughout Susan’s life.

3.4.2 Susan's home life gradually worsened as she approached and entered her teenage years. Her father's increasingly debilitating, and finally terminal illness was a huge part of her existence, and she often had to care for him rather than him being able to support her. Her parents separated in 2006 in very difficult circumstances, and Susan was left living with her father and brothers at a time in her adolescence when female support would have been extremely important.

3.4.3 The relationships within the family were difficult. The brothers were angry with their mother and this prevented Susan maintaining effective contact with her. Some of her brothers were also becoming known to the police and there appears no doubt that authority figures or statutory organisations were unpopular in the household. The family, by their own admission, were resistant to any outside involvement and were fearful of Susan being "taken away", i.e. into care.

3.4.4 Susan was a child in need but engagement was "inconsistent", and it is clear she was unenthusiastic about the involvement of social services. This is not unusual and her home circumstances and the attitudes of her family will have exacerbated this. Her mother was seen to be, and on occasions was, a support mechanism. It was this point that seems to have allowed Children's Services to close and not re-open the case. This, when reviewing Susan's case in the round, seems to have denied Susan the continuing professional support which she needed.

3.4.5 What we know from Glebe School is that the mother lived far away for the two years Susan's parents were separated, there was great animosity towards the mother from the brothers, and Susan continued to participate in risky behaviour. If her mother was less of a protective factor, which could have been established by a discussion about Susan amongst those who knew her, the Panel feel it is likely that more support from a social worker would have been preferable. The meeting at the school in 2007, attended by social workers, gives yet more weight to this proposition.

3.4.6 This issue resulted in much debate at the panel meetings. What is clear is that there is no direct causal link between Susan's contact with Children's Services and Susan's death. It may be considered, however, that her vulnerability, social skills and risky behaviour could all have been ameliorated with ongoing professional help.

3.4.7 It is potentially possible that increased support may have allowed her to adopt a safer lifestyle and a more productive existence which could have altered the outcome of her life. The fact that she did not receive help to the extent that a

difference could have been made may be a question of thresholds and a failure to grasp the many challenging factors in her life (across all the agencies). The indications remain however that she deserved greater support from within Children's Services, albeit that her family were unenthusiastic about agency involvement. This of course cannot be a reason for not seeking to provide help wherever possible..

3.4.8 What must be emphasised is the quality of support given by Susan through the teaching assistant at Glebe School. It is abundantly evident that this support was of the highest standard and went beyond what it is reasonable to expect, even in these circumstances.

3.5 Susan and contact with Health agencies

3.5.1 Susan had very considerable amounts of contact with General Practitioners in relation to urinary tract infections and other issues which give cause for concern, e.g. unprotected sex and lesions of the nipple. None of these seem to have resulted in an exploration of the circumstances of her life which could have elicited more information on which a GP could have provided a broader form of support.

3.5.2 When discussing her wish to conceive, it is possible to see how a more questioning and intrusive stance could have revealed the character of her relationship with Alex. She had clearly been a vulnerable child, now adult, with learning difficulties. Whilst routine questioning is by no means universal this case could easily have been one which attracted a "selective" questioning approach[7]. The term used within the relevant IMR is a lack of "professional inquisitiveness", partially ascribed to the move to computer based notes, but opportunities to support Susan in a more rounded way were missed. Of course the process beyond an initial enquiry has to support a disclosure or an identification of risk and this is a wider partnership issue.

3.5.3 Attendance at Princess Royal University Hospital and Bromley Healthcare services in connection with dog bites, cutting her foot on glass, drunkenness, injuries to a finger, abdominal pain and similarly pain in ribs and stomach all were dealt with appropriately in terms of the presenting issues. What was not

[7] Selective or routine questioning is a practice conducted in some GP practices where the possibility of domestic abuse in the life of a patent is explored. See recommendations around the IRIS programme.

considered was the possibility of the factors leading to that presentation and whether domestic abuse in Susan's life, for example, was a possibility.

3.5.4 Bromley Healthcare's IMR states that the care provided was "appropriate to the presenting conditions and complies with current health guidance and practice". It is suggested that the relatively newly introduced guidance from the National Institute for Health and Care Excellence (NICE) would lead to further development about the approach of health professionals to domestic abuse.[8] The panel, it should be noted particularly those from the health arena, felt that this guidance, whilst a useful step did not go far enough and was insufficiently prescriptive.

3.6 Susan and specialist support

3.6.1 Susan was referred to Victim Support on a number of occasions. Only one case was flagged as domestic abuse and the relevant policy was implemented. It was apparent that Susan was not enthusiastic about support but the number of referrals, all involving the possibility of violence, did not lead to a more concerted approach. Victim Support's policies do now direct that action is taken with repeat referrals of this kind and this would lead to increased attempts at intervention.

3.6.2 The possible support of specialist services from other Boroughs cannot be fully progressed for confidentiality reasons. However, there must be a possibility of doubt about referral mechanisms and actions following these referrals if made because of the subsequent response of the victims. The evidence of the benefit of an independent domestic violence adviser (IDVA) for example shows that victims become safer and make more informed and productive decisions about their future.[9]

3.7 Over-arching issues

3.7.1 There are a number of general issues which have become evident during this review:

3.7.2 The communication between and within agencies has not been as effective as might be expected. Examples are:

a. The knowledge about Susan held by various agencies could have been better utilised in a multi-agency setting and particularly by Children's Services.

[8] http://www.nice.org.uk/guidance/PH50

[9] See http://www.caada.org.uk/policy/Safety_in_Numbers_full_report.pdf

b. The existence of the NICE guidance could have prompted a revised and improved approach to domestic violence.

c. Inter-MPS (and beyond the MPS) communication about a serial abuser may have led to a more proactive approach.

3.7.3 These issues are addressed in the conclusion and recommendations, but on a local basis it has long been held that a partnership functioning effectively will support a multi-agency approach based around communication, joint understanding and united efforts. It has not been possible within this review to witness such processes working well across the whole of the Borough and within all agencies leaving doubt as to their efficacy. Appendix 5 gives a brief overview of the concept of a coordinated community response. Such a concept is ideally suited to a local partnership area such as Bromley.

3.7.4 An example of an area of partnership working, somewhat removed from the core purpose of this review but nonetheless related, is the eviction of Susan's family after her father's death. The evidence within the documentation shows considerable efforts to allow rent arrears to be cleared. There was also knowledge of Susan's vulnerability which extended into her adulthood (as she was an adult at the time of the eviction) and the complex circumstances of the family. Hyde Housing attended the meeting at Orpington five years prior to the eviction, but the impact of the eviction and the family context do not seem to have been connected and additional efforts were not made to examine Susan's need at this very difficult time.

3.7.5 Policy adherence is clearly an issue for the MPS. There are suggested recommendations for the MPS within the relevant IMR but of the other London Boroughs involved it was possible to see gaps in practice in each of them. This points to a wider problem within that organisation which may require a force-wide response. (The IMR from the MPS makes three recommendations for internal action which are provided below.) Operation Dauntless may have had an impact on these issues, but its relatively recent introduction (November 2013) denies this review the certainty that the procedural and supervisory issues identified in this report have been resolved.

3.7.6 The use of Clare's Law is also a positive opportunity but it is unlikely that Susan, given her circumstances would have made use of this legislation and asked about Alex. As no agency had knowledge of this relationship, it also follows that the "right to know" element of the law could not be utilised.

3.7.7 It is reasonable to assume from this review that the issue of domestic abuse within someone's life is rarely considered within their presenting context. It appears to have never been considered in Susan's case despite her level of vulnerability and the likelihood of an abuser seeking her out or discovering her vulnerability as happened in this case. This shows a failure to understand the prevalence of domestic abuse and the dynamics of this crime. In part this is a partnership issue but it is also an issue of professional skill and one that requires further consideration.

3.8 Equalities

3.8.1 See paragraph 1.9.

3.9 Good practice

3.9.1 The support provided by the teaching assistant at Glebe School was of a highly impressive nature.

3.9.2 Also the efforts of the Metropolitan Police to secure Alex's return from abroad and the subsequent prosecution demonstrate a commitment and determination which is worthy of praise.

4. Conclusions and Recommendations

4.1 Preventability

4.1.1 The very limited contact by Susan with any agency when in the relationship with Alex, or any broader awareness of that relationship, makes it impossible to describe this death as preventable. What this review has shown is that different approaches to the following issues can potentially make a difference and increase the likelihood of preventing domestic homicides and abuse:

a. The vulnerability of children and young people.

b. The repeated offending (albeit occasionally unproven) of a very dangerous individual.

c. Increased and knowledgeably delivered professional inquisitiveness.

d. Adherence to policies and practice aligned with good supervision.

e. A well organised partnership process overseeing the individual and combined responses of agencies involved with victims and perpetrators.

4.1.2 Of course prevention and early intervention are generally key objectives of any domestic abuse or violence against women strategy. Whilst both objectives are

difficult to quantify, this review indicates how domestic abuse can be a possible outcome of varying influences and issues within childhood and early adulthood. To address these factors effectively, the statutory and voluntary sector need to work in an integrated and pro-active way. This approach is known to be best delivered within a coordinated response in a multi-agency setting.

4.1.3 Examples of areas where an effective partnership could have made a difference are:

a. during the eviction of the family
b. dealing with violent men
c. supporting vulnerable children and young people
d. multi-agency training
e. a specialist domestic violence court
f. a joined-up approach within Health agencies.

4.2 Conclusions

4.2.1 Susan had a most difficult childhood and adolescence. The context of her family circumstances, her own learning difficulties and an inability of the agencies involved in her care to change those circumstances led to her being a vulnerable individual. Eventually, Susan came into contact with a man known to be extremely violent, who then killed her.

4.2.2 This was not a pre-destined fate for Susan that could have been accurately foreseen. What is known is that vulnerable individuals, particularly women, are more likely to suffer abuse and that such abuse becomes increasingly violent and ends in death too often.

4.2.3 Alex's childhood, adolescence and adulthood were full of warning signs about his potential dangerousness. He was dealt with in the main by single agencies and the added value of a joined up approach was not realised. The opportunity, albeit limited, to provide Alex with a programme to address his abuse whilst in prison was also not realised.

4.2.4 It would be unfair to blame any organisation who had dealings with Susan or Alex for her death. What is possible is that the lessons learnt from this case could lead to developments in Bromley, particularly within the partnership arena, Children's Services and within Health organisations, which would allow for continuing improvement in this difficult and complex area. The issue of how to deal with

families resistant to intervention where support would be beneficial also bears some consideration.

4.2.5 Partnership, training, policies and processes are all capable of improvement to reduce the risk to vulnerable women and deal with serially violent perpetrators.

4.2.6 It is also to be hoped that this case would stimulate change in other localities where the opportunity to examine their processes in such detail has not been grasped. The MPS obviously play a crucial role in responding to domestic abuse, and on the evidence of this review may still be able to improve their processes and practice. Health organisations who deal with such individuals on a regular basis must also take a more intrusive and holistic approach. It is hoped that the recommendations achieve that possibility.

4.2.7 This death should provide an opportunity for agencies to be motivated to perform their roles differently and with a greater understanding of how vulnerable women can be supported to avoid the chances of victimisation. The thoughts of the family are also important at this stage. It is hoped that their wishes can be achieved through the development of a better partnership approach and the other more specific issues within the recommendations below.

4.2.8 Finally, the death of Susan was the responsibility of one person and that is Alex. His history makes it crystal clear that more must be done with male adolescents and men, particularly those who are clearly dangerous and that the delivery of this work is regarded as a priority.

4.3 Internal Agency Recommendations (not included in general recommendations)

4.3.1 Whilst it is assumed that these recommendations will be followed through by the agency involved, they should also form part of the action plan for the general recommendations overseen by the CSP.

4.3.2 **Metropolitan Police**

a. Recommendation 1 - Borough Level– Investigation. Officers should be reminded to review the investigation as a whole, ensuring sufficient enquiries are undertaken to identify any existing or potential witnesses.

b. Recommendation 2 - Borough Level – Supervision. Supervisors must ensure that they provide intrusive, timely and effective supervision, detailing clear action plans and direction to investigating officers. These actions and directions must be documented and checked for completion.

c. Recommendation 3 - Service Level. Investigating Officers are reminded that any DA Risk Assessment assessed as medium or high must lead to completion of a Part 2/Secondary risk assessment.

4.3.3 Victim Support

a. Victim Support management in the Southeast Division audit against internal policies shown below, a sample of domestic abuse referrals randomly from the Case Management System (CMS) for the borough of Bromley for the period January – March 2014:

- Victim Support's DV Service Delivery Operating Instructions (DVSDOI)
- Victim Support's Safeguarding adult and children policies
- Victim Support's Data Compliance policy.

4.4 General Recommendations

4.4.1 The local domestic abuse partnership must review its membership, structure and processes to ensure the delivery of a coordinated response to domestic abuse and report directly to the Community Safety Partnership and local Children and Adult Safeguarding Boards.

4.4.2 All partnership agencies should provide all staff with domestic abuse training appropriate to their level of responsibility (e.g. all staff should receive basic awareness training, and staff at level 3 or above should receive advanced training to include risk assessment, safeguarding and referral pathways.) Providing this training is the responsibility of individual agencies that will nominate a lead officer and maintain records of their training programme and levels of delivery.

4.4.3 All agencies work with the CSP and the Children and Adult Safeguarding Boards to identify a domestic abuse champion within their agency, each department, or each team (according to size) to attend advanced training and take responsibility for disseminating updates, sharing best practice, and maintaining awareness of domestic abuse within their agency.

4.4.4 Local agencies must review or introduce core competencies, training plans, and policies and procedures in relation to domestic abuse, and provide these to the Community Safety Partnership (CSP) and local Children and Adult Safeguarding Boards.

4.4.5 That the local CCG and Public Health Bromley consider implementing the IRIS programme[10] to support GP's in identifying and responding to domestic abuse.

[10] www.irisdomesticviolence.org.uk

4.4.6 All Health agencies to implement and use the NICE guidance to support the delivery of recommendations within this review as they relate to Health.

4.4.7 The Bromley Safeguarding Children's Board (BSCB) should work closely with schools, colleges and youth services to ensure both young people and the professionals working with them are aware of the realities and dynamics of domestic abuse and where support is available.

4.4.8 Children's Services & the BSCB should review 'The Child's Journey In Bromley ' to ensure referral routes to early intervention services & children's social care services are clear for all partners and that 'escalation' is also clear when referrals are not sufficiently addressed.

4.4.9 Children's Services & the BSCB should consider how to improve the success of necessary interventions when families are resistant to those interventions.

4.4.10 Children's Services to lead on a multi-agency SCIE review[11], using this case as an example, to improve practice in relation to vulnerable young people who may come into contact with oppressive and abusive individuals.

4.4.11 All agencies should work with the CSP to accurately map the prevalence of domestic abuse in the borough, and the provision of services to feed into an updated strategy and commissioning plan.

4.4.12 The CSP and safeguarding boards should work with partner agencies to organise public awareness campaigns to raise residents' understanding of domestic abuse and publicise services: including what friends or family members can do if they are concerned about someone they know.

4.5 Recommendations beyond Bromley

4.5.1 The Home Office to consider further developing, in partnership with the Department of Health, a minimum standard of reporting and response in all health settings, i.e. beyond the NICE guidance to ensure better support for victims of domestic violence.

4.5.2 That Her Majesty's Courts Service and partners reconsider the issue of a Specialist Domestic Violence Court in Bromley (which may include other relevant boroughs who utilise this court) to ensure a more effective delivery of justice in domestic violence cases.

[11] http://www.scie.org.uk/children/learningtogether/what-to-expect/commissioners-of-reviews.asp

4.5.3 The MPS and Probation Services (NPS and CRC) review how closer work between the police CSUs and Probation could strengthen the management of domestic abuse cases.

4.5.4 Police lists of Previous Convictions (MG16) should always note where a violent offence is an offence of domestic abuse or where any offence is committed in a domestic abuse context.

4.5.5 Probation should request from Police a full intelligence picture on all domestic abuse perpetrators.

4.5.6 That the MPS review their use of the 'Recency-Frequency-Gravity-Risk' model to ensure that it addresses the harm, opportunity and threat posed by high impact offenders of domestic abuse

4.5.7 That the MPS (with ACPO) consider the viability of a National Flagging System for serial perpetrators and repeat victims of domestic abuse to ensure the most dangerous perpetrators are identified and response are made commensurate to that risk.

4.5.8 That Her Majesty's Prison Service recognises the importance of programmes for violent abusers, including those on short sentences, and reviews their capacity to deliver such programmes to take the opportunity to change perpetrators behaviours before release.

4.5.9 That the identification (flagging) of domestic abuse perpetrators be introduced in all criminal justice agencies to ensure that the characteristics of such abuse are addressed within reports, sentencing and joint responses.

4.5.10 That this review, when finalised, be forwarded to the CSP at Bexley for them to consider the learning opportunities possible from the evidence of Alex's possible needs when a child within that borough.

Appendix 1: Domestic Homicide Review Terms of Reference for Susan

Domestic Homicide Review Terms of Reference for Susan

This Domestic Homicide Review is being completed to consider agency involvement with ***Susan***, and **her partner**, ***Alex***, following **her** death in November 2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

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

2. To review the involvement of each individual agency, statutory and non-statutory, with ***Susan*** and ***Alex*** during the relevant period of time:
    a. **All agencies** – January 2012 to 12th November 2013 plus:
    b. **Police** – any relevant history in relation to Alex from 2000 until January 2012
    c. **LBB – Children and Young People** – a précis of Susan's history up to January 2012
    d. **Victim Support** – from 2010 until January 2012 and others referred to VS in relation to Alex

3. To summarise any other relevant agency involvement prior to **January 2012**.

4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.

6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

7. To commission a suitably experienced and independent person to:

   a. chair the Domestic Homicide Review Panel

   b. co-ordinate the review process

   c. quality assure the approach and challenge agencies where necessary

   d. produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Bromley Community Safety Partnership.

Membership

9. The following agencies are to be involved:
   - Clinical Commissioning Group (formerly known as Primary Care Trusts)
   - Local domestic abuse specialist service provider e.g. IDVA
   - Education services
   - Children's services
   - Adult services
   - Health Authorities
   - Substance misuse services
   - Housing services
   - Local Authority
   - Local Mental Health Trust
   - Police
   - Prison Service
   - Probation Service
   - Victim Support

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

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

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

Collating evidence

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

13. Each agency must provide a chronology of their involvement with ***Susan*** and ***Alex*** during the relevant time period.

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

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

15. 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 ***Susan*** or ***Alex*** into contact with their agency.

Analysis of findings

16. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:

    a. Analyse the communication, procedures and discussions, which took place between agencies.
    b. Analyse the co-operation between different agencies involved with the victim, perpetrator, and wider family.
    c. Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d. Analyse agency responses to any identification of domestic abuse issues.

e. Analyse organisations access to specialist domestic abuse agencies.

f. Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

17. Sensitively involve the family of ***Susan*** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

18. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

Development of an action plan

19. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

20. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

21. Any enquiries from the media and family should be forwarded to the chair who will liaise with the CSP. Panel members are asked not to comment if requested. The chair will make no comment apart from stating that a review is underway and will report in due course.

22. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

23. 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.

24. 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.

25. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

Appendix 2: Members of the Panel

Name	Organisation	Job Title
Anthony Wills, Chair	Standing Together	Associate
Claire Elcombe	LB Bromley	Domestic Abuse & Violence Against Women and Girls Strategy
Helen Flanagan	Met CIAT	DS
Anita Gibbons	LBB Children and Young People	Head of Safeguarding and Quality Assurance
Anita Reid	Victim Support	Divisional Manager
Derec Craig	Victim Support	
Charlie Clare	Bromley MET	ADI
Conal Percy	London Ambulance Service	
Dawn Mountier	London Ambulance Service	Safeguarding Officer
Diane Tudway	MET Murder Investigation Team	DCI, Senior Investigating Officer
Nicola Clark	NHS England	Patient Safety Lead for Mental Health
Paula Townsend	Kings NHS Trust	
Louise Hubbard	Bromley Probation	Assistant Chief Officer
Nike Adeoye	Bromley Healthcare	Designated Doctor, Safeguarding Children
Ann Hamlet	Kings NHS Trust	Adult Safeguarding Manager
Lisa Moylan	Oxleas	Head of Mental Health Legislation & Safeguarding Adults
Amanda Mayo	Bromley Healthcare	Head of Nursing
Claire Lewin	Bromley CCG	Interim Designated Nurse Adult Safeguarding

Claire Lynn	LBB Education, Care & Health Services	Drug & Alcohol Services Commissioner
Nigel Davies	LBB Environment & Community Services	Executive Director
Terry Parkin	LBB Education, Care & Health Services	Director
Sally Innis	Croydon CCG	Safeguarding
Rachel Blaney	Croydon CCG	Safeguarding Lead
Steve Kelly	DC FLO	
Jade Davies	LBB Community Safety	Graduate Intern
Susie Clark		
Andrea Kilvington	Bromley Women's Aid	
Susan Clinton	Affinity Sutton	Head of Housing (London Region)
Lisa Moore	Probation	ACO Probation
Kevin Clarke		DCI
Nicola Payne		
Sheridan Morrison		
Amanda Martins	Bromley Women's Aid	Refuge Officer
David Stevens	Kent Police	
June Rosewell	Bromley Y	
Kevin Parrett	Glebe School	Deputy Head
Tim Smith	Kent Police	DS
Julie Abel	Glebe School	Support Assistant
Jenna Oates	Probation	
Lynn Thring	Kent Police	Secretary

Appendix 3: Action Plan

Appendix 4: MPS action plan in relation to their recommendations

RECOMMENDATION	**ACTION** What are we going to do?	**BY WHOM** Who is going to do it?	**OUTCOME** What do we intend to achieve?	**MONITORING** What has been achieved?	**BY WHEN?** What further action is needed?
It is recommended that the MPS review their use of the 'Recency-Frequency-Gravity-Risk' model to ensure that it addresses the harm, opportunity and threat posed by high impact offenders of Domestic Abuse	Using the context of recent DHRS to assess and review the current model functions and suitability and ensure any improvements are identified and implemented to improve service delivery. This will include Identifying searchable features that may have selected the victims / offenders involved.	Through the MPS DA Steering Group	Achieve dedicated methods of identifying harm, opportunity, threats posed by high impact offenders to victims.	Progress will be reviewed every 4-6 weeks by the steering group	Next working group will be held in November / December 2014 Further actions will be allocated and reviewed via this process.
It is recommended that the MPS consider the viability of a National Flagging System for serial perpetrators and repeat victims of Domestic Abuse.	Look at how to improve the management of repeat victims and serial perpetrators	National ACPO Lead for DA, ACC Louisa Rolfe and Supt Helen Chamberlain (Notts police)	To identify and implement a National flagging system to identify repeat victims & serial perpetrators to police to ensure that high risk victims/perpetrators are identifiable.	Awaits update from the National Tasking Group	

Appendix 5: The elements of an effective domestic abuse partnership - the coordinated community response

Why a Coordinated Community Response?

Domestic violence is a complex social problem. It harms the whole of society. The outcomes are the responsibility of all the agencies with a remit for health, social care and crime. It damages families and the education of our children; it affects businesses and employers, and increases the demand for housing. Agencies and organisations are often dealing with the same problem from different angles, with different responsibilities for intervention, and are seeking different outcomes.

In the middle of this complexity are the victims and the children suffering abuse. Often they have received little support or conflicting advice, and may even be seen as culpable because they have not found their own way out of the damaging situation.

The scale of the problem is immense. In our experience every children's service is seeing over 70% of their children experiencing or witnessing domestic violence. Nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs. The damage to families, in so many ways, is incalculable.

To provide victims with a better response and increase their chances of escaping harm, the need to weave a unified effort within the local community and services becomes clear.

The coordinated community response (CCR) was initially developed in Duluth, Minnesota, Untied States. Partners there believed that the coordination of local services would greatly improve the success of the responses to domestic violence, both to keep victims and children safe, and to hold perpetrators to account. They found that the effectiveness of the CCR was enhanced when local responses to the disclosure of domestic violence were consistent. It also became apparent that when people and organisations were held accountable to other members of the CCR the response improved. Later, they noted that subsequent initiatives in tackling domestic violence were also found to be more effective when implemented within an already organised response to this issue.

Wills, A. (2013) 'In Search of Excellence: A Guide to Effective Domestic Violence Partnerships.

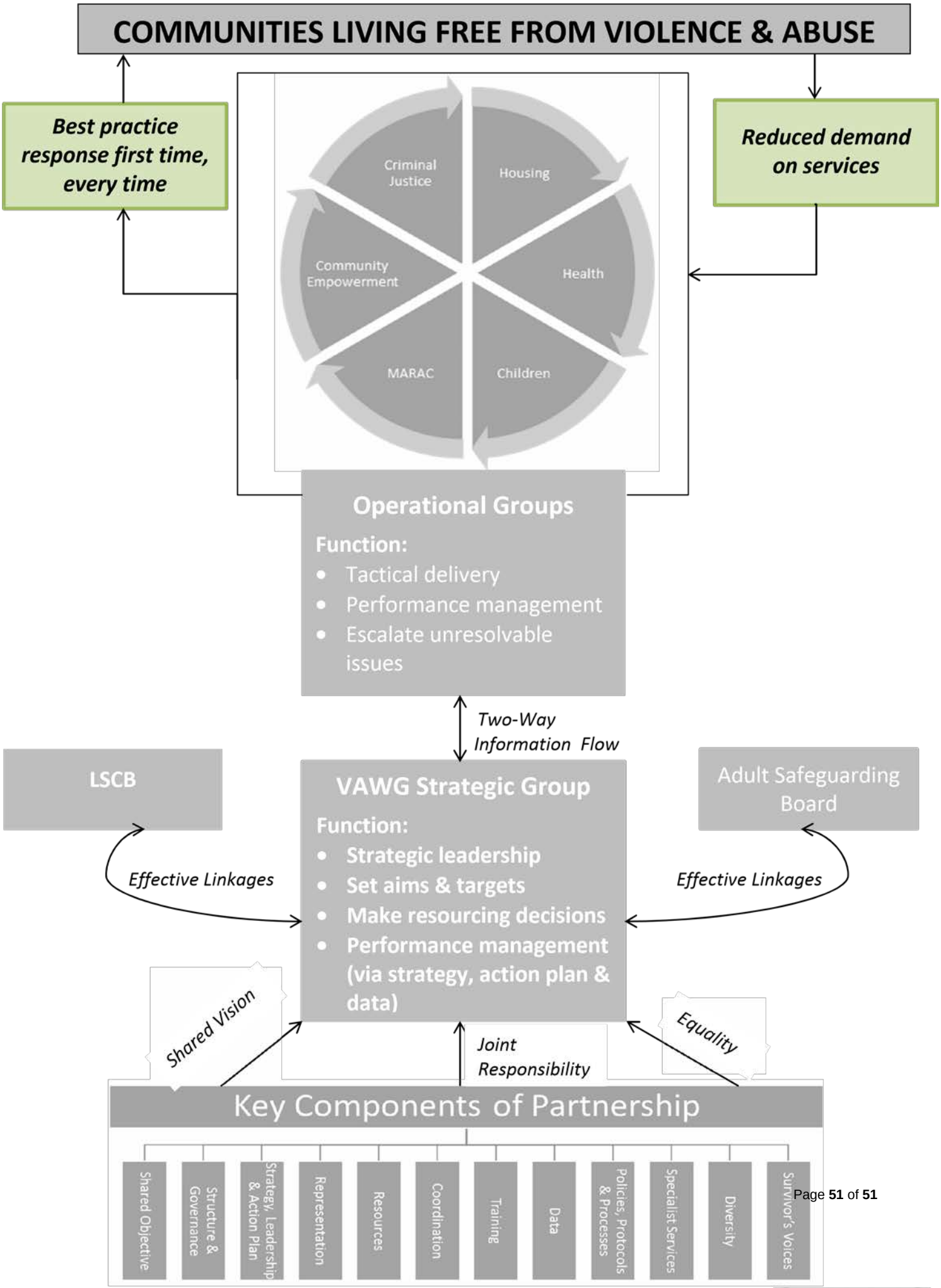
Standing Together Against Domestic Violence, pp 3-4.

The Coordinated Community Response to Domestic Violence:

Components of Excellent Partnerships

COMPONENTS	KEY QUESTIONS
Shared Objective	• Do all partners commit to a shared vision & understand the need to work together on equal terms? • Can they articulate a series of objectives?
Structure & Governance	• Do all partners accept accountability to the partnership? • Does the partnership have strategic direction and the ability to deliver operational outputs? • Are there are effective strategic links to the related areas of work? • Are there clear and consistent pathways for information to travel throughout the structure?
Strategy, Leadership & Action Plan	• Is genuine leadership given to this issue? • Do the intentions of the partnership & the action plan include prevention & early intervention alongside high risk responses? • Is the statutory sector aware of their responsibility to deliver responses as well as the specialist sector?
Representation	• Is every relevant agency represented within the partnership structure? • Is there good strategic leadership supported by systems and people? • Is the voluntary sector valued for its expertise and commitment?
Resources	• Does the partnership know how much domestic violence costs its members each year and how much they spend? • Does the partnership know, and recognise, the value of the voluntary sector in terms of its contribution, financially and in services, to the community? • Does the strategy or action plan match the availability of funding and other resources?
Coordination	• Do partners commit to the principle of a coordinated system of response & action within it? • Is the importance of the coordinator's role acknowledged with support and trust?
Training	• Do partner agencies understand the dynamics of domestic violence? • Do front-line staff and their managers have the skills and knowledge to identify and respond to domestic violence? • Is the approach to training linked to the strategy, policies, and procedures?
Data	• Do all partners contribute data that is collated for the whole partnership? • Is there a system of accountability to which all partners submit? • Is qualitative consideration of performance a partnership tool?
Policies, Protocols & Processes	• Is the partnership based on individuals or systems? • Are there protocols or policies for the key areas of activity? • If so, are there dates for their review?
Specialist Services	• Are the IDVAs and other services funded sustainably? • Are there gaps in the service provision for victims? • Is the statutory sector playing its part in responding to victims?
Diversity	• Do the partners know and understand the diversity of the population? • Is diversity a genuine, strategic priority? • Is there a joint approach which includes the whole community?
Survivor's Voices	• Are survivor's voices heard within the partnership? • Is there a system and process for using the experience of survivors? • What more can be done to learn from those who have actually experienced the abusive exertion of power and control?

Wills, A. (2013) *In Search of Excellence: A Guide to Effective Domestic Violence Partnerships.* Standing Together Against Domestic Violence


COMMUNITIES LIVING FREE FROM VIOLENCE & ABUSE
Best practice response first time, every time
Reduced demand on services
Criminal Justice
Housing
Health
Children
MARAC
Community Empowerment
Operational Groups
Function:
Tactical delivery
Performance management
Escalate unresolvable issues
Two-Way Information Flow
LSCB
Adult Safeguarding Board
VAWG Strategic Group
Function:
Strategic leadership
Set aims & targets
Make resourcing decisions
Performance management (via strategy, action plan & data)
Effective Linkages
Effective Linkages
Shared Vision
Joint Responsibility
Equality
Key Components of Partnership
Shared Objective
Structure & Governance
Strategy, Leadership & Action Plan
Representation
Resources
Coordination
Training
Data
Policies, Protocols & Processes
Specialist Services
Diversity
Survivor's Voices