**CROYDON COMMUNITY SAFETY**

**PARTNERSHIP DOMESTIC HOMICIDE REVIEW**

**EXECUTIVE SUMMARY**

Report into the death of Christopher

November 2014

Independent Chair and Author of Report: Nicole Jacobs

Standing Together Against Domestic Violence

Date of Completion: May 2017

****

 **Table of Contents:**

[1. Executive Summary 3](#_Toc508029082)

[1.1 The Review Process 3](#_Toc508029083)

[1.2 Contributors to the Review 3](#_Toc508029084)

[1.3 The Review Panel Members 4](#_Toc508029085)

[1.4 Chair of the DHR and Author of the Overview Report 5](#_Toc508029086)

[1.5 Terms of Reference for the Review 5](#_Toc508029087)

[1.6 Summary of Chronology 6](#_Toc508029088)

[1.7 Background Information on Victim and Perpetrator: 6](#_Toc508029089)

[1.8 Summary of information known to the agencies and professionals involved: 7](#_Toc508029090)

[1.12 Conclusions and Key issues arising from the review and Lessons to be learned 9](#_Toc508029095)

[1.13 Recommendations from the Review 10](#_Toc508029096)

1. Executive Summary
	1. The Review Process
		1. This summary outlines the process undertaken by Croydon Community Safety Partnership domestic homicide review panel in reviewing the homicide of Christopher who was a resident in their area.
		2. The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:
		3. *The victim:* Christopher, a white British man who was 24 at the time he was killed.
		4. *The girlfriend of the victim:* Cheryl
		5. *The daughter of the victim:* Lilly
		6. *The perpetrator:* James, a white British man who was 59 at the time he committed the homicide.
		7. *The wife of the perpetrator:* Karen
		8. The pseudonym for the victim was agreed by the long-term girlfriend of Christopher, Cheryl, and the chair selected the other pseudonyms used in this report.
		9. Criminal proceedings were completed in early June 2015 and the perpetrator was given life imprisonment.
		10. The process began with an initial meeting of the Community Safety Partnership who sought clarification with the Home Office as to whether they should conduct a DHR in the instance. In late March 2015, the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Christopher or James prior to the point of death were contacted and asked to confirm whether they were involved with them.
	2. Contributors to the Review
		1. The Croydon Family Justice Centre reviewed their files and notified the DHR Review Panel that they were not involved with the families who are part of this review aside for unrelated support of Christopher’s former partner and mother of Lilly. This support was not in relation to Christopher or his family and therefore had no information for an IMR.
		2. The following agencies reviewed their files and notified the Review Panel that they were not involved with this family relevant to the case and therefore had no information for an IMR:
* Croydon Office for Public Safety
* The Croydon Health Centre
* Croydon Adult Safeguarding
	+ 1. IMRs were received from:
* Metropolitan Police (summary of limited involvement with Police prior to the date of the murder)
* Children’s Services
* London Fire Brigade (James’ former employer)
* South Norwood Hill Medical Centre General Practice Surgery
	+ 1. The Chair contacted Virgo Fidelis Preparatory School to provide information to the chair about their safeguarding policy and practice and their interactions with this family and their referral to Children’s Social Care. The school was not responsive although information about the response from the school was gained in family interviews.
	1. The Review Panel Members

|  |
| --- |
| **Job title, Organisation** |
| Carl Parker, Partnership Officer (CSP Lead), LB Croydon |
| Rachel Blaney, Lead Nurse for Safeguarding Adults, Croydon CCG |
| Chris Howell, Met Police – Homicide & Serious Crime Command |
| Maureen Floyd, Manager Croydon Safeguarding Children's Board, LB Croydon |
| Paula Doherty, Strategic Lead DASV & Troubled Families, LB Croydon |
| Steve Hall, S+QA Manager, Children’s Social Care |
| David Lindridge, Borough Commander Croydon, London Fire Brigade |
| Sally Luck, Clinical Quality Manager (Patient safety), NHS England London |
| Janice Cawley, CIAT, MPS |
| Patricia Clarke, Adult Safeguarding Lead, Croydon Adult Integrated Health Service (SLAM) |
| John McQuade, Senior Investigator, Croydon Police |
| Andy Opie, Director of Safety, LB Croydon |
| Pratima Solanki, Director of Adult Care Services, Croydon Council  |
| Nicole Jacobs, CEO, Standing Together Against Domestic Violence, independent Chair |

* + 1. The Review Panel met on in mid-November 2015. The next meeting was on the late July 2016 and it was agreed by the Review Panel that this would be the final meeting to be proportionate to this review and the Review Panel would sign off the Overview Report via direct contact with the chair unless information changed substantially due to an upcoming appointment with Karen and James from prison (which was subsequently cancelled by James).
		2. The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review
	1. Chair of the DHR and Author of the Overview Report
		1. The Independent Chair of this Review is Nicole Jacobs, CEO of Standing Together Against Domestic Violence (STADV), an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. She has conducted domestic abuse partnership reviews for the Home Office (HO) as part of the STADV team that created the HO guidance on domestic violence partnerships, ‘In Search of Excellence’. She has worked in the field of domestic abuse intervention for over 20 years.
		2. STADV is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors’ safety, hold perpetrators to account and ultimately prevent domestic homicides
		3. *Independence:* The chair has no connection with Croydon Council or any of the agencies involved in this case.
	2. Terms of Reference for the Review
		1. The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning for the tragic death of Christopher and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.
		2. The Review Panel comprised agencies from Croydon, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the DHR was established to inform them of the review, their participation and the need to secure their records.
		3. At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from early May 2008 to the date of the homicide which covers the time from which Christopher’s daughter was born to the time of his murder. Agencies were asked to summarise any contact they had had with all parties prior to May 2008.
		4. *Key Lines of Inquiry:* The Review Panel considered both the “generic issues” as set out in 2013 Guidance and identified and considered the following case specific issues related to caring responsibilities, gender and age. Christopher was a young father and the lines of responsibility for caring for his young daughter were often blurred as it was perceived by outside services and agencies that the child’s grandmother was the main carer. Also, the panel explored his perceptions and awareness of support for him as a young father.
	3. Summary of Chronology
		1. In late November 2014, at 2:50 am, police were called to South East London. Witnesses reported that a male had been seen to remove a large object from the boot of a vehicle and head towards the river’s edge. The male drove off but was stopped by police, who found the lifeless body within the boot. The driver, James, was arrested for murder and taken to Lewisham police station.
		2. The body found in the car was his adult son Christopher. His life was pronounced extinct by the London Ambulance Service (LAS) at 3:40 am.
		3. James lived with his wife Karen and his adult son Christopher and Christopher’s 5-year-old daughter Lilly.
		4. *Judge Sentencing Remarks:* When sentencing James at the Old Bailey, Judge Richard Marks, the Common Sergeant of London, said: "The word tragedy is greatly over-used but if ever it is appropriate to describe a case in these courts, this is that case." "It is a tragedy for you as well, as you will have to live until the end of your days with the terrible knowledge of what you did, with all the pain and suffering that has caused."
	4. Background Information on Victim and Perpetrator:
		1. Christopher was a white British male and was 24 at the time of the homicide. At the time of the homicide, he worked at an auto-glass company.
		2. James is a white British male and was 59 at the time of the homicide. He is a retired fire-fighter.
		3. Christopher is described by friends as a well-liked, affable character who enjoyed being with his friends, his girlfriend and his daughter Lilly. He had a challenging upbringing and as a young father he required help from his parents in the raising of Lilly. Karen’s caretaking of Lilly enabled Christopher to work and to carry out his daily routines. In some ways, this pattern made it difficult to assert himself as Lilly’s parent but in his last year he was asserting his need to move out of his family home and live with his girlfriend Cheryl and his daughter as a family. He was on the brink of this move at the time of his murder.
		4. Christopher was born in 1990 and was one of seven children. He was taken into the care of the Local Authority in 1992 initially with one brother and one sister into the same foster care setting. In 1995, he was considered for adoption. He was placed with James and Karen in 1996 and formally adopted by them in 1999 along with his older brother. His brother did not remain with the family and Christopher was the only child to remain adopted by James and Karen.
		5. Christopher maintained links with his birth family which in some years were more active than others.
		6. Christopher became a father to Lilly in May 2009. His partner at the time and Lilly moved in with Christopher and his parents. Lilly’s mum eventually moved out with Lilly into a foster placement. She later agreed that Lilly live with Christopher and his parents. Christopher was subsequently granted custody of Lilly.
		7. At the time of his murder, Christopher had been in a relationship with Cheryl for approximately 4 years. She was a frequent visitor to the family home.
		8. Christopher and Cheryl planned to move out with Lilly as they felt it was time to live independently of James and Karen. Christopher had worked for months on the logistics of this move.
		9. He informed James and Karen that he wanted to remove Lilly from the private school they had placed her in and enrol her in a state school, as he would not be able to afford the fees. In mid- November 2014, a week prior to the murder.
	5. Summary of information known to the agencies and professionals involved:
		1. *Children’s Social Care (CSC)*
	6.
	7.
	8.
	9. + 1. Lilly’s mum, the girlfriend of Christopher had contact with CSC as she was a young mother who required support which included accommodation by the Local Authority in a mother and baby foster placement. Lilly eventually moved to live with Christopher and his parents in February 2010 with the support of the Local Authority. In December 2010, a Residence Order was granted to Christopher in respect of Lilly.
			2. In mid-November 2013, a police Merlin\* (Merlin is the name of a database run by the Metropolitan Police that stores information on children who have become known to the police for any reason. In all Domestic Violence incidents reported to the police, where there is a child is present, this information is recorded on the Merlin database) was received following an altercation between Christopher and his mother, Karen related to the care and authority for Lilly. Karen advised police that Christopher was jealous of her relationship with Lilly, that he was drinking heavily and that his behaviour was getting worse. The referral was considered by the Multi-Agency Safeguarding Hub (MASH) service and, as Lilly was not harmed during the incident, it was not considered to warrant further intervention.
			3. On 19 March 2014, CSC was contacted by Lilly’s school raising a number of concerns about Christopher as reported to them by Karen. As there were not overriding concerns about Lilly, the Karen was advised to continue to report alleged incidents of violence and aggression by Christopher, and that the grandparents should seek legal advice should Christopher decide to move out and take Lilly with him.
			4. There was no further contact with, or about the family, until the day of the murder when the Emergency Duty Team (out of hour’s team) received notification of the alleged murder and a foster placement was identified for Lilly.
	10. *London Fire Brigade*
		+ 1. James was employed by the London Fire Brigade between November 1983 and end of March 2014 when he accepted voluntary redundancy.
			2. James was appointed as a Firefighter with the London Fire Brigade in 1983. He was promoted to Leading Fire Fighter in 1989; Crew Manager in 2003; and to Watch Manager in 2006. All performance assessments were satisfactory and James was awarded the Fire Service Long Service and Good Conduct Medal in March 2004. There are no records of any disciplinary action.
			3. On two occasions his employment record shows that he requested special leave due to domestic responsibilities and in early March 2014, James submitted a request for special leave for “Urgent domestic personal problem involving violent family member” 5 days before the school reported concerns to CSC reported to them by Karen.
			4. James was made voluntarily redundant on 31 March 2014.
	11. *Metropolitan Police Service*
		1. There is no recorded police history of violence between Christopher and James. However, there is one reported incident of Domestic Abuse between Christopher and his mother in mid-October 2013 as described above. Christopher was arrested and made a full admission, expressed remorse and agreed that his behaviour was unacceptable. He was of previous good character. Karen was consulted and agreed for him to return to the family address. A DASH Risk Assessment was completed which was graded as ‘Standard’. Alcohol use, strangulation and jealously were recorded as risk factors. A Merlin report was created with regard to Lilly and shared with Croydon Social Services.. Christopher was then released by to the home address where he resided with Karen. As an adult caution was administered there was no option to add bail conditions.
	12. *Croydon Medical Services*
		1. Primary care service records were viewed for Christopher, Lilly, James and Karen.
		2. There are incomplete notes for Karen as she may have been deducted from the GP surgery list in 2012 due to “non-response.” She reregistered in 2015.
		3. All records show medical visits by Christopher, Lilly, James and Karen for common complaints or routine examinations.
		4. Contacts with CSC are recorded in the GP records with full detail relating to assessments and concerns reported to them in relation to Lilly. There is no record in the documentation that the GP will have mentioned or brought up the CSC information to the family at subsequent visits.
	13. Conclusions and Key issues arising from the review and Lessons to be learned
		1. *Invisibility of fathers:* There are examples from both the CSC and Lilly’s school where Christopher was allowed to be invisible to services. This reflects wider learning from other DHRs and Serious Case Reviews (SCRs) in terms of the need to engage with fathers as parents more generally and for services to understand more fully the nature and relationship of the child and the father.
		2. *Lack of advice services:* Cheryl noted that Christopher required support and advice but he would not have found it easy to access the support he needed as it did not fit neatly into any one box. He may have needed support to assert his role as a parent, financial support and advice or he may have needed support for feeling intimidated at home or for conflict between him and Karen. Perhaps more overt information and support targeted for fathers of young children may have caught his eye. He may have only seen this in the waiting area of services that he attended such as the GP surgery. However, if health visitors, CSC, schools and other key services, were focused more on understanding the role of the father in a family, it may have supported Christopher to be a more proactive parent.
		3. *Knowledge of Informal networks:* The one place the Christopher sought advice and support was through Cheryl, his friends and co-workers. He spoke at work and was supported in his pending move in the weeks before his murder. This information was managed within these social networks who equally would not have had an awareness of where Christopher could have sought advice and support.
		4. *Safeguarding and Schools*: Schools are often a first point of contact for young families and the support and advice they give is critical for families and to address issues related to safeguarding. Lilly’s school was proactive in alerting CSC when concerns were alleged by Karen about Christopher. However, it appears that further contact for follow up between the school and CSC was not made. Their judgement of Christopher would have been informed by what Karen had reported about him. Christopher did not appear to achieve a positive channel of communication with the school.
		5. *GP surgeries:* This review highlights the potential role of GP surgeries in providing services and advice to the whole family. In this case, the GP was aware of the referral information from CSC yet there is no documentation that this was followed up in subsequent visits to inquire safety concerns at home.
	14. Recommendations from the Review
	15. 1. The recommendations are multi-agency recommendations arising from the review which should be acted on and initial reports on progress should be made to the Safer Croydon Partnership quarterly. Recommendations should be considered alongside other similar reviews and findings.
		2. It is the expectation that all agencies involved in this review or the wider Safer Croydon Partnership will share the learning from this review as widely as possible and will incorporate its findings into existing learning and development frameworks.
		3. Consolidate work in relation to invisibility of fathers in the context of CSC and other frontline family services and audit progress to date in relation to this area of work to ensure both the Safer Croydon Partnership and the Children’s Safeguarding Board has adequate oversight on progress to date and further development required.
		4. Consider if the public information provided in a wide range of services such as the CAB, Croydon Family Justice Centre, GP surgeries and general support and advice centres target a range of potential service users including men so that there is wider understanding to those seeking help and their social networks of the range of service provided locally.
		5. Report on progress to date in relation to work in both schools and primary care which relate to recommendations and actions from prior reviews which are reflected and further understood in this review.