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SAFER CROYDON PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the Death of Louise

May 2018

Independent Chair and Joint Author of Report: Mark Yexley

Independent Co-Chair and Joint Author: John Trott

Associate Standing Together Against Domestic Abuse

Date of Completion (sent to CSP): February 2021

A dedication from Louise's mother:

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

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1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Croydon Partnership Domestic Homicide Review (DHR) panel in reviewing the murder of Louise who was a resident in their area.

1.1.2 The following pseudonyms have been in used in this review for the victim, perpetrator and victim's family to protect their identities and those of their family members:

The victim: Louise – a White-British woman, aged 31 at the time of her murder

The perpetrator: David – a White-British man, aged 35 at the time that he killed his wife

Eldest child of victim and perpetrator: Child A – aged six years at the time of their mother's murder

Youngest child of victim and perpetrator: Child B – aged four years at the time of their mother's murder

Mother of victim: Adult U

Sister of victim: Adult W

Friend of victim: Adult X

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

1.1.4 The DHR process began when the Community Safety Partnership commissioned an Independent Chair for a DHR in January 2019. All agencies that potentially had contact with the victim/perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.2 Contributors to the Review

1.2.1 This Review has followed the statutory guidance for Domestic Homicide Reviews 2016 issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. The DHR Panel was comprised of agencies from the Croydon and Bromley areas. Louise and David had first lived together in Bromley, and later moved to Croydon. At the time of Louise's murder both parties were separated, Louise remaining in Croydon and David in Bromley. On notification of the homicide agencies were asked to check for their involvement with any of the parties concerned and secure their records. An initial meeting was held to discuss the findings of the agencies. A total of 26 agencies were contacted to check for

involvement with the parties concerned with this review. Independent Management Reviews (IMRs) and chronologies were submitted by 13 agencies. The chronologies were combined and a narrative chronology written by the Overview Report writer. One agency provided a summary of engagement only, due to the historic nature of their involvement. 12 agencies returned a nil contact.

1.2.1 The following agencies had contact with either the victim and/or perpetrator and their contributions to this Review are:

Agency	Contribution
Bromley Clinical Commissioning Group (CCG) (for David's records at General Practice)	IMR and Chronology
Bromley General Practice (for the Louise and Children)	IMR and Chronology
Bromley Healthcare - Improving Access to Psychological Therapies (IAPT)	IMR and Chronology
Bromley Healthcare Universal Health Visiting and School Nurse	IMR and Chronology
Croydon Clinical Commissioning Group (CCG) (for the General Practice)	IMR and Chronology
Croydon Health Services NHS Trust	IMR and Chronology
Kings College Hospital (KCH) NHS Foundation Trust	IMR and Chronology
London Borough of Bromley Childrens' Social Care	Summary of Engagement
London Borough of Croydon Childrens' Social Care	IMR and Chronology
London Borough of Croydon Housing Services	IMR and Chronology
South London and Maudsley (SLaM) NHS Foundation Trust	IMR and Chronology
Metropolitan Police Service (MPS)	IMR and Chronology
Primary School	IMR and Chronology
Victim Support	IMR and Chronology

1.3 The Review Panel Members

1.3.1 The Review Panel Members were:

Panel Member	Job Title	Organisation
Dr Shade Alu	Director of Safeguarding	Croydon Health Services (CHS) NHS Trust
Sandra Anto-Awuakye	Safeguarding Children Advisor	Bromley Health Care - Health Visiting

Rashida Baig	Head of Service Social Work with Families, CWD and Transitions and YOS	London Borough of Croydon – Children's Social Care
Caroline Birkett	Head of Service	Victim Support
Not listed - to protect identity of children	Head Teacher	Primary School
Janice Crawley	A/Detective Inspector Review Officer	MPS – Serious Crime Review Group (SCRG)
Kate Dyer	Named GP for Safeguarding Children	Bromley CCG
Alison Eley	Named Nurse for Safeguarding Children	South London and Maudsley (SLaM) NHS Trust
Sian Foley	Head of Service Department	London Borough of Croydon Housing
Ciara Goodwin	Domestic Abuse & Sexual Violence Coordinator	London Borough of Croydon
Sarah Hayward	Director Violence Reduction Network	London Borough of Croydon
Alison Kennedy	Operations Manager	Croydon FJC (Domestic Abuse Agency)
Estelene Klaasen	Designated Nurse Safeguarding Adults	Croydon CCG
Tessa Leake	Named GP for Adult Safeguarding	Bromley CCG
Sharon Murphy	Interim Head of Tenancy & Caretaking services	London Borough of Croydon Housing
Heather Payne	Head of Adult Safeguarding	Kings College Hospital (KCH) NHS Foundation Trust
Russell Pearson	Review Officer	MPS – Serious Crime Review Group (SCRG)
Alvin Romero	Clinical Service Lead	South London and Maudsley (SLaM) NHS Trust
John Trott	Independent Co-chair	Standing Together
Guy Van Dichele	Executive Director Health Wellbeing and Adults	London Borough of Croydon – Adult's Social Care
Mark Yexley	Independent Chair	Standing Together
Jenab Yousuf	Interim Safeguarding Adults Lead	Croydon Health Services NHS Trust

1.3.2 *Independence and expertise*: Agency representatives were at the appropriate level for the Review Panel and demonstrated expertise in their own areas of practice and strategy, and were independent of the case.

1.3.3 The Review Panel met on four occasions, with the first meeting of the Review Panel on the 9 May 2019. There were panel meetings to review the IMRs on 25 September 2019 and 11 December 2019. Interviews with the family and friend then took place. The Overview Report was then drafted in April 2020, at the start of the COVID 19 'lockdown' period. The COVID 19 impact on services resulted in a delay to the next meeting. There was an online meeting to review the draft Overview Report on 22 June 2020.

1.3.4 The Chairs of the Review wish to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chairs of the DHR and Authors of the Overview Report

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

1.4.2 The Co-chair and author of the review is John Trott, an Associate DHR chair with Standing Together. John has worked for over 34 years in the domestic abuse sector. He retired from the Devon and Cornwall Police having served as the Detective Chief Inspector and head of the Cornwall Police Public Protection Unit. John currently works with victims and survivors of domestic abuse and additionally he delivers consultancy and training within his specialist knowledge areas of domestic abuse, coercion and control and stalking. He has also been the CEO of a National Stalking Advocacy Service and speaks at various conferences throughout the UK on coercive control and stalking.

1.4.3 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but

many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

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

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

1.5 Terms of Reference for the Review

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

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

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

1.6 Summary of Chronology

1.6.1 Louise first met David when she was in her early 20s. They were married in September 2011 and living in the London Borough of Bromley. There were no known safeguarding concerns recorded by agencies before this time. The couple had their first child in 2012.

1.6.2 In October 2013 Louise was pregnant with her second child when she was assessed by her GP as having depression. At this point Louise described her marriage as 'falling apart'. This started a period of engagement with mental health services in Bromley.

1.6.3 In January 2014 Louise and David moved to Croydon and their second child was born.

1.6.4 In February 2014 Louise attended hospital, having been assaulted. There was no evidence of the identity of the perpetrator and no record of the matter being reported to the police.

1.6.5 Throughout 2014 Louise was seen by her GP for post-natal depression. In August 2015 Louise saw her GP reporting that she had mood swings affecting her relationship with David. She said that she was working full time, with two small children and a husband who worked away from home.

1.6.6 During 2016 Louise was seen on a number of occasions by her GP in relation to her mood. Later in the year she told her GP that David had lost his job. She also reported delusional thoughts. Louise was referred to mental health services.

1.6.7 In December 2016 David attended a hospital Emergency Department with suicidal ideation. She was assessed in the presence of David and was referred again to mental health services. At this point it was established that David had accused Louise of having an affair with a man online. There was an insistence, from David, that Louise should be admitted to hospital. Louise remained on home treatment.

1.6.8 Louise and David separated at Christmas 2016. Louise later reported to police that David had assaulted her and damaged her property on 29 December 2016. Police arrested David for assault and criminal damage, but no further action was taken. A MARAC referral was not made.

1.6.9 From this point Louise lived with the two children in Croydon. David moved away and eventually lived in a flat in Bromley.

1.6.10 Louise continued to be seen by mental health teams at home until she was discharged in February 2017. On 6 February 2017 Louise saw her GP with a minor head injury, stating she had been assaulted by a stranger. This was not reported to the police.

1.6.11 In May 2017 Louise drafted an application for divorce, this was never submitted to court. The application stated that Louise was “controlling and jealous” and was having a “major effect” on her mental health.

1.6.12 In July 2017 David faked injuries to himself, pretending to stab himself with a knife. Later that month Louise reported to police that she had been assaulted by David’s mother. Louise took out an injunction against her mother-in-law.

1.6.13 In August 2017 Children’s Social Care commenced a Child and Family assessment. It was decided that there were no significant concerns.

1.6.14 In September 2017 David attended a hospital emergency department reporting depression and substance misuse. He left before he was fully assessed.

1.6.15 In November 2017 David was convicted of drink driving.

1.6.16 In January 2018 Louise saw her GP with a routine appointment, but she stated that her mood had been low and she had not been sleeping well.

1.6.17 At the start of May 2018 Louise’s oldest child attended an urgent care centre with a minor injury. It was not established who took the child to hospital. This was the last recorded contact with agencies.

1.6.18 Later in May 2018 Louise met with David, and their two young children for a day out together. Louise had been asked by David to meet him, on the pretence that he was due to be arrested by the police and may not see his children again. Louise and David took the children out for the day to a wildlife park in Kent. They all returned to David’s flat to stay there overnight. The following day David took his children from his flat to his mother’s house and left them there. Family became concerned David had not returned home and went to his flat to find him. David could not be found but the family discovered Louise dead in David’s flat. She had been murdered by David.

1.6.1 **Bromley Childrens’ Social Care (CSC):** In 2012 a routine police visit was made to the home of David’s uncle and it was discovered that David and Louise were living at the address with Child A. The uncle was cautioned and an initial assessment was undertaken by Bromley CSC in December 2012. It was recorded that Child A’s parents showed insight and took responsibility for ensuring that Child A was protected.

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

1.6.3 Louise was seen by the practice for ante-natal care for her pregnancy with Child A. The practice saw Louise following the traumatic birth of Child A and she was seen for appointments in relation to her mental health. Louise was also seen for routine

medical appointments. Louise then received ante-natal care during her pregnancy with her second child before she changed GP practice.

1.6.4 Louise transferred to the Croydon CCG area in February 2014 with Child A. There were 51 contacts recorded in chronology for the period under review.

1.6.5 **Bromley Healthcare:** BHC provided Health Visiting services to Louise and her children whilst they were living in Bromley. BHC saw the family from 2012 through to 2014 before the family moved to Croydon. There were 15 contacts recorded in chronology for the period under review.

1.6.6 BHC also provides Improving Access to Psychological Services (IAPT). BHC had contact with Louise of just over four months from the end of 2013. This contact was as a result of referral from maternity services. There were 11 contacts recorded in the chronology for the period under review.

1.6.7 **Croydon CCG:** Louise and her two children were registered with a GP practice in Croydon from the start of 2014 until her death in May 2018. Louise and her two children were also known to the GP Out of Hour service.

1.6.8 The IMR covered Louise's treatment for low mood and depression. A significant incident was recorded in November 2016 when Louise was seen by her GP reporting delusional thoughts and worries that it was affecting her relationship. There were 85 contacts recorded in the chronology for the period under review.

1.6.9 **Croydon Health Services NHS Trust:** Louise attended a number of CHS Outpatient departments. These included screening services, dermatology and ultrasound. Louise was also seen at the Emergency Department of Croydon University Hospital. Child A and Child B received services from Heath Visiting and School Nursing. This followed the family's move from Bromley to Croydon in 2014. There were 22 contacts recorded in the chronology for the period under review.

1.6.10 **Kings College Hospital NHS Foundation Trust:** The only recorded contact with persons subject of this review was when Louise attended the Emergency Department at Kings College Hospital. The attendance was because Louise had been victim of assault and she left the department before she could be fully assessed or examined.

1.6.11 **London Borough of Croydon Children's Social Care:** Recorded contact started in January 2017 after a notification from the police. Later notifications from police came in July 2017. A Children and Families assessment was conducted. There were ten contacts recorded in the chronology for period under review.

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

1.6.13 **London Borough of Croydon Housing Services:** There was one recorded contact in the chronology with Louise for the period under review. This concerned an online application for housing made in 2017.

1.6.14 **Metropolitan Police Service:** Louise and David have always lived within the Metropolitan Police District area. Police contact with the family started in 2012 when they were living in the London Borough of Bromley. Contact was with the Borough Jigsaw Team when David, Louise and Child A were in the same household as a Registered Sex Offender. Police notified local Children's Social Care. There was no further contact with the family until January 2017, this involved Croydon Borough Police. Police contact involved the investigation of reported domestic abuse. Croydon Police also investigated a reported assault against Louise by her mother-in law. There were further contacts between David and Bromley Police in 2017, this included his arrest for drink driving. There were 17 contacts recorded in the chronology for the period under review.

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

1.6.16 **Primary School:** Child A attended the Primary School in the London Borough of Croydon joining the school in September 2016. Whilst the school had contact with both parents, David had also helped the school with classroom support in lessons. Child A has remained in the school since and was later joined at the school by their sibling Child B. There were six contacts recorded in the chronology for the period under review

1.6.17 **South London and Maudsley NHS Foundation Trust:** SLaM provided Mental Health care services for Louise whilst she was resident in Croydon. The first occasion followed the birth of her second child in 2014 with a referral to the Perinatal service. The second period started in November 2016 when Louise was referred by her GP due to suspected bipolar affective disorder. Louise was then seen by SLaM staff when she presented with David in December 2016 at the Emergency Department of her local hospital, where SLaM supplied psychiatric liaison services. The last contact with Louise was recorded in March 2017. There were 38 contacts recorded in the chronology for the period under review.

1.6.18 **Victim Support:** The only contact recorded in the chronology between Victim Support and Louise was in January 2017 following the referral from the MPS for the Domestic Assault that took place on in December 2016.

1.7 Conclusions

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

1.7.2 David demonstrated controlling behaviour towards Louise. Friends and family have provided clear information to the panel on the way in which David would undermine Louise and exert control on her. He controlled her use of her car and he controlled her finances. The agencies have seen how David interposed himself on Louise's contact with agencies and how he was often present. He tried to influence mental

health professionals, taking control and undermining Louise as a mother. When Louise had started to forge a new life for herself and move forward, David lured her to his home and ended her life.

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

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

1.7.5 As with many reviews, there must be continued momentum to train and provide tools and policies to ensure that professional curiosity and identification of domestic abuse is fostered in all settings. This is particularly true in relation to healthcare settings where there is opportunity to engage with both the victim, the perpetrator, and the wider family. This could be the place of earliest intervention. If these tools are available then they must be effectively marketed so that practitioners are fully aware of them and supervisors must ensure they are being complied with.

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

1.7.7 Importantly, it is not only professionals who require support and information about domestic abuse. Louise was isolated by David from friends and family who if understood what was going on with their daughter and sister, would try to support her. On many occasions, family and friends know much more accurately the

situation and feelings of victims and survivors. However, more needs to be done to ensure that family and friends know pathways to support and when to encourage engagement with services, particularly during a recent separation.

1.7.8 **Lessons to Be Learnt:**

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

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

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

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

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

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

1.7.15 **Lesson 2. Training**. The review showed that many practitioners do not understand the complexities of domestic abuse and as a result they are not always professionally curious and do not conduct routine explorations of domestic abuse and stalking with the person or family they are dealing with. By receiving such training practitioners will better understand domestic abuse within the context of their normal role and how therefore a victim and perpetrator may present. Previous reviews have shown that for the training to be effective it needs to be face to face as opposed to a short online eLearning package. Whilst it is recognised that for

some agencies there is a shortage of staff and therefore a reliance on temporary bank and agency staff it is incumbent for agencies to ensure that there is a thorough induction to organisational systems, processes and domestic abuse training.

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

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

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

1.7.19 The Metropolitan Police Service need to take a wider view of the potential offences committed including coercive control and stalking and conduct the necessary investigation and safeguarding. This will only occur if officers and staff receive domestic abuse and stalking training. Officers should have considered pursuing a coercive control investigation linked into a stalking investigation as Louise was the victim of the offences she alleged after she and David had separated. Coercive control behaviours can be included as part of the evidence when conducting a stalking investigation. Neither coercive control nor stalking offences were considered either in the recording of the offences or in their investigation. Had these offences been investigated then a more thorough investigation and therefore a better of the risks the victim and the children were enduring would have been realised.

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

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

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

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

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

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

1.7.26 **Lesson 4 Information Sharing.** The review shows that organisations held information on Louise, David and Child A and B which, if shared, could have assisted in understanding that domestic abuse and stalking were present. This would have allowed a better understanding of what was happening within Louise's life and as a result informed actions and safeguarding measures could have been taken. Even within the same organisation information has not always been shared or systems interrogated to ascertain such information. The MARAC process generally works well to protect victims of domestic abuse and stalking because there is a multi-agency response to it. Whilst the MARAC process is for those victims that are assessed as High Risk the basis of sharing information is key and therefore it is incumbent on organisations to make enquiries not just within their own organisations but others equally within the Information Sharing Agreements they should hold. As a result of the review CCCG recognise that Partnership working between practitioners in primary care, health visitor, Police (MAPPA) and social care needs to be evidenced fully.

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

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

1.7.29 **Lesson 5 Separation**: It is known that the issue of separation can lead to increased risks in the area of domestic abuse. The division of one household into two will normally bring about the need for housing, Louise raised housing as an issue with her GP as a being a cause of stress in 2013. In 2017 she made an application for

housing from Croydon Housing Services. There was no section within the application to prompt the applicant to record any concerns on domestic abuse. Within three months of that application the review established that Louise had drafted, but not submitted, a divorce application citing David's domestic abuse. It is hard not to conclude that if she were given the opportunity to outline abuse from David in her housing request she would have used it.

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

1.7.31 This lesson is reflected in Recommendation: One.

1.8 Single agency recommendations

1.8.1 **Bromley CCG**

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

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

1.8.4 **Bromley GP Practice**

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

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

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

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

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

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

1.8.11 **Bromley Healthcare (BHC) IAPT**

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

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

1.8.14 **Croydon CCG**

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

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

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

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

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

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

1.8.21 **Croydon Health Services**

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

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

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

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

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

Update: Croydon University Hospital Emergency Department now have a toolkit that was ratified in 2019 by the Governance Committee and the Named Nurse for Safeguarding Children has presented the toolkit to medical practitioners working within the Emergency Department. It will be kept under review by the Safeguarding Adult and Children's teams.

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

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

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

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

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

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

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

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

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

1.8.36 **London Borough of Croydon Housing Services**

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

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

1.8.39 **Metropolitan Police Service (MPS)**

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

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

1.8.42 **Primary School**

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

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

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

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

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

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

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

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

1.8.51 **Victim Support (VS)**

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

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

1.9 Panel Overview Report Recommendations

1.9.1 **Overview Report Recommendations**

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

1.9.3 **National Recommendations**

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

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

1.9.6 **Local Recommendations**

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