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Croydon

Community Safety Partnership

Domestic Homicide Review

Executive summary

Under section 9 of the Domestic Violence, Crime & Victims Act 2004
into the death of:

Ana (who died in December 2020)

Ana is a pseudonym

Independent Chair & report author: Kevin Ball

1. The review process

1.1. This executive summary outlines the process and findings from a Domestic Homicide Review (DHR) undertaken by Croydon Community Safety Partnership. The review has examined the contact and involvement of professionals and organisations with a 30-year-old woman, of Portuguese ethnicity, who was murdered in December 2020. Ana lived with Adult A, her partner, and father of their young baby. In December 2020 the Police were called to Ana's home address by Adult A's sister and husband, to find Ana had been fatally stabbed by Adult A. Adult A had also sustained serious stab wounds and needed urgent medical treatment at hospital. At the time of the incident, Ana and Adult A's only child was in the home. For the purposes of this review, the child will be known as Child 1. Adult A was arrested on suspicion of murder and remained in hospital receiving treatment whilst under arrest.

1.2. A family member has described Ana as *' … a happy, caring, calm, sensitive, a person with values, respectful and passionate. As a sibling, she was always caring and worried if we were ok, and all she wanted was to see us happy and close. As a mother she was very caring and protecting of her baby, she loved cuddling, talking and playing with her baby; after-all her biggest dream was always to be a mother. Her favourite colour was pink and her favourite food was seafood rice. She loved being with family and friends, travelling and going to the beach. She loved the sun, she wasn't a big fan of rainy days …'*.

1.3. This review was conducted under section 9 of the Domestic Violence, Crime & Victims Act 2004. The decision to conduct a review was agreed in April 2021, and review process has taken approximately 31 months to complete, and has benefitted from a Review Panel that have maintained regular oversight of the process. Protracted criminal proceedings account for the length of time it has taken to complete the review.

2. Contributors to the review

2.1. From an original list of 13 separate agencies and services initially contacted to find out if they had any contact or involvement with Ana and family, it became apparent that four agencies/services should be asked to submit an Individual Management Report. This is set out below, in table 1.

Table 1: Agencies/services asked to submit an Individual Management Report
Metropolitan Police
Croydon Borough Council Early Help & Children's Social Care
Croydon Health Services
GP Practice for Ana & Child 1
GP Practice for Adult A

2.2. The review has had limited contributions from family members, who declined the opportunity to participate.

3. The review panel members

3.1. A Review Panel was established, and comprised of the following agency representatives, all of whom were independent of any case management responsibilities.

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Table 2: Review Panel membership		
Name	**Agency**	**Role**
Kevin Ball	Independent	Independent Chair & author
Estelene Klaasen	Clinical Commissioning Group	Designated Nurse for Safeguarding Adults. South West London CCG
Michael McInerney & then Paul McGough	Metropolitan Police	Detective Sergeant: Specialist Crime Review Group
Dr Folashade Alu	Croydon Health Services NHS Trust	Director of Safeguarding
Jo Joannou	Croydon Housing	Operational Manager
Dr Ravi-Shankar	General Practitioner – for the victim & child	GP
Jenny Moran	Croydon Borough Council Adult Social Care	Quality Assurance Officer
Dawn Mountier	London Ambulance Service	Safeguarding Officer
Ciara Goodwin	Croydon Community Safety Partnership	Domestic Abuse & Sexual Violence Coordinator
Alison Kennedy	Croydon domestic violence specialist service provider – FJC	Strategic Lead for Domestic abuse, Sexual Violence and Modern Slavery
Alison Eley	South London and Maudsley Mental Health Trust	Trust Wide Named Nurse for Safeguarding Children and Domestic Violence and Abuse Lead
Rosalie Kenton	Care Grow Live - Substance misuse services	Deputy Services Manager
Dawn West	Croydon Borough Council Children's Social Care	Acting Head of Safeguarding and Quality Assurance

4. Author of the over-view report

4.1. In December 2021, the Chair of the Croydon Community Safety Partnership appointed Kevin Ball as the Independent Chair and report author for this Domestic Homicide Review. He is an experienced Chair and report author, notably of cases involving the harm or death of children, but also Domestic Homicide Reviews. He has a background in social work, and over 32 years of experience working across children's services ranging from statutory social work and management (operational & strategic) to inspection, Government Adviser, NSPCC Consultant and independent consultant; having worked for a local authority, regulatory body, central Government and the NSPCC. Over his career, he has acquired a body of knowledge about domestic abuse through direct case work, case reviews and audit, and research and training, which supports his work as a Chair and reviewer of Domestic Homicide Reviews. During his career, he has worked in a multi-agency and partnership context and has a thorough understanding about the expectations, challenges and strengths of working across complex multi-agency systems in the field of public protection. In the last 10 years he has specifically focused on supporting statutory partnerships identify learning from critical or serious incidents and consider improvement action. He has contributed to the production of Quality Markers for Serious Case Reviews, developed by the Social Care Institute for Excellence & the NSPCC – which are directly transferable and applicable to the conduct of Domestic Homicide Reviews. He is a member of the Department for Education's Child Safeguarding Practice Review Panel's pool of reviewers to be used for national reviews. He has completed the Home Office on-line training for Domestic Homicide Reviews and the Chair training course provided by Advocacy after Fatal Domestic Abuse (AAFDA). He has no association with any agencies involved and is not a member of the Croydon Community Safety Partnership. There is no conflict of interest.

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5. Terms of reference for the review

The following Terms of Reference, and lines of enquiry were agreed by the Review Panel in January 2022:

1. Retrieve, examine and offer an analysis on any information between the period 01/10/2019 and the date of Ana's murder. This timeframe was agreed as this is when it is believed that Ana formed a relationship with Adult A. Any relevant background information prior to this timeframe, would be considered as necessary.
2. The opportunity for agencies to identify and assess domestic abuse risk.
3. Agency responses to any identification of domestic abuse issues.
4. The communication, procedures and discussions, which took place within and between agencies
5. The co-operation between different agencies involved with Ana, Adult A, & Child 1.
6. Organisations' access to specialist domestic abuse agencies.
7. Policies, procedures and training available to the agencies involved on domestic abuse issues.
8. The impact of Covid-19 restrictions on circumstances for Ana and Child 1.

6. Summary chronology

6.1. Information about the following individuals is of interest to this review:

- Ana – the victim and subject of this review
- Adult A – the perpetrator
- Child 1 – the child of Adult A and Adult B
- Adult B – a former partner of Adult A, and her two children

6.2. Information has been submitted which relates to a previous relationship that Adult A had with Adult B, and two children. This is relevant to consider.

6.3. In November 2015 Adult A came to the attention of the Police. A former female partner, (to be known as Adult B) of Portuguese ethnicity, aged 32 years, attended Croydon Police station to report domestic abuse. She reported herself and Adult A being in a married relationship prior to them moving from Portugal to the UK, now having financial problems, and Adult A having an online gambling addiction. This, she reported, left them short of money to pay for household bills and food. An argument about money had resulted in Adult A becoming angry, and assaulting her. The couple's children, aged one year and eight years, had reportedly witnessed this incident and the assault. Agency records go on to provide further details about this relationship, further domestic abuse and controlling behaviours, notably one incident of Adult B being physically and sexually assaulted, and a threat of being killed (by waving a knife in front of Adult B) if Adult B ever left Adult A, or ever took the children away and prevented him from seeing them. As a result of this, Adult B and the children moved out and went to live with extended family. The Police arrested Adult A, who accepted that he had challenged Adult B, but denied any assault or any threatening behaviours. Following consultation with the Crown Prosecution Service (CPS), Adult A was charged with sexual assault and common assault and remanded into Police custody. As a result of this, and appearing at Court, Adult A was granted conditional bail with conditions of not having any contact with Adult B or to enter the Borough of Croydon. In July 2017, Adult B withdrew her allegations, providing a statement to the Police confirming that she did not support a prosecution. The withdrawal statement process was supported by the use of a Portuguese interpreter given that Adult B's first language was not English, but also an Independent Domestic Violence Adviser (IDVA) and the ongoing support from the Family Justice Service. Review of records indicates that a risk assessment was conducted about Adult B's wish to withdraw the statement and whether a prosecution was still viable, but also assess any ongoing risk of harm. Also, a further appraisal was completed to assist the CPS determine whether it was proportionate to consider a witness summons to enable a prosecution to continue. The CPS formed the view that the case should not proceed as it was not in the public interest. No further action was taken.

6.4. Ana, the victim and subject of this DHR, moved from Portugal to the UK in 2014. A close friend has described her '[she] *was a very good person and she was very friendly.* [she] *was always smiling and she got along with people. She gave more to people than she asked, and she was a good person.*'

6.5. In 2018 Ana formed a relationship with Adult A and moved in to live with him, within a couple of months of them seeing one another.

6.6. Records indicate that Ana registered with a GP Practice in December 2019, and her first contact with her GP was in January 2020, and her last contact was in November 2020. No concerns were noted in any interactions and there was no indication or disclosure about domestic abuse or any safeguarding related matters. Her attendance was mainly for antenatal and postnatal care, for which she had originally self-referred. Adult A had registered with a GP in 2013, but never visited the Practice.

6.7. In the summer of 2020 Child 1 was born. Ana had received ante-natal care from January 2020 up until the birth. Between January and July 2020, Ana had 23 face-to-face contacts with the maternity services. This number of appointments over the duration of the pregnancy was not considered abnormal and within policy guidelines, and for the majority of them Ana was seen alone.

6.8. Ana was seen postnatally by Midwives in clinic in July 2020 for a postnatal check. The handover records to the Health Visitor indicates no concerns or safeguarding risks. Based on the handover received from the maternity services, Ana and Child 1 was seen as part of the routine and scheduled health and wellbeing reviews. Records confirm that Child 1 was brought to the GP Practice for routine child development checks and immunisations over the following months.

6.9. Although it was considered stable by some family members, others were aware of ongoing problems that Ana was experiencing – notably coercion and control by Adult A. Ana moved out of the home in December 2020, going back to live with her father. It is believed that Adult A had grabbed hold of Ana and caused her to fall and injure herself, which led to the rapid deterioration in the relationship between Ana and Adult A. One close family member has recounted a number of conversations about Adult A being controlling, abusive and demanding sex with Ana on a frequent basis. Later in December, Ana was fatally stabbed to death and received 53 stab wounds.

6.10. A close friend commented during the Police investigation about one meeting she has with Ana, '*Once Ana did meet me, she had bruises on her chest and upper left arm. She showed me the pictures. She said that Adult A was drunk and jealous, so beat her up. Ana was crying when she told me this, and she said that she is scared of him. Ana said that this wasn't the first time and that she was trying to handle the situation. She was always scared of him and she was scared to leave. I told* [her] *not to be scared and to call the police if that happens. I told* [her] *many times to leave* [him] *…*'.

7. Key issues arising from the review

7.1. From review of agency submissions plus Police witness statements used for the criminal proceedings, it is clear that Adult A had a history of violence towards women, plus coercive and controlling behaviours. Records indicate that this behaviour would not distinguish when children were present, and as such, as well as there being adult women who have been a victim, children that have witnessed these behaviours are also victims.

7.2 Information strongly points to Ana, a new mother, feeling trapped in her relationship with Adult A, and fearful about her circumstances and how to safely exit. Family and friends clearly knew about the relationship dynamics and Adult A's behaviours, and despite being advised to leave the relationship Ana felt her choices were limited. From the limited contact Ana had with professionals, no information was disclosed which might indicate she was in an abusive and controlling relationship.

7.3. As a woman of Portuguese ethnicity, a new mother, and disempowered by her relationship, Ana experienced multiple intersecting factors which undermined her capacity and ability to find safety, and enjoy the experiences connected to being a new mother.

8. Conclusions

8.1. This Domestic Homicide Review has examined agency contact and involvement with a 30 year old woman, who had recently become a first time mother, and who was then murdered by her partner. The person responsible for her murder is now serving a life sentence in prison.

8.2. The review has benefitted from information being submitted from a range of agencies that had contact with the victim, the child, and the offender. It has also had sight of relevant witness statements gathered by the Police as part of their investigations. Family contributions have been minimal, despite good efforts to engage close family in the review process.

8.3. The review has captured learning, in part based on information obtained about a historical relationship between the offender, and a former partner and children. This learning is relevant as it has highlighted a pattern of abusive and controlling behaviour by the offender. This previous history was not shared with the victim, as she never disclosed to any professional any concerns or worries about her relationship with the offender. On that basis, agencies that did have contact with her, and the baby, were not able to offer support or protection, despite it being known by some family members that she was, in fact, being controlled, coerced and in an abusive relationship.

8.4. Agencies have identified learning, and opportunities for improvement, in order to strengthen their response to victims of domestic abuse. The report concludes with recommendations.

9. Lessons to be learned

9.1. Croydon Health Services have identified a number of lessons to be learnt. These include:

- This IMR has generated learning points which include practice and training requirements for staff, consideration for exceptional circumstances (such as the pandemic and/or social restrictions) and the review of domestic abuse training across the organisation.

- Staff training must include requirements regarding the use of interpreters and the potential impact lack of use can have on health disparities and partnership working with women. For example, the consistent use of interpreters could encourage women to speak openly about domestic abuse during consultations and visits and may also encourage staff to adopt the practice of routine and targeted enquiries.

- Further training is needed to promote routine questions about domestic abuse. There were some indications that Ana was isolated due to the language barrier, limited close family and the Covid 19 Pandemic. At the new birth visit, it was not possible to ask about domestic abuse as her partner was present. In these circumstances, practitioners may have benefited from a discussion with the safeguarding team and/or hospital Independent Domestic Violence Abuse to support decision making around how best to ask women about domestic abuse safely. Practice must be strengthened regarding questions being asked about domestic abuse at subsequent appointments particularly if there had not been an opportunity to explore in previous contacts.

- Services to protect women and their families must work together to develop an effective Safeguarding Business Continuity Plan including the revision of processes such as asking women and/or men about domestic abuse during exceptional circumstances, such as a national lockdown.

- It was clear that the existing policy to organise a separate or additional visit to ask women about domestic abuse could not be implemented given that it was likely that victims were living in the same home as their potential abusers. This inhibited the opportunity to find a safe space which would support a disclosure of

domestic abuse. Contingency planning regarding how to ask about domestic abuse when the partner is present. This could include more indirect questions regarding relationships, support, emotional and physical well-being and planning for the baby. In hindsight, safeguarding supervision may have helped to support risk management about the partner being present in the home had it been identified for case discussion. This case was not identified for discussion in safeguarding supervision whilst Ana was alive.

- There is limited information available about Child 1's father. This is a recurring theme in statutory reviews and more work must be completed regarding the importance of significant males in women and children's lives. Better record keeping could have improved understanding of risk.

9.2. As noted above, Croydon Children's Services was graded as inadequate in June 2017, resulting in an improvement programme being put in place. The ILACS (Inspection of Local Authority Children's Services) inspection in February 2020 identified significant improvements and the authority was graded as good. This was further endorsed when Ofsted carried out a monitoring visit in June 2021. Practice and management arrangements and standards have considerably improved since being involved with Adult B and her son five years ago. Nonetheless, lessons have been learnt as a result of conducting this DHR, and which include:

- The need for prompt decision making with the Single Point of Contact and timely allocation to a Social Worker is critical, especially when concerns of a child protection nature are referred.

- Social Worker's undertaking and completing assessments in a timely way, and within required timescales is important to providing children and their families with the right support at the right time.

- Managers and Social Workers must have a clear understanding of the impact of domestic abuse of children, but also the protective parent who may be living in a coercively controlling relationship. Understanding threshold criteria in order to escalate concerns and respond in a timely manner is important.

- Clear management oversight of the Social Worker's cases to ensure timescales are met, decision making is appropriate and thorough assessments are completed, is an important part of the overall process of responding to concerns.

- Multi-agency information sharing and joint working arrangements are vital to conducting timely and effective assessments of risks to children and protective parents living with domestic abuse.

- Appropriate practice guidance and learning opportunities are necessary to help ensure all staff have a good understanding of the impact of domestic abuse on both the victim and their children.

- Children are victims of domestic abuse too; alongside any parent that is also a victim of being in an abusive relationship.

9.3. The Police have identified that a non-standard recording template was used to record a withdrawal statement from a victim of domestic abuse. Following interrogation of this finding, it is apparent that it was a one-off matter, and not a systemic issue. No further action or recommendation is needed on this matter.

9.4. No specific learning has been identified by any other agency or service that had contact with either Ana, Adult A or child 1 i.e., London Ambulance Service.

9.5. Additional learning has also been captured;

- Ana had moved out of the family home to live with her father; this signifies an attempt to change the nature of the relationship or the start of her wishing to leave the relationship with Adult A. Research[1] reminds us that

[1] Why don't women leave abusive relationships? Women's Aid

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leaving relationships is often the most risky time for victims of domestic abuse. It is often very difficult for victims of domestic abuse to leave an abusive relationship; this can be made all the more difficult if the victims have parenting and caring responsibilities to children who live in the same house, and who are clearly totally reliant on the care they receive i.e. Child 1. All professionals need to be aware of the often-conflicting demands and dilemmas faced by victims and support them to find a safe route out of an abusive relationship. In this particular case, the impact of Covid-19 made separation even more challenging.

- Ana is likely to have experienced a range of intersecting factors which did little to enable or empower her to seek support, and find protection; these include her minority ethnicity status of being Portuguese, language barriers, being a women, and being a mother with a very young infant. The concept of intersectionality is relevant - the complex the ways in which systems of inequality based on gender, or race, or ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination 'intersect' to create unique dynamics and impact. In order to provide effective services to all local residents, design and delivery of services need to have built in mechanisms to avoid service users, albeit unwittingly, being discriminated against.

- All forms of inequality are mutually reinforcing and must therefore be analysed and addressed simultaneously to prevent one form of inequality from reinforcing another. The intersect of being a woman, being the victim of domestic abuse, and being a young mother, as well as experiencing language barriers will act against someone trying to seek support and protection.

- In areas where there is a strong and diverse population comprising of different racial, ethnic, religious and cultural constituents, service design and delivery that counteracts the cumulative effect of intersecting discrimination will be important. Empowering and involving local communities to design and deliver support services for victims and perpetrators of domestic abuse may be a productive approach to strengthening the local offer.

10. Recommendations

10.1. As a result of this review those agencies that have contributed due to their involvement with the victim have identified recommendations and actions for themselves.

10.2. Croydon Early Help & Children's Social Care have advised that as their intervention with the family was over five years ago and practice has significantly progressed since then due to the Improvement Plan required following the Ofsted inspection, any recommendations in respect of the findings made, would no longer be relevant or would already be part of overall improvement activity.

10.3. Croydon Health Services have generated a series of recommendations applicable to their service; these include:

1. Existing training should be extended to include the use of indirect questions about domestic abuse which will be safe to use when partners are present risk assessment and risk escalation, asking questions about domestic abuse in a safe manner and environment, following up on contacts when it has been unsafe to ask and gathering information on significant males.

2. Consideration to be given to how practitioners can re-visit questions about safe relationships and potential domestic abuse throughout pregnancy and following birth and embed this in practice.

3. Consideration to be given to following up questions about domestic abuse when it has been unsafe to ask and embed this in practice.

4. Training and supervision to emphasise the need to use interpreting services when required and consideration to be given to recording in Mothers own language in handheld records when required.

5. All business continuity plans must provide explicit guidance for how practitioners should manage domestic abuse during times of extraordinary circumstances such as the pandemic.

6. A domestic abuse clinical recording keeping audit should be undertaken and included lessons learnt from all statutory reviews relating to domestic abuse. This will be repeated to demonstrate evidence that practice improvements have been made.

7. When completing assessments, and during all contacts with children and families, all practitioners need to consider the role of any male in the household, or one closely associated with the household and any care they may provide to children i.e., step-parent, partner, grandfather.

8. The Domestic Abuse & Sexual Violence policy is reviewed and taken through the governance process for ratification in a timely manner.

10.4. The GP Practice for Ana and Child 1 have agreed that the following actions are needed;

1. Maintain and update domestic violence/safeguarding/vulnerable person files and policies.

2. Ongoing safeguarding training for clinical and non-clinical staff.

3. Display up to date posters relating to safeguarding in the surgery and on the practice website.

4. Non attended and patients living outside the area to be monitored and actioned appropriately.

5. Improved communications with Multi Disciplinary Teams.

6. Practice committed to IRIS (Identification in visit and safety) programme to improve and learn any lessons.

7. Safeguarding lead at the practice to attend safeguarding meetings as maximum as possible, minimum being 50%.

10.5. On the basis of information and evidence used for this review, two additional recommendation are made for the Community Safety Partnership, as follows;

1. The Community Safety Partnership should promote awareness about the impact of coercive and controlling behaviour, especially targeting other nationalities or ethnic groups resident in the Croydon area. In raising awareness, the Partnership should also conduct a locality analysis of support groups/services available to those specific populations, and consider the most effective way of raising the profile of these groups/services.

2. In undertaking the above exercise the partnership should consider the findings from the Violence Against Women & Girls consultation in order to inform targeted support, advice and protection for victim/survivors disadvantaged by intersectionality ensuring they receive the appropriate support at the right time.