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Croydon

Safer Community Partnership

Domestic Homicide Review

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

Date: August 2024 – Final Version following Home Office review

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1. Introduction to the case subject to review

1.1. This Domestic Homicide Review examines the contact and involvement of professionals and organisations with Ana, 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.

Ana was 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. (reflections from a close family member)

1.2. The Domestic Violence, Crime & Victims Act 2004 sets out the circumstances when a Domestic Homicide Review should be considered referring to the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse, or neglect by a) a person to whom he/she was related or with whom he/she had been in an intimate personal relationship, or b) a member of the same household as himself/herself. Based on statutory guidance[1], the purpose of any Domestic Homicide Review is to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.3. Based on the above criteria, and the circumstances of Ana's death, the Croydon Safer Community Partnership determined that a Domestic Homicide Review should be carried out. Domestic Homicide Reviews are not inquiries into how a person died or who was responsible for the death; those are matters for Coroners and criminal Courts respectively to determine. A subsequent Police investigation and criminal trial in 2023 found Adult A guilty of murder and he was sentenced to life imprisonment. There were no other parallel reviews taking place in respect of this matter.

1.4. The Safer Croydon Partnership and the Independent Chair would like to offer their formal condolences to Ana's family.

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016, Home Office.

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2. Methodology for conducting this review, including terms of reference & contributors to the review

2.1. Using the criteria detailed above, the Safer Croydon Partnership were notified about this death on the 5th January 2021 by the Metropolitan Police. The Partnership notified the Home Office on the 5th April 2021 about the intention to conduct a Domestic Homicide Review. This incident occurred during the Covid-19 pandemic and associated restrictions; invariably, this caused some delays to the usual processing of activities that needed to be taken. The following steps were then taken by the Partnership;

a) Requests for initial information about any contact or involvement with Ana, Adult A, and Child 1, were made to agencies/services in January 2021. Table 1 below provides details of those contacted at this initial stage.

Table 1: Agencies/Services contacted at the initial scoping stage

Agency/Service	**Agency/Service**
Clinical Commissioning Group (GP for each person)	London Ambulance Service NHS Trust
Croydon Borough Children's Social Care	Croydon Community Safety
Croydon Borough Adult Social Care	Croydon Borough Housing Services
Croydon Borough Education Services	Change, Grow, Live (Substance misuse services)
Croydon Health Services	Metropolitan Police
Local domestic abuse specialist service providers	National Probation Service
South London & Maudsley NHS Trust (Mental health services)	-

b) 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. In April 2024 he was appointed by the Home Secretary as the third Panel member for the new pilot Home Office Offensive Weapons Homicide Review Oversight Board established under the Police, Crime, Sentencing and Courts Act 2022. 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.

c) In January 2022 initial information was gained by the Independent Chair from the Police Senior Investigating Officer responsible for the investigation. This helped the Independent Chair gain a better understanding about the investigation and whether there were any factors that may inhibit contacting family members.

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d) Also in January 2022, an initial Review Panel meeting was convened to provide oversight and scrutiny to the process, agree the Terms of Reference, offer relevant expertise, and ensure the smooth and timely conclusion of the review. Table 2 below provides details about membership of the Review Panel, all of whom were independent of any case management responsibilities.

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 (and then the ICB)
Michael McInerney & then Paul McGough	Metropolitan Police	Detective Sergeant: Specialist Crime Review Group
Dr Folashade Alu	Croydon Health Services NHS Trust	Director for 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	Safer Croydon 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

e) Following the initial Review Panel meeting in January 2022 the Independent Chair contacted family members, initially by letter, and then followed up by phone call, to explain the review process and offer them the opportunity to contribute to the review. Ana's brother, who resided in Portugal and only occasionally visiting the UK, was contacted first. He expressed a desire to contribute to the review; he was also signposted to an advocacy service by the Chair. It was not possible to make meaningful early contact with Adult A's sister and her husband due to them being witnesses in the Police investigation. The Chair was only able to contact them directly until after the criminal trial had concluded, however they did not respond to efforts made. Ana's sister and father were also contacted following the conclusion of the criminal trial.

f) 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.

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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.

g) Based on the limited contact by Ana, Adult A and Child 1 as identified following the request for initial information, Table 3 below, provides details about those agencies/services that were asked to submit Individual Management Report. All report authors were independent, having had no direct management responsibility with any practitioner that may have had contact with members of the family.

Table 3: 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

h) The Review Panel met to examine information provided by the IMRs in May 2022. Further Review Panel meetings were scheduled as necessary; with Review Panels being held in October 2022, and November 2023. The criminal trial concluded in July 2023, and a final Review Panel was held in November 2023.

i) Access to statements taken by the Police was provided to the Chair post the criminal trial. This included statements from family and friends. Information from these was used by the Independent Chair as deemed necessary.

j) The final report was presented to the Safer Croydon Partnership in December 2023. As such, the review process took 31 months to complete; the delay in completing it were due to the impact of Covid-19, as well as needing to wait for the conclusion of the Police investigation and Court process. Delays due to the Home Office Quality Assurance Panel reviewing the report also account for the timeline taking longer to get to the point of publication, adding several months to the report being finalised.

k) The content of the overview report and executive summary have been anonymised to protect the identity of the victims, perpetrator, relevant family members, and others, and to comply with the Data Protection Act 1998. The detailed findings of all information provided to the review remained confidential. Information was available only to participating officers / professionals and their line managers. A confidentiality agreement was signed by DHR Panel members at the commencement of the DHR. To secure agreement, pre-publication drafts of this overview report were seen by the members of the Review Panel, and the Safer Croydon Partnership. It has also been shared with the Home Office Quality Assurance Group. This overview report and executive summary will be made public and the recommendations will be acted upon by all agencies, to ensure that the lessons of the review are learned. Furthermore, it the report will be disseminated to the following:

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- Safer Croydon Partnership
- Croydon Adult Safeguarding Board
- Croydon Children's Safeguarding Board
- The Domestic Abuse & Sexual Violence Partnership Board
- The Domestic Abuse Commissioners Office.
- A translated version of the report has been shared with the victim's father.

2.2. The review has kept in mind the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Due to the age of Child 1 at the time of the incident, age is a protected characteristic. The characteristic of sex has not been discounted given the researched evidence of women being the greater victims of violent crime caused by men[2], and being the greater victims of homicide[3]. The characteristic of race is also considered relevant and applicable given the Portuguese ethnicity of the victim. The characteristic of pregnancy and maternity is relevant given the young age of the child, and the nature of the relationship between the victim and perpetrator during pregnancy. Research[4] shows that '*… risk of domestic violence and abuse may increase for some women during pregnancy or shortly after the birth of a child …*.'. The remaining five characteristics were considered and discounted as not being relevant to any individuals in this case.

2.3. The family have no involvement with Victim Support[5]; they either declined or withdrew from support. Although provided with details, they did not access any other advocacy or support service.

3. Family, friends, and other's contribution to the review

3.1. Seeking the contributions of family members has been an important consideration for this review. Family members have, understandably, found the whole situation very difficult to come to terms with and given the extended timeframe of the review process due to the protracted legal proceedings, establishing lines of communication has been challenging.

3.2. One close family member of the victim, Ana, did initially engage with early discussions with the Independent Chair, however despite further attempts to maintain that engagement, there was no further contact. Similarly, good efforts were made by the Independent Chair to contact and engage other family members – again, these were not successful. Contact with the victim's father was successfully made at the end of the review process, and through the use of an interpreter he shared his sadness about what had happened, but did not have any thoughts about anything agencies or professionals could have done differently. As such family engagement with family has been very limited.

3.3. Police witness statements have been accessed, and where relevant and helpful to do so, information from statements of family and friends has been used for this review.

4. Chronology of relevant case history

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

- Ana – the victim and subject of this review

[2] Thiara, R., & Radford, L., Working with domestic violence and abuse across the life course: Understanding good practice, 2021, Jessica Kingsley.

[3] Home Office, Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews, September 2021.

[4] Thiara, R., & Radford, L., Working with domestic violence and abuse across the life course, p. 23, 2021, Jessica Kingsley.

[5] Victim Support is an independent charity that provides support to anyone affected by a crime, Victim Support

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

4.2. 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.

4.3. 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. Adult B had contacted the Croydon Family Justice Centre[6] who provided advice that she, and the children, should stay with friends until Adult A was arrested. Three days after this incident, Adult A was arrested, admitted an assault but minimised his actions. Following discussion with Adult B, Adult A was given a Police Caution for Common Assault. This incident was shared with a referral to Croydon Children's Services, via a MERLIN report[7] following an assessment using the B.R.A.G risk assessment model[8] given the children were present in the house at the time of the assault. There was no previous intelligence about Adult A, and the Caution was recorded on the Police National Computer (PNC). Adult B, through referral to the MARAC[9], was advised and supported by an Independent Domestic Violence Advocate and by a solicitor to make an application for a Non-Molestation Order; Special Schemes[10] were also placed on Adult B's address as an added precaution.

4.4. Following the referral to the London Borough of Croydon Children's Services, a Child & Family Assessment was initiated. Assessment activity included speaking with the children alone (age and developmentally appropriate) and observing them in the home environment, undertaking other agency checks, exploring parenting capacity and ability to protect the children, thresholds, and speaking with Adult A. The findings of the assessment included, no previous involvement by Adult B or Adult A with the Police or any other organisations prior to the recent event. Adult B did however disclose domestic abuse whilst in the relationship from when they lived in Portugal. Adult A, when spoken with, did admit some of his behaviours but minimised or denied the seriousness of them. The eldest child was able to express some views, and confirmed witnessing domestic abuse between Adult A and Adult B; going to the bedroom to hide and sometimes being hurt or shouted at, by Adult A. The child's school were contacted, provided support, but did not have any concerns about attendance, behaviour, presentation, or performance.

4.5. The assessment concluded that there were concerns about coercive control by Adult A, but that Adult B intended to end the relationship with Adult A. It also recognised that Adult A would likely maintain contact with the children. Later in November 2015 Adult A had contact with his two children at a family friend's address; this appears to have

[6] Croydon Family Justice Centre offers support, comfort and understanding to domestic violence victims and their families - along with easy access to essential services.

[7] MERLIN – a reporting and recording database used by the Police.

[8] B.R.A.G – a model of risk assessment used by the Police to determine levels of need, risk and associated actions that may be needed.

[9] MARAC – Multi-Agency Risk Assessment Conference: A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim.

[10] Special Schemes allow the Police to enter comments on their databases which aid despatch responses to particular addresses, for example, where there may be known domestic abuse, or persons at risk of assault.

been an impromptu visit, but which resulted in the Police being called. No offences occurred and Adult A left the address accompanied by the Police. Given the findings from the assessment, the decision to close the case, on the basis that the relationship was ending, was endorsed by a manager from Children's Services. No ongoing support was recommended given that the Family Justice Centre were involved and the family were known to MARAC. The case was closed in May 2016.

4.6. In March 2017, Adult B and Adult A appeared to have resumed their relationship. Adult B attended Croydon Police station reporting domestic abuse from the previous day. She reported that Adult A had accused her of having an affair with another man, then physically and sexually assaulted her, but also threatened to kill her by waving a knife in front of Adult B. Adult B stated that he threatened to kill her if she ever left him, 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 using 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 Centre. 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.

4.7. During her report to the Police in March 2017, Adult B disclosed that Adult A had previously assaulted their eldest child, by slapping, and made threats to the child. These incidents were reported to have happened over a lengthy period, but not recently. This information was appropriately shared by the Police with Croydon Children's Services, who advised that they had conducted an assessment in May 2016 (following the earlier incident) and that no allegations, complaints or disclosures had been made by the eldest child. On this basis, the Police decided that no further action would be taken on this matter. The assault and accompanying information were referred to the MARAC in May 2017. In turn, this prompted an onward referral to the local Domestic Abuse Service that were able to provide advice to Adult B and resulted in the allocation of an Independent Domestic Violence Adviser.

4.8. Ana, the victim, and subject of this DHR, moved from Portugal to the UK in 2014. At this point she formed a relationship with a male in the London area, moved in to live with him, but which last approximately six months. Having moved out, Ana then went to live with her father. 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.*'

4.9. 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.

4.10. 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.

4.11. 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. Of these, there were

two telephone conversations and one virtual contact. These were to assist her with becoming a new mother, but also some personal health complications which routinely need additional care and support whilst pregnant. 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.

4.12. Ana was seen postnatally by Midwives in clinic in July 2020 for a postnatal check. There is no mention of whether her partner, Adult A, was present or whether domestic abuse was discussed or disclosed. She was later discharged in August 2020 following contact with the Health Visiting Service. 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.

4.13. 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[11].

4.14. A close friend commented during the Police investigation about one meeting she had 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 …*'.

5. Findings & analysis

1. As set out in section 1.2, the purpose of this review is to establish any lessons to be learnt regarding the way in which local professionals and organisations worked individually and together, begin the process of improvement and development activity based on lessons learnt, and support a preventative and coordinated approach to identifying and responding to domestic abuse.

2. Information has been submitted to this review which has helped establish lessons to be learnt. These have been based on a review of documents submitted of agency contacts and involvement with Ana, Adult A, and Child 1. Although not related to the relationship between Ana and Adult A, nor the circumstances around her death, known information about Adult A's relationship with a former partner, where domestic abuse was a strong feature, has been examined to aid learning; this is relevant and necessary to examine as it evidences a thread of concern that carried through from one relationship to another – and which ultimately resulted in the murder of a woman, who had recently become a mother for the first time. Additionally, statements and material used by the Police during their investigation and the subsequent Court trial have been examined. The contributions of family members, from witness statements, have also helped shape the findings and analysis. The agreed lines of enquiry, as set out below, provide further detail about agency contact and involvement, which then lead to identifying lessons learnt.

5.1. The opportunity for agencies to identify and assess domestic abuse risk.

Croydon Early Help & Children's Social Care

[11] Often referred to as 'overkill' - usually indicates the infliction of massive injuries by far exceeding the extent necessary to kill the victim. Solarino, B., Punzi, G., Di Vella, G., Carabellese, F., Catanesi, R., A multidisciplinary approach in overkill: Analysis of 13 cases and review of the literature, Forensic Science International, Volume 298, 2019, pp 402-407, ISSN 0379-0738, https://doi.org/10.1016/j.forsciint.2019.03.029.

5.1.1. Croydon Early Help & Children's Social Care provide statutory services to children in need, or in need of protection to promote better outcomes for children and families in the Croydon area. They have detailed their involvement with Adult A, prior to him entering a relationship with Ana. This is relevant history to examine given the consideration of domestic abuse.

5.1.2. It has been identified that opportunities to assess risk, following confirmed incidents of domestic abuse, were not maximised between November 2015 and May 2016 whilst Adult A was in a relationship with Adult B. This included:

- Delays in the case being allocated to a Social Worker following Adult B attending the Police station and disclosing domestic abuse, and the Police referring this matter to the Early Help & Children's Social Care. The referral should have been progressed within a set period, dependent on the risk rating judgement. As a result, the Social Worker then did not undertake an initial visit within the required timeframe (10 days from date referral received).

- There is evidence that there were gaps in recording of visits to the family. This is not in line with the recording procedure as set by Early Help & Children's Social Care. These omissions were also not picked up by the Social Worker's manager.

- There was delay in completing the assessment. The manager recognised this when authorising the assessment and explains this was due to conflicting work pressures.

- Adult B disclosed significant current and ongoing domestic abuse and physical abuse of her child, who confirmed this child had witnessed the abuse and that the father had hurt him, causing bruising. This should have prompted a Strategy[12] discussion at the referral stage or when further concerns came to light; it did not.

- There was limited evidence of multi-agency liaison recorded on the file. The social worker liaised with the child's school but no contact was made with other professionals who may be able to assist with the initial assessment of risk i.e., GP or the Health Visitor.

- There is limited management oversight recorded, which may have identified the delay in progressing the assessment and considered the need for a strategy discussion at an earlier stage.

- There is no indication that the decision to close or not convene a Strategy discussion was challenged by the professional network – which of course, would be limited, as there was minimal contact with other professionals.

5.1.3. Examination of their later involvement, in April 2017 when the relationship between Adult B and Adult A resumed, highlights a further episode where opportunities were not maximised to consider risk of harm to either the child or Adult B. This includes:

- Although the resumption of the relationship was recognised as a risk factor, there was no consideration of a Strategy discussion given the significance of the relatively recent domestic abuse disclosed by Adult B. It is recorded that no further action was taken on this matter as Adult B again confirmed that she was going to end the relationship.

[12] Strategy discussion, Children Act 1989, section 47 - Where a local authority - (a) are informed that a child who lives, or is found, in their area - have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

5.1.4. Factors which are highly likely to have contributed to the quality and effectiveness of the service offered to Adult B, and her child, during this time from Croydon Early Help & Children's Social Care have been noted. Croydon Children's Services was graded as inadequate and/or requiring improvement in June 2017 by Ofsted[13]; this will have impacted on service provision in the preceding months and years (since the previous inspection in 2012). Comments by Ofsted, which shed light on the effectiveness of the system include *'… There are widespread and serious failures in the services provided to children and their families in Croydon that leave some children at risk of significant harm. … Poor managerial oversight of cases fails to ensure that basic social work practice is of a good enough standard. This means that not all children receive help in a robust and timely manner. … too many children living in families affected by domestic abuse do not receive the appropriate level of help and protection to substantially reduce risk …'*.

5.1.5. No concerns about domestic abuse between Ana and Adult A have been highlighted in information submitted to this review, other than some knowledge about some relationship problems in December 2020, a few days before Ana's death. On that basis, Croydon Early Help & Children's Social Care had no information, no justification or reason to be aware of this family. As such, they had no opportunity to identify or assess domestic abuse; nonetheless, have identified learning and this is set out in section 6 of the report.

Metropolitan Police

5.1.6. The Police had no contact or involvement with Ana, Adult A or Child 1 whilst they were together in their relationship and as a family. As detailed above, they did have contact and involvement with Adult A whilst in a former relationship due to domestic abuse and child protection concerns. Records confirm that on the occasions that Adult B did contact the Police disclosing abuse, appropriate actions were taken to manage Adult A, resulting in information being shared with Children's Social Care, risk assessments being conducted, referrals to the MARAC, charging and imposing of bail conditions following release from custody.

5.1.7. The Police have identified that a non-standard withdrawal statement was used by the investigating officer when responding to the March 2017 incident in which Adult B had alleged physical and sexual assault, but later withdrew her statement. The risk identified with the use of such a non-standard template was that it was too prescriptive and did not allow for the victim to be freer in her recall of information, thereby potentially inhibiting an open and discursive recollection of events and options. This must also be considered alongside Adult B's revelation that she had felt pressured into withdrawing her statement by her family, but was also receiving support from an IDVA and the Family Justice Centre. Whilst this does not appear pivotal to how the case was managed or decisions made, it is a useful reminder about the importance of all professionals allowing time for victims to feel able to freely recall events, consider their options (and consequences) and feel empowered to make informed decisions – rather than being on the receiving end of an overly prescriptive process that inhibits decision making.

Croydon Health Services

5.1.8. The contributions of Croydon Health Services are important to consider, notably in the context of their contact with Ana during her pregnancy and after-care for Child 1. Croydon Health Services (CHS) NHS Trust provides integrated NHS services to care for people at home, in schools and health clinics across the Borough as well as at Croydon University Hospitals (CUH). It provides more than 100 specialist services, including an emergency department and 24-hour maternity services and Child Health Services. Maternity services provided by the Service include antenatal care, intrapartum and post-natal care. In cases of successful pregnancies, mothers and their babies are then transferred

[13] Ofsted, London Borough of Croydon, Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children Board, Inspection date: 20 June – 13 July 2017, Report published: 4 September 2017

seamlessly into the Child Health Services Health Visiting service. Croydon Health Visiting service provide integrated health services to support families from pregnancy until their child starts school at age five years.

5.1.9. Croydon Health Services have identified three areas in relation to care delivery, and which are relevant to the identification and assessment of domestic abuse risk. These include:

- the use of language interpreters for non-English speaking service users.
- domestic abuse routine enquiry and targeted enquiry.
- clinical record-keeping.

5.1.10. Ana's 23 face-to-face contacts with the maternity services are in line with national guidance and Croydon Health Services policies, and are consistent in supporting Ana as a young mother to help manage the complexities of her pregnancy. Records also identified one single missed appointment. There is no written evidence to suggest that the reason for the missed appointment was explored. However, this issue is not uncommon but may indicate cause for concern when viewed within the context if there had been other risk factors. In this instance, there were no other risk factors flagged in the records by health professionals who had contact with Ana and as such, did not prompt any cause for concern. The Midwife followed Croydon Health Services Missed Appointment Policy and immediately re-booked the appointment, which is expected practice.

5.1.11. Throughout Ana's contact with services there is documented evidence to show that practitioners used interpreters on four occasions; this means that on 19 occasions, an interpreter was not used. Importantly, there is no documented evidence to indicate whether Ana spoke and or understood English sufficiently to be seen without an interpreter. Ana's hand-held records were entirely written in English and key information regarding her medical conditions were not translated. It is therefore unclear how care was delivered effectively without the use of an interpreter. Research[14] has shown that communication barriers have deterred service users from seeking preventative support but can also lead to poor knowledge and comprehension of diagnosis, poor adherence to treatment, and increased risk of medical errors and poor health outcomes. An added factor that invariably exists in such a scenario is a reluctance to, and/or reduction in, domestic abuse disclosures. Whilst there is no evidence to suggest that this omission contributed to gaps in domestic abuse disclosure, Croydon Health Services have highlighted room to improve equity and access in relation to language barriers for pregnant women.

5.1.12. The clinical record keeping shows that Ana was asked about domestic abuse, and denied any, during her first contact with maternity services with the help of an interpreter. There is no information to suggest this not to be true given witness statements confirming that in the earlier stages of their relationship, there were fewer reported problems between Ana and Adult A. However, it is important to remember, based on the findings from research[15] that victims and or survivors of domestic abuse do not always disclose incidents of abuse during the first contact with professionals and in some instances, victims need to build a trusting relationship with professionals to overcome perceived barriers, particularly those victims from an ethnic minority background. Information gathered from witness statements has confirmed the presence of a coercive, controlling, and abusive relationship between Ana and Adult A. Clearly, Ana did not feel able to disclose these difficulties, and it might be reasonable to conclude that professional interactions at the time did not create the conditions in which Ana felt she could discuss any problems she was having.

5.1.13. Domestic abuse was considered during the new birth visit by the Health Visitor. However, it was noted that Adult A was present during the visit and therefore it would not have been appropriate to ask about domestic abuse.

[14] Kaur, R., Oakley, S., & Venn., P., 2014, Using face-to-face interpreters in healthcare, Nursing Times; 110: 21, 20-21.

[15] a) Heron, R.L., Eisma, M.C. & Browne, K. Barriers and Facilitators of Disclosing Domestic Violence to the UK Health Service. J Fam Viol 37, 533–543 (2022). https://doi.org/10.1007/s10896-020-00236-3 b) Robinson, L., & Spilsbury, K., Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence, Health & Social Care in the Community, 2007, https://doi.org/10.1111/j.1365-2524.2007.00721.x

This is good practice; however, it was not followed up or escalated. Croydon Health Services Domestic Abuse Policy 2019 guidance suggests that practitioners should make alternative arrangements to ask women about domestic abuse either by inviting them to clinic or during a separate visit. This visit was undertaken during the Covid 19 Pandemic restrictions and women were not being invited to community clinic settings. A review of Croydon Health Services domestic abuse processes during the Covid 19 pandemic, identified that the process in relation to asking women about domestic abuse at new birth visits were not amended to reflect the circumstances whereby potential perpetrators were more likely at home during Health Visitors contacts. This is relevant because there is overwhelming evidence[16] that points to a significant increase in domestic abuse nationally during the pandemic. It should also be noted that it would not have been practical for the Health Visitors to return to the home or leave domestic abuse information with Ana without assurances that it would be safe to do so. This particular set of circumstances reflect the challenging times all services were working in, due to the pandemic, and how revised policies and procedures were not fully aligned to support staff in dealing with 'out of routine' events. It also highlights the need for all practitioners to be skilled at exercising professional curiosity, in a discursive and exploratory way, to gauge the quality of parental relationships, and then evaluating whether there may be value in further follow-up discussions.

5.1.14. One family member commented during the Police investigation about the relationship between Ana and Adult A, *'… the arguments became frequent and he accused her of being a bad mum, and that she did nothing at home. Child 1 had a difficult beginning because* [of sleeping*] … As Ana was a first-time mum she wanted to spend all her time with Child 1. Adult A would complain that Ana spent all her time with Child 1 and not with him …*'.

5.1.15. A review of clinical record keeping identified specific difficulties in trying to understand the nature of communication between Ana and those who came into contact with her. For example, it is difficult to decipher whether gaps in domestic abuse discussions/documentations were related to omissions of duty to discuss domestic abuse or failure to adequately document discussions. There is also no information regarding Adult A in the records. Whilst it is recognised that Ana attended most of her appointments alone, thereby somewhat limiting the opportunity to record observations about Adult A, and gather his views, it is evident that opportunities did exist to capture information about Adult A via Ana. There is considerable research[17] to support the fact that male partners or fathers are often overlooked by professionals during assessment activity or do not actively engage with professionals during their partner's pregnancy.

5.2. Agency responses to any identification of domestic abuse issues.

5.2.1. Croydon Early Help & Children's Social Care were not involved with Ana, Adult A or Child 1 at any point up until Ana's murder; it is at this point that they became involved due to the immediate (and long term) care and welfare needs of Child 1 needing to be formally considered. However, as noted above, they did hold relevant information about Adult A from a previous relationship. Contributing factors relating to the unsatisfactory response to domestic abuse and child welfare concerns between 2015 – 2017 have already been commented in section 5.1.

5.2.2. For the duration of their contact and involvement, Croydon Health Services did not identify any domestic abuse issues during their contacts with Ana. Whilst they confirm that Ana was seen alone, was provided with some support of an independent Portuguese language interpreter for a small number of contacts, and specific questions were asked and recorded during the initial antenatal appointment, this good practice was then not consistently followed through in other appointments. At the initial antenatal appointment, Ana denied any incidence of abuse - this may have

[16] a) How the Covid-19 lockdown affected the domestic abuse crisis, UK Research and Innovation, and b) Domestic abuse & Covid-19: A year into the pandemic, House of Commons Library

[17] a) NSPCC, Hidden men: learning from case reviews, March 2015. b) Department for Education, Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, Final report May 2016, University of Warwick & University of East Anglia.

influenced the forming of an assumption and bias, resulting in questions not being asked at subsequent appointments. As noted above, the conditions during these professional interactions were seemingly not conducive to Ana sharing her worries about being in the relationship with Adult A, or the control and abuse she was experiencing.

5.2.3. The Police had no contact and no information of concern about Ana, and her relationship with Adult A. On this basis, there was no reason for them to use or share the information they had available to them about Adult A's previous relationship and domestic abuse.

5.3. The communication, procedures, and discussions, which took place within and between agencies.

5.3.1. Information provided by all agencies confirms that there had been no involvement with Ana or Child 1 that caused concern – either from a domestic abuse or child welfare/child protection perspective. On this basis, there was no rationale or legal basis for agencies to communicate with one another, or share information. The Police have commented *'… In examining the domestic abuse incidents prior to Ana's death, consideration has been given as to whether any additional measures could have been implemented to protect Ana. By way of example, if one considers MARAC and Domestic Violence Disclosure Scheme (Claire's law), there may have been an opportunity to engage with Ana to offer advice and support, however given there was never any reported incidents between Ana and Adult A, or any information to suggest domestic abuse against Ana, the opportunity to intervene never arose ...'.* Following this line of opportunity through to other agencies, there was no opportunity for those agencies that were having contact with Ana or Child 1 to become aware of Adult A's previous relationship and history.

5.4. The co-operation between different agencies involved with Ana, Adult A, and Child 1.

5.4.1. Information submitted by Croydon Health Services, Croydon Early Help & Children's Social Care, the Police, and GP Practices indicates no known concerns about the relationship between Ana and Adult A, or about Child 1. On that basis, there is no learning regarding how agencies or professionals might have needed to cooperate with one another.

5.4.2. In respect of agencies contact and involvement with Adult A, and his previous relationship with Adult B, Croydon Early Help & Children's Social Care have identified that actions should have been taken in response to information which suggested actual, or likely, significant harm to Adult B's child; this would have been in the form of convening a Strategy discussion involving other agencies. Reasons for this not taking place have already been set out above and it is anticipated that if a similar situation occurred in 2022, their response would be more robust and in accordance with the London Child Protection Procedures.

5.5. Organisations' access to specialist domestic abuse agencies.

5.5.1. Specialist services available in the local area include; Bromley and Croydon Women's Aid, Victim Support, Black & Minority Ethnicity Forum, Lioness circle, Hersana, BAME Domestic Abuse Partnership, and ANOS (Another Night of Sisterhood). These are all accessible by agencies and can be used to signpost victims for support.

5.6. Policies, procedures, and training available to the agencies involved on domestic abuse issues.

5.6.1. Those agencies that contributed to this review have confirmed the presence of policies, procedures, and training available to staff.

5.6.2. Croydon Health Services, policy, the Management of Domestic Abuse and Sexual Violence Policy, was last reviewed in June 2020. Learning captured as a result of analysing their contact and involvement with Ana has highlighted the policy and procedure is in need of review.

5.6.3. Croydon Health services has also confirmed training available to staff, which is delivered as part of the safeguarding Anand safeguarding children's training programme. Domestic abuse training is delivered as a standalone training. Prior to Covid 19 lockdown in March 2020 this training was conducted face to face by Croydon Health Services Independent Domestic Violence Advocate (IDVA). Since the suspension of all face-to-face training in March 2020, staff

requiring level 3 safeguarding adults and safeguarding children training have been directed to Croydon Health Services Electronic Staff Record (ESR) to book their level 3 training. Bespoke domestic abuse training is available for all services and departments on request and is jointly delivered by the IDVA and the safeguarding adult team. As we come out of having to manage Covid-19 additional training opportunities will be considered as necessary and staff compliance with training on this subject matter will be reviewed during 1-1 staff appraisal sessions.

5.6.4. Croydon Early Help & Children's Social Care have confirmed that they use the London Child Protection Procedures in terms of procedural guidance in relation to identifying and responding to domestic abuse in the context of child welfare concerns. These are monitored and updated on a regular basis. These procedures are relevant and applicable to all agencies and services coming into contact with children, including Croydon Health Services, the Metropolitan Police, London based GP services, and London Ambulance Service.

5.6.5. Croydon Early Help & Children's Social Care have also confirmed training available to staff on an internal basis. This includes training about engaging with perpetrators of domestic violence, assessing risk and harm in domestic abuse, intersections, and intersectionality in domestic abuse, exploring coercive control, working with men as fathers through a domestic abuse lens, partnering with survivors, direct work with children experiencing domestic abuse, and supervising domestic abuse cases (coaching for managers). Additional training on domestic abuse, risk assessment and MARAC is also provided locally by the Family Justice Centre.

5.6.6. The Police have confirmed their relevant policies/procedures to be the Domestic Violence guidance and Standard Operating Procedures, Domestic Violence Risk Identification, Assessment & Management Model (SPECSS+), and the Multi-Agency Public Protection Arrangements guidance and Standard Operating Procedures. As well as having domestic abuse champions that focus on continuous policing improvement, training is also provided to Police Officers. Between the 02 July and the 30 September 2021, the MPS delivered 'DA (Domestic Abuse) Matters' training to its emergency response officers. This training would have been delivered sooner were it not for the impact of the Covid pandemic. The training was provided to 87% of the 8000 officers identified, the shortfall of training being due to absence reasons including Covid. It is a classroom-based training programme designed specifically for UK Police first responders. The training used real-life footage, case studies and exercises to demonstrate how to identify and gather evidence of coercive controlling behaviour, recognise perpetrator tactics, and understand the dynamics of domestic abuse. It also aimed to cover a number of topics: responding to vulnerable people, honour-based violence, child protection and Anabuse as well as how to deal robustly with perpetrators.

5.6.7. The Family Justice Centre in Croydon provide domestic abuse & sexual violence training borough wide for partners, voluntary sector, and communities. Specific training is delivered to trainee Detective Constables as part of their induction.

5.7. The impact of Covid-19 restrictions on circumstances for Ana and Child 1.

5.7.1. Most of Ana's pregnancy occurred during a national lockdown due to the Covid-19 pandemic. It is hard to imagine how this would not have been worrying for Ana during her pregnancy. Based on research[18] conducted, it is reasonable to conclude that there would have been some impact on Ana during her pregnancy.

[18] a) NSPCC, Mental health risks for new and pregnant mothers during coronavirus,2020-05-06, NSPCC News b) López-Morales, H., Del Valle, M. V., Canet-Juric, L., Andrés, M. L., Galli, J. I., Poó, F., & Urquijo, S. (2021). Mental health of pregnant women during the COVID-19 pandemic: A longitudinal study. Psychiatry research, 295, 113567. https://doi.org/10.1016/j.psychres.2020.113567, c) Borges, R. P., Reichelt, A., Brito, A., Molino, G., & Schaan, B. D. (2021). Impact of the COVID-19 pandemic on mental health of pregnant women with diabetes mellitus and hypertension. Revista da Associacao Medica Brasileira (1992), 67(9), 1268–1273. https://doi.org/10.1590/1806-9282.20210504

5.7.2. The NSPCC commented on this[19], *'… families across the UK are facing unprecedented pressure as they attempt to cope with the impact of COVID-19, with pregnant women and new parents having to manage one of life's biggest changes in the middle of a national health crisis …'*. Services that had been actively engaged with Ana during this time included her GP and Croydon Health Services. No concerns of a safeguarding nature, domestic abuse or mental health difficulties were identified by the GP Practice and no information has been provided to indicate that their contact with Ana was impacted by Covid-19.

5.7.3. Most of Ana's contacts with Croydon Health Services occurred whilst the nation was faced with national lockdown's due to the Covid-19 pandemic, and which caused all agencies and professionals to have to rapidly re-think how to deliver safe and effective services. Croydon Health Services have identified that the Covid-19 pandemic did impact on their service delivery. Whilst this does not appear to relate to service delivery during the pregnancy, thereby highlighting that Ana's physical health care was not compromised, it relates to the opportunity for the Health Visitor to follow up questioning about domestic abuse after the new birth visit. This opportunity was not taken due to women not being invited to community clinics due to Covid-19, and opportunities to engage with all new mothers beyond any medical and clinical requirements, would have been stretched. This has highlighted the need for the Health Visiting Services to ensure robust processes are in place to follow up and seek assurance about situations where there are known safeguarding related concerns, during circumstances such as a national lockdown. In this case, there were no known safeguarding related concerns.

5.7.4. Also, during the Covid-19 pandemic and associated lockdown's, team briefings were delivered to Children's Social Care in relation to how to have conversations regarding domestic abuse over Zoom and when victims were isolating with perpetrators. Safe space campaigns in supermarkets and pharmacies were carried out during lockdowns and were later introduced to schools when children returned to school. Posters were displayed in six different languages.

6. Conclusion

6.1. 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 in December 2020 having been fatally stabbed multiple times. The person responsible for her murder is now serving a life sentence in prison.

6.2. 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.

6.3. 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. Her contact with agencies and professionals was minimal. 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.

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

7. Lessons to be learnt

[19] Andrew Fellowes, Public Affairs Manager, NSPCC, 2020-05-06 / News.

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7.1. 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.

7.2. 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 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.

7.3. 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.

7.4. 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.

7.5. 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[20] reminds us that leaving relationships is often the riskiest 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 even 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 case, the impact of Covid-19 made separation even more challenging.

- Ana experienced a range of intersecting factors which combined did not enable or empower her to seek support, and find protection; these include her minority ethnicity status of being Portuguese, language barriers, being a woman, 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. To provide effective services to all 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.

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

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- 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.

8. Recommendations

8.1. 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.

8.2. 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.

8.3. 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.

8.4. 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.

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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%.

8.5. On the basis of information and evidence used for this review, three additional recommendations 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 to inform targeted support, advice and protection for victim/survivors disadvantaged by intersectionality ensuring they receive the appropriate support at the right time.

3. The Croydon Violence Against Women Group network should ensure it seeks representation from organisations who support minoritised victims/survivors, including those from the Portuguese community.

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Appendix 1 - Single Agency Recommendations and Template Action Plan – Action plan is a live document and subject to change as outcomes are delivered.

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No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
Croydon Health Services 8.3							
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.	Revise and implement domestic abuse training delivery as mandatory			Named Professionals NW/MLW		05/01/2023- MW to discuss this in maternity training and update mandatory training.
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.						Waiting for update to be provided
3	Consideration to be given to following up questions about domestic abuse when it has been unsafe to ask and embed this in practice.	The CHS Domestic Abuse Policy and the Maternity Care of Women with Complex Social Factors policy to be reviewed and updated			OO/ NW		05/01/2023 Policy is currently under review 21/02/2023 – Emailed AW (SGA) to confirm if this has been added to the DA policy. 21.03.2023

							The maternity policy is being reviewed and the DASVSW has contributed to this 30.05.23 DA policy going for ratification June 10.10.23 Policy updated, awaiting Complex care policy to be updated 19.12.2023 Care of the woman with complex social factors policy updated and ratified December 2023 All training around domestic abuse includes the need to ask about supportive relationships and how to explore a line of enquiry about domestic abuse
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.	Review clinical recording processes to explore opportunities to record essential information in Mothers first language when required. Relevance of interpreters in safe practice to be promoted			OO		This has been considered. The trust are currently reviewing their contract with the interpretation services provider This has also been discussed at a South West London Level and within CHS. This will need to be discussed to see what neighbouring trusts are doing and if there is any learning that can be shared Maternity policies have been updated to reflect the need for interpreters.

		Review training, policies, and supervision processes to include sufficient reference. Include in audit processes.					HEARD campaign leaflets promoting use of interpreters. 21/02/2023 – OO to add HEARD Campaign leaflets to evidence folder 19.12.2023 - Care of the woman with complex social factors policy - Antenatal Care pathway and clinical risk assessment Guideline updated and ratified December 2023
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.	Revised and update business continuity plans			Named professionals		02.01.23 Sat will arrange a meeting with the CHS safeguarding team to have a pathway All business continuity plans will give due regard at the time to safeguarding in terms of domestic abuse and routine enquiry when making plans that may involve virtual consultations during a 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	Devise and implement an audit.			OO		05/01/2023 Audit to be undertaken in quarter ¾ 21/02/2023 – Audit being completed 13.11.2023 Audit completed and written up, presented at Children

	practice improvements have been made.						and adults group. Sent to audit department Saved in the evidence folder
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.	All practitioners to consider significant partners when completing assessments and during contacts. Review training, policies, and supervision processes to include sufficient reference. Include in audit processes.			OO/ AW		05/01/2023 – Updated training to include professional curiosity and add to maternity training. 21/02/2023 – included in MARF audit Children's/Maternity. Emailed AW (SGA) to confirm if this has been added to the DA policy. 10.10.23 Discussed in training and community midwifery meeting on 30.08.23
8	The Domestic Abuse & Sexual Violence policy is reviewed and taken through the governance process for ratification in a timely manner.						
GP for Adult A and Child 1 8.4							
No.	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
1	Maintain and update domestic violence/safeguarding/vulnerable person files and policies.	Have a governance process in place and ensure policies are reviewed and signed off in a timely manner	Policies updated on an yearly basis these area available on a shared drive. The Patient Participation Group at the Practice meet quarterly to	-Continual improving of safeguarding practices -Updated clinical system	Dr Ravi-Shankar	31 March 2025	All safeguarding documents received into the practice are coded as appropriate. The register is recorded on the clinical system

			discuss Practice issues and patient experience to improve the service provision. Minutes of these meetings are available on request				
2	Oversight of safeguarding training for clinical and non-clinical staff.	Continues to be mandatory for all staff. All staff are expected to complete safeguarding training at induction then the required hours over 3 years.	Certificate of attendance or training compliance report. Spreadsheet in place to monitor compliance	Compliant with intercollegiate guidance for safeguarding adults and children (including children looked after).	HR	On-going	Safeguarding competencies are assigned according to the various job roles for staff
3	Display up to date posters relating to safeguarding in the surgery and on the practice website.	-Practice Manager to ensure posters are displayed - Optimise website – Tab for safeguarding to be updated with local safeguarding information	Available in waiting room, patients' toilets and consultation rooms for patients to access. All posters have to be infection control compliant	Patients are informed and confident that all staff at the Practice take their safeguarding responsibilities serious. Public facing website makes reference to safeguarding	Practice Manager	On-going	Information available on website Abuse Services (stjamesmedicalcentre.nhs.uk)and practice waiting rooms
4	Non attended and patients living outside the area to be monitored and actioned appropriately.	Registered patients have the responsibility to	Receptionists routinely ask patients to confirm	Process in place to monitor that	Practice Manager and	On-going	DNA protocol introduced – admin team monitor all DNA and make contact with vulnerable patients

		notify the GP Practice about changes in personal information i.e address, telephone numbers, etc.	that their personal information is up to date. Telephone calls and a written letter to patients and work collaboratively with partner agencies i.e Social Care and Police	patients are live on the register. NHS spine is the portal which allows information to be shared securely through national services such as the Electronic Prescription Service, the Personal Demographics Service, the Summary Care Record and the e-Referral Service. Patients are advised to register with services local to them and the Practice staff support them with this.	Administrative staff		who DNA appointments – if no response from patient, GP is notified – this is in relation to DNA in settings outside of the practice. Clinicians are responsible for contacting vulnerable / safeguarding patient who did not attend their general practice appointment. Vulnerable patients are flagged on the clinical record system
5	Improved communications with Multi Disciplinary Teams.	Continue to ensure attendance at MDT meetings and regularly liaise with social services	Minutes of meetings/ Huddle meetings attended by social care/Feedback from Personal	Maintain a Good rating from CQC St James Medical Centre - Care Quality Commission (cqc.org.uk)	All staff	On-going	Liaise with social services – and discussion in wider MDT team via huddles. Social prescribers closely liaise with social services and attend

			Independence Coordinators	This inspection was focused on the management of access to appointments			ICN plus meetings for case discussions. For vulnerable nursing home patients, we engage the complex care team and attend monthly care home meetings to discuss these patients.
6	Practice committed to IRIS (Identification in visit and safety) programme to improve and learn any lessons.	Become an IRIS Practice - 75% of staff (all clinical and non clinical) to complete training and repeat 3 yearly - Engage with the IRIS programme and submit referrals Display IRIS posters and leaflets for patients to access - Implement SnoMed on EMIS - Where patient presents with potential domestic abuse (i.e health indicator), ensure patients is routinely asked about domestic abuse and	Referral data/ IRIS related data. NNNGP Primary Care Safeguarding Codes v	Implementation and active use of safeguarding Snomed codes across Practice	Practice Manager to liaise with IRIS team	31 March 2024	IRIS Advocate Educator allocated to the Practice. IRIS team has engaged with GP Practices. IRIS Clinical Lead provided an update at Primary Care Quality Working Group. Due to receive IRIS clinical refresher training. SWL ICB secured funding to sustain the IRIS programme

		offered appropriate support services.					
7	Safeguarding lead at the practice to attend safeguarding meetings as maximum as possible, minimum being 50%.	GP Safeguarding leads to engage and attend the quarterly training sessions and forums hosted by the ICB's safeguarding team	Certificates of attendance Reflective practice	Support the practice staff with their safeguarding queries. Provide staff with safeguarding supervision	Dr Ravi Shankar	On-going	Safeguarding lead remains fully engaged with the ICB's safeguarding development offer
Multi-agency recommendations 8.5							
No	Recommendation	Key Action	Evidence	Key Outcomes	Named Officer	Date	Update
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.	Develop a new borough-wide website for DASV/VAWG to promote local grassroots organisations and VCS organisations.	The Croydon Design team and the DASV Co-ordinator has initiated work and has held four planning meetings in 2023.	To create a dedicated online space for residents and professionals to access all information relating to DASV/VAWG including controlling and coercive behaviour. Provide access to a local directory of support including by and for organisations and grassroots organisations.	VAWG team	September 2024	The design team's current quote is unattainable due to budget constraints, and alternative options are being explored, with meetings scheduled for February 2024. Update: 1/2/2024 – meeting to update on budget available and options explored. Micro-site or update on current council website to be explored further. Update 20205 – the council webpage and now been updated. Domestic abuse and sexual violence | Croydon Council

		The Croydon Comms team will utilise social media to promote local VAWG organisations, both by and for and grass-roots.	Comms Safer Croydon Partnership plan	Increased awareness being raised for by and for organisations working with V/S in Croydon.	Comms Team/VAWG team		During the 16 days of activism in 2024 Croydon comms team highlighted the work of local by-and-for organisations and specialist VAWG organisations including updating the Council webpage to include a directory of local VAWG organisations.
		Conduct a comprehensive locality analysis to identify support groups and services for specific nationalities and ethnic minorities in Croydon that offer information and support on controlling and coercive behaviour.	Provide Assessment and report on completion. AVA VAWG strategy consultation report.	Map out existing resources, understanding their reach and effectiveness and identifying any gaps in provision. Raise profile of support groups and services identified in the locality analysis.	VAWG Team	July 2024	Independent consultation completed. Updated council webpage with local support groups and services. December 2024.

		Follow up with 4 workshops focusing on C&C in the community working with by and for organisations in the borough targeting specific ethnic groups and nationalities	Agendas/promotion material.	Increase understanding of C&C and increase likelihood of reporting. Dispel misconceptions about abuse being limited to certain demographics encouraging victims to seek help regardless of their background.	VAWG team	September 2024	Outstanding to complete.
		Engage with specific nationalities and/or ethnic groups to understand their needs and concerns.	Croydon VAWG Consultation report.	Identify and understand the need of specific groups in relation to controlling and coercive behaviour.	Croydon VAWG team	Feb 2024	Independent consultation concluded in August 2024

Permission granted by the Home Office to publish the review

	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	Continue to collaborate with the Croydon VAWG network and Croydon BAME DA forum (BDAP) to access all Croydon-based groups assisting victims/survivors.	Agendas and meeting actions.	Attend quarterly meetings for both and request agenda slots to provide update on this recommendation.	Croydon VAWG Team	Ongoing	Next BDAP meeting taking place in February 2024 and DASV coordinator will be attending to update. AVA will attend the BDAP meeting in February 2024 to participate in the VAWG strategy consultation work. Update: Independent consultant attended meeting in during 2024.
		Undertake a review of current awareness raising campaigns to ensure that controlling and coercive behaviour is recognised as abusive and targets specific ethnic minority groups.		Review content to ensure up to date with current research and practice. Promote revised campaigns in target areas and communities.	VAWG Team	July 2024	Croydon has published its first Tacking VAWG delivery plan which considered the findings from the independent consultation across the borough including a three year action plan including reviewing current awareness campaigns.

		Share the findings of the AVA VAWG Strategy consultation which will draw on work undertaken with survivor focus group and professional workshops.	AVA Report.	Report to be shared at the scrutiny panel and with the Croydon VAWG Network, Bame DA forum and professionals working in VAWG locally.	VAWG team	Feb 2024-June2024	Report shared with Scrutiny and also presented at local VAWG community Meetings. May 2024
		Croydon is set to conduct a comprehensive VAWG survey across the borough, including one for survivors and one for professionals.	Survey link.	The Survivor and Professional surveys will utilise equities data and geographic information to identify understanding trends and gaps in provision.	VAWG team		Survey completed for victim/survivors and professionals. Findings included in the 'Croydon Voices' consultation report.
		Implement the findings of the consultation report.		The Croydon VAWG Strategy 2024-2028 will outline Croydon's priorities including targeted support,	VAWG team		Findings of the Croydon Voices consultation report were included in Croydon's Tackling VAWG Delivery Plan 2024-2027.

				advice and protection for victims/survivors disadvantaged by intersectionality ensuring they receive the appropriate support at the right time.			
	The Croydon VAWG Network should ensure it seeks representation from organisations who support minoritised victim/survivors, including those from the Portuguese community	Contact Respito to invite to the panel as a member Enquire about leaflets and posters that can be shared across the borough. Map existing by and for services in Croydon that support					

		minoritised women, including the Portuguese community Encourage the network to adopt a intersectional approach in its work to better understand and address the complex needs of minoritised women. Promote culturally-sensitive practice training for professionals working with minoritised victims/survivors.					