Domestic Homicide Review – AA

London Borough of Barking and Dagenham

Overview Report

1. Introduction

2. Outline of the Incident

3. Police were called by the ambulance service to the address where AA lived; attending paramedics pronounced AA dead.

4. It has been reported that AA was at home on that day with her child, getting ready to go and look at properties for her and her child to move into; her mother and brother were at work. AA's mother called her, and AA informed her that BB was outside, ringing the doorbell; AA had ignored BB as he had not arranged to come round.

5. BB was arrested for the murder of AA, and subsequently pleaded guilty to murder and was sentenced to life imprisonment with a recommendation that he serve at least 17 years imprisonment.

6. These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the Community Safety Partnership (CSP) in Barking and Dagenham.

7. The Domestic Homicide Review Process

8. Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.

9. The purpose of these reviews is to:
10. 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.

11. 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.

12. Apply those lessons to service responses including changes to policies and procedures as appropriate.

13. Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

14. This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

15. **Terms of Reference**

16. The full terms of reference are included at Annex 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

17. The first meeting of the Review Panel was held on 5 July 2013. The Review Panel were asked to review events from 1 January 2007 up to the homicide. Agencies were asked to summarise any contact they had had with AA or BB prior to 1 January 2007.

18. Home Office guidance states that the Review should be completed within six months of the initial decision to establish one. This Review has been delayed by waiting to ensure that AA's mother was able to contribute when she felt able to; and to allow time for the interview with BB to take place.

19. **Independence**

20. At the start of the review, the independent chair of the DHR was Anthony Wills, an ex-Borough Commander in the Metropolitan Police, and Chief Executive of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has no connection with the London Borough of Barking and Dagenham or any of the agencies involved in this case.

21. Anthony was shadowed on the DHR by Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Anthony resigned from Standing Together while the Review was progressing, and the Panel agreed for Althea to continue and complete the review as independent chair.

22. Althea has over seven years experience working in the domestic violence sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence. Althea received training from Anthony Wills. Although Althea previously worked in the Domestic Violence Team in Barking and Dagenham Council (2007-2009), she has no current connection with the London Borough of Barking and Dagenham or any of the agencies involved in this case.

23. **Parallel Reviews**

24. There were no reviews conducted contemporaneously that impacted upon this review.

25. **Methodology**

26. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with AA, her child, or BB. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.

27. IMRs were provided by the Metropolitan Police's Specialist Crime Review Group, North East London Foundation Trust, Barking Havering and Redbridge University Hospitals NHS Trust, and Broad Street Medical Practice, as they were the only agencies or services known to have had contact with the victim and/or the perpetrator in the time specified in the Terms of Reference.

28. The London Borough of Barking and Dagenham confirmed information about AA's housing application, however an IMR was not sought due to the very minimal contact.

29. London Probation Trust, Victim Support Barking and Dagenham and Refuge, reviewed their files and notified the DHR Review Panel that they had no involvement with AA or BB and therefore had no information for an IMR.

30. The Crown Prosecution Service was contacted for further information about the incidents in which BB was arrested. No response was received. (Information requested is at Annex 4.)

31. Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

32. All IMRs included chronologies of each agency's contacts with the victim or perpetrator. The Police and NELFT IMRs provided were comprehensive and the analysis supported the findings. The IMRs from BHRUT and the GP surgery were felt by the Panel to initially be lacking in analysis and findings / recommendations. However following comments, questions and suggestions the BHRUT IMR was redrafted and once complete was comprehensive and high quality.

33. Following receipt of the IMR from the General Practice, written and telephone contact took please between the Practice Manager and the independent Chair, aiming to ensure that all available information and analysis had been provided. Unfortunately at the time of submitting the

Report the additional information requested had not been received. (See Annex 3.)

34. Once the IMRs had been provided, panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

35. The Review Panel members and chair are:
    - Standing Together, Chair
    - Metropolitan Police Service (Chief Inspector Partnership and Safer Neighbourhoods, Barking and Dagenham & Specialist Crime Review Group)
    - London Borough of Barking and Dagenham
    - London Probation Trust
    - Victim Support
    - Barking and Dagenham Clinical Commissioning Group
    - NHS England

36. The chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

37. **Contact with the family**

38. The independent chair made contact with AA's mother via the police family liaison officer, and an interview was conducted over the phone. AA's mother also saw the final draft of the report, and her comments have been incorporated.

39. The Review Panel extends its sympathy to the family of AA at this difficult time.

40. The independent chair also made contact with BB, and an interview was held with him in prison.

41. The Panel agreed that an interview with BB's previous partner could assist the findings of the review in relation to Police involvement and BB's abusive and violent behaviour. An approach was made, but the individual concerned declined to be involved in the Review. As this was outside the immediate remit of the Review, no further attempts at contact were made.

42. The Facts

43. AA was 30 at the time of her death. BB was 35. AA and BB had been in a relationship for approximately three years until BB ended the relationship while AA was pregnant with their child in 2010. From the child's birth to when the child reached approximately 16 months, there was little or no

contact between AA and BB. At this point AA contacted BB to encourage contact, believing this to be in the best interests of the child. However, BB also wanted a relationship with AA, which AA did not want. Contact arrangements from this point were problematic.

44. **Information relating to AA**

45. AA was 30 at the time of her death. She lived in Barking and Dagenham with her two year old child, her mother and her brother. She had attended the London College of Fashion and had a BA Honours in Fashion Design. At the time of her death she was planning to move to a property for herself and her child, out of borough.

46. MPS

47. AA made two reports of incidents/crimes to the police during the time under review. Both incidents/crimes are unrelated to this case, and represent the only contact by AA to the police on record.

48. GP

49. Information was provided from the General Practice AA was registered with at the time of her death. AA had attended on eight occasions between registering in September 2010 and the last visit in March 2013. These were routine visits.

50. Additional information was requested on the practice's policies and procedures in relation to domestic violence; and whether there was any further information available with regard to AA's daughter. Unfortunately at the time of submitting the Report the additional information requested had not been received. (See Annex 3.)

51. Barking Havering and Redbridge University Hospitals NHS Trust

52. AA was referred to maternity services on becoming pregnant in November 2009. Her pregnancy, and the birth, proceeded normally and AA attended all appointments.

53. She listed her next of kin as her mother; BB's details were also documented. Documentation indicates that AA was not asked about domestic violence.

54. AA attended the Accident and Emergency Department on three occasions in 2010 and 2011 with her child, all of which were routine.

55. North East London Foundation Trust

56. Following the birth of her child, AA was referred from maternity services to the health visiting service run by NELFT.

57. Contact with the service was normal with the exception of two missed appointments: the 6-8 week check for the child and AA with the GP, and the

two-year check to which AA was invited in November 2012.

58. Barking and Dagenham Council

59. AA registered on the Council choice-based letting list on 28 January 2010. She met the threshold based on overcrowding, as she was living with her mother and brother and would require an additional room for the child due to be born in August of that year.

60. In early March 2013 she successfully bid for an advertised property in another borough. The Council endorsed her application on 6 March and nominated to the Housing Association, Triathlon. According to housing staff she would then have been invited by Triathlon for an interview.

61. Triathlon sent an email to the Council on 2 April stating AA had been withdrawn from the process, as she had not responded to letters inviting her to interview. (This of course due to the fact that AA had died.)

62. Information from the Family

63. The independent chair of the Review held a telephone interview with AA's mother as part of the review process. The chair is extremely grateful for this contribution, which has both added to the learning of the review, and also given a perspective on AA as a person.

64. For AA's mother, and for other members of the family, the homicide of AA came completely "out of the blue" and was entirely unexpected given the previous behaviour of BB towards AA and the family.

65. AA's mother described AA as loving, supportive, down to earth; she knew family values and was "a child that other parents would crave for". She treasured her pregnancy and child, was a "get up and go" person and an academically qualified fashion designer.

66. AA knew BB for three years prior to becoming pregnant with their child. During those three years, AA would complain that the relationship was going nowhere; that she was going to "get out". She also told her mother that BB had a temper, and a "drink problem".

67. AA's mother recalls that once AA was pregnant, BB changed and was barely around during the pregnancy and after. Although he attended one antenatal class, he showed very little interest.

68. Despite AA living with her, AA's mother saw very little of BB in the years following the birth of AA's child. He would attend the house primarily when AA was alone (with her child). When they did encounter BB, he showed "no disrespect or arrogance".

69. AA's mother felt that, were BB to have been violent or aggressive towards

AA, then AA would have told her, as she was always very open. AA complained of BB only taking an interest in her, and not in their child; and that he could be intimidating and patronising towards AA. She mentioned that he "had a temper" and that he had destroyed property, e.g. throwing a phone to the floor when angry, or throwing pots around after burning food.

70. AA's mother would see BB on some occasions leaving the house after what were clearly arguments with AA. She would challenge him, but felt that he had "issues" that he couldn't or wouldn't deal with that were impacting on his relationship with AA and with AA's child. This included BB possibly feeling jealous that AA had family where he did not.

71. In January before the homicide, AA felt that things may have been improving; that BB had "good intentions" around their child. As a result she took him to a local social place that she liked to visit. Following this however, BB returned to the venue and threatened the bouncers, warning them to "stay away from" his child's mother.

72. AA's perception of BB's good intentions is in contrast to other behaviour in which he refused to acknowledge the child as his; going so far as denying the child to his grandmother, and to the older child he had with a previous partner.

73. A few weeks prior to the homicide, AA had told her mother that BB was "getting on her nerves" and that she wasn't going to let him in the house any more unless her mother or brother were present. AA's mother did not feel that AA was afraid of BB; AA felt that she could "handle him" and if anything happened she would call for help.

74. The day before the homicide, AA's mother spoke with BB on the phone. This was because AA did not want to call him – following numerous occasions in which he had promised to visit (to see their child) and had not done so. AA's mother said he sounded calm during this phone call.

75. AA's mother was keen to stress her view that, where the Police are aware of someone's violence in the way that they were about BB (against his previous partner) that this should be communicated in some way to others he is in contact with. This point is addressed in the analysis and recommendations in relation to the national roll out of the Domestic Violence Disclosure Scheme.

76. AA's mother, on reading the Overview Report, challenged the information provided below by BB during his interview. She stated that at no time did AA restrict BB's access to their child – that in fact she was trying to help him to be a father to the child. She also stated that on the day she was killed, AA would not have let BB in to the house to play with the child, as they were going out.

77. **Information relating to BB**

78. BB was 35 at the time of the incident. He had a nine-year old child from a previous relationship, with who he was not in regular contact. He was a trained chef; although not in full-time employment he undertook work on an irregular basis through an agency. His address at the time of AA's murder is not known.

79. MPS

80. Barking and Dagenham Police had no contact recorded with BB prior to AA's murder. The Metropolitan Police Service (MPS), in another borough, did have extensive involvement with BB, nearly all in relation to domestic violence reported by his previous partner.

81. Between January 2005 and December 2009, BB's ex-partner called the police on thirteen occasions due to verbal arguments with and assaults by BB. The outcomes for these occasions were as follows:
    - No further action taken on offences (due to victim withdrawal or lack of evidence) – 6
    - Cautions – 1
    - Incidents involved no offences – 4
    - Harassment warning given – 1 (the IMR notes that the way in which this warning was given – over the phone – was "questionable" and should have taken place in person or in writing to confirm BB was fully aware of the details of the allegation)
    - BB pleaded guilty to assault on one occasion and was given a fine, plus costs and compensation

82. On two of these occasions, it was the CPS that made the decision to take 'no further action', and they were asked for information on these decisions but no response was received.

83. In February 2010 BB was arrested following a stop and search, and showed as wanted for one of the thirteen incidents described above; and separately for non-payment of fines. This led to no further action for the incident, and separately BB was remanded for the non-payment.

84. The Police also record that in December 2009 BB was assumed to have been behind an anonymous call to Social Services accusing his ex-partner of neglecting her child. A joint investigation was carried out by Social Care and police, which showed it to be a spurious allegation.

85. Information from the Perpetrator

86. A Standing Together associate-DHR Chair[1] interviewed BB in prison as part

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[1] Mark Yexley; this was because the independent chair of this review was unwell on the date of the interview.

of this review. The interview answers were written up, and are presented here.

87. BB stated that he had been with AA for about three years, and that there was no violence in the relationship – only verbal disagreements. The police had never been called. BB said that he was frustrated on access and the availability of when and where he could see his daughter. (NB: AA's mother disputes this). BB was asked if anyone knew details of his relationship with AA. He said not really, on the surface there was good communication but it was not good. He said "In theory it looked good, in practice it wasn't".

88. BB was asked about factors that could have made the relationship difficult. He said that there was no jealousy and he was not aware if AA had a new relationship. He said there were no concerns over a new job, AA was planning to sort out accommodation and working on fashion stuff. She had just bought a new sewing machine. He was asked about substance abuse, he denied this and said that he had just had a can of beer before the incident. He stated that he was in the middle of negotiating a full time job, as he was a freelance chef.

89. BB was asked to describe what happened on the day AA was killed. He stated that on that day he had decided that, as he had not seen his child at the weekend, he would see her as he had the morning off. He spoke with AA on the phone to tell her. AA was getting ready to go somewhere.

90. BB stated that he was mainly playing with his child. He and AA got into a discussion about why BB could not come over at the weekend to see his child. BB said it was because of no tubes and heavy rain, and that AA wants him to come over when it was not the right time for him.

91. BB told the interviewer that he tried speaking to AA, but she said she did not want to speak, that there is no reason for them to have communication. BB reported telling AA that she kept moving the goalposts. He then went to leave the house, and was "leaving in a huff"; AA said BB was always running away from his responsibilities. AA went to close the front door, and the child was in the living room. BB went to get his rucksack, which he had forgotten.

92. BB told the interviewer "I instinctively retrieved a knife out of my bag. I told her that this the way it's going to be all the time when… She told me to grow up and bring down the money when she tells me. I said 'Am I just a cash cow?' I just lashed out and started stabbing her. She fell on the floor in the hallway. First thing I just went to get my daughter out of the house."

93. As reported in the Police information, BB then took the child and the family dog to a friend's house.

94. BB did not hear AA say anything to him after he attacked her. Despite telling the interviewer that he knew he should have phoned the ambulance and the police at that point, it was established that he didn't.

95. BB was then asked if any other services could have helped. BB said that, with hindsight, he should have sought counselling and he was suffering from "mild depression" at the time. He had spoken with his family, but not medical services.

96. BB was asked about previous violence in relationships. He said that there was with his older child's mother. He said that the police had been involved and there was support for his son's mother but not for him. He was asked if he could have done anything to prevent the violence. He said that after the initial calls to police and there was any domestic disagreement the police would be called again "as if buying an ice cream from a shop". Police told him that it was not a healthy relationship, he had a young son and should move on.

97. He compared his first relationship to the one with AA. They were two different types of relationships but both had children and problems with access to children.

98. BB was asked if there was any trauma in his childhood. He said that his mother passed away when he was 15. He also stated that his aunt was murdered but he did not know the circumstances.

99. BB was asked if there was anything that could have helped him. He said that someone in his situation should have been seeking help, advice and guidance. The police could have told him that he had been arrested numerous times and he should go to "meetings, therapy or classes". He also said that when police are called and a man is accused they should not take everything at face value.

100. **Analysis**

101. Overall this review has shown that there was minimal information in any agency on AA, and what information was available was primarily from the health service. While there was extensive information from the Police on BB, this was the only agency with any information on him, and this did not relate to AA.

102. Significantly, none of the information provided by agencies on AA related to any disclosure of domestic violence.

103. The government definition of domestic violence is:
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or

have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

104. A working description of domestic violence used by the National Domestic Violence Helpline is: *the abuse of one person within an intimate or family relationship. It is the repeated, random and habitual use of intimidation to control a partner*.

105. The information provided by AA's mother as part of the review process suggests that AA could be seen as a victim of domestic violence from BB, within the above definition and description. AA clearly had to adjust her behaviour as a result of how BB treated her. He also displayed jealousy and attempts to control AA's behaviour.

106. However, it is clear that neither she, nor her family, recognised it as such. This is understandable in a context in which AA did not appear to be in fear of BB, and experienced no physical violence or threats from him – if anything, the information provided in the interview with BB suggested that she felt comfortable answering him back and speaking her mind. From AA's mother's perspective, the independent chair sympathises with the feeling that the homicide was an event that "came out of the blue". Even with hindsight, there were minimal – if any – signs that BB was heading towards such an extreme act.

107. AA's involvement with agencies was generally routine – relating to health matters, most significantly her pregnancy. However, there were opportunities for professionals to explore her relationship and home life with her, and to ask directly about domestic violence. These opportunities were apparently not taken, and may have allowed AA to talk about what may have been happening with BB, and be offered support.

108. The opportunity to discuss her relationship with BB with health professionals who understood the nature of domestic violence could have allowed them to support her in identifying BB's behaviour as inappropriate. It also may have enabled discussions about what options she could take to get support.

109. It is also relevant to ask here what role a public awareness raising campaign or information around the nature of domestic violence – particularly where the behaviour is not as obvious, and not physically violent – could have played in increasing AA and her family's understanding of BB's behaviour and what support they could get about it.

110. For example AA, her mother, brother, friends, or even the 'social place' at which BB made threats around AA could have been made aware through a campaign of the unacceptability of BB's behaviour and offered routes for support. This was particularly relevant due to the lack of contact with agencies.

111. <u>Police</u>

112. All the contact detailed is with regard to BB and his previous partner, not AA.

113. There was a succession of incidents in which there was either insufficient evidence to proceed, or a lack of willingness to cooperate by the victim (BB's ex-partner).

114. This is very common – in many domestic violence cases, victims don't support the case from start, or withdraw at a later point; this is often the case where the victim does not receive independent support at the earliest stage possible (for example, an Independent Domestic Violence Advocacy – IDVA – service).

115. From the information provided in the police IMR, it seems that the victim's withdrawals were often due to the fact that BB was the father of her child. This can put victims in a difficult situation in which they may be being encouraged (by family, services, the perpetrator) to maintain contact between the child and father, and this prevents them from seeking the help they need in dealing with an abusive (ex)partner.

116. We also know from research that victims withdraw / do not support prosecutions for other reasons, such as fear of the perpetrator, weariness with the situation and wanting the situation just to end, lack of belief that anything will change, and lack of support in the case.

117. Had BB's ex-partner received specialist, independent support at an early point in reporting to the Police, she may have felt able to continue to support some of the prosecutions that may have impacted on BB's behaviour.

118. In relation to BB the question is whether more could have been done by the police to hold him accountable for his abusive and violent behaviour to his ex-partner, that may have shown him that this was unacceptable and

discouraged any abusive behaviours he may have then used against AA.

119. In his interview as part of the review, BB also suggested that more help could have been offered to him following numerous arrests. He reports being told that the relationship was not healthy and that he should “move on”; this could have been extended to show BB that he was responsible for ending the violent behaviour and suggesting routes for him to seek support and change this.

120. All of the incidents and offences happened in another borough to the one in which the homicide occurred. The IMR details the changes across the MPS since these occurred to ensure that the response has improved. This includes:

a. Improved risk assessment through the implementation of the DASH (Domestic abuse, stalking harassment and ‘honour’-based abuse risk identification checklist)
b. Adopting the new (2013) Government definition of domestic violence which includes coercive control
c. Ensuring that initial reports and investigations are passed from reporting officers to the Community Safety Unit as quickly as possible to remove any delays in secondary investigations
d. Improved supervision of all domestic violence cases through the Police database system (CRIS).

121. Barking and Dagenham Police have confirmed that these processes are in place locally; and further to discussions at the Panel meetings, have also looked into the links to the MASH for when children are involved.

122. This includes the MPS-wide implementation of ‘Operation Dauntless’ (provided by MPS as part of this Review):

The new MPS Continuous Improvement Plan for domestic violence was introduced on 5 November 2013. This is an Activity Tracker attached to a Tactical Plan to ensure the MPS monitors activity in relation to domestic violence. It involves a ‘whole borough’ response to tackling domestic violence and performance is monitored from call handling through response teams, Community Safety Units and Neighbourhood Policing Teams. There are three strands: Total Victim Care (Enduring Risk), Offender Management and Emerging Risk. The recent introduction of a Recency Frequency Gravity Matrix (RFGR) is used to identify the five most prevalent domestic violence perpetrators on each borough. There is more focus on the perpetrator and the use of tactics against these violent individuals, which can include:

- *Cocooning (with the victim’s consent)*
- *Alcohol prohibitive bail conditions*
- *Temporary driving bans (where vehicle used to commit offence/breach bail)*
- *Requests for a period of disqualification upon conviction (where vehicle*

used)

- *A new methodology to identify High Risk offenders – RFGR*

123. No recommendations have been provided by Barking and Dagenham Police as part of their IMR, due to their lack of involvement. However the Panel agreed that in light of the circumstances of the case, and findings of the Review, that recommendations were appropriate concerning the local approach to victimless prosecutions, local responses to perpetrators in relation to support to change their behaviours, and a national recommendation with regard to the lack of involvement of the CPS in this review.

124. GP

125. The information in the IMR all related to AA; BB's health information could not be found due to the lack of any address for him. A request was made via the prison to find out if he had been registered, but unfortunately this could not be provided.

126. All AA's contact with the GP was routine; there was nothing that prompted anyone to ask about domestic violence.

127. The Practice confirmed that they have policies in place, and staff received training: so if AA had disclosed, they are confident that staff would have been able to respond appropriately. (However, see above and Annex 3 for additional information requested that would have allowed further exploration of this.)

128. A recommendation has therefore been included here for the General Practice to reflect on its policies and staff training, in light of the findings of this review and the introduction of the Domestic Violence Disclosure Scheme; and for the CCG to raise awareness of the new Scheme to all health providers.

129. BHRUT

130. The information in the IMR all related to AA, her pregnancy (maternity service) and her child (accident and emergency).

131. *Accident and Emergency*

132. The contacts detailed from the A&E department represent routine contact relating to AA's child, including nothing that would have prompted asking about domestic violence.

133. The IMR states that the Trust's safeguarding training includes information on how to respond to disclosures of domestic violence, and how to practice selective enquiry.

134. The IMR makes an appropriate recommendation that: current practice be

reviewed within the Accident and Emergency Department to confirm selective enquiry as the best method to use; and for a final decision to be made and that the use of an agreed protocol to support staff within this clinical setting may be of benefit.

135. *Maternity Service*

136. The largest amount of agency contact with AA was with maternity services, from the point at which AA was referred by her GP due to her pregnancy.

137. Although there was mention of BB as the father, no details were taken and there was no exploration of this relationship; AA's mother was given as her next of kin.

138. The IMR makes clear that staff in maternity services should have asked AA about domestic violence as part of their routine enquiry policy, and suggests that she may not have been asked because she was accompanied.

139. BHRUT are confident that this now happens with all women presenting to the service. This includes seeing all women alone for the first fifteen minutes of the first midwife appointment so that they can be asked safely.

140. Data is collected on routine enquiry and this is reviewed at Maternity and Safeguarding Forums.

141. Research supports the need to routinely ask pregnant women about domestic violence[1], as it is a key risk factor both for abuse to start and for it to escalate.

142. This research also shows that women want to be asked, and are unlikely to disclose otherwise; it also highlights that it is equally important *how* the question is asked: i.e. openly, sympathetically, and repeatedly as relationships of trust develop.

143. In addition to the improvements in relation to routine enquiry, the IMR outlines that training is now mandatory.

144. All of the changes outlined above suggest that the maternity service response – proactive and reactive – to domestic violence has received significant attention and improved since AA was in contact with the service.

145. The IMR recommends the 'continued provision of maternity domestic violence service to identify and support victims of domestic abuse and family'. The Panel felt that it would also be appropriate, given the many changes and developments in the service, to add a recommendation in this

[1] Feder, G. et al (2009) 'How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee Criteria' Health Technology Assessment Vol 13 (16)

Overview Report for BHRUT to conduct an audit ensuring that routine enquiry is in place, effective and with appropriate pathways.

146. For a time the Independent Domestic and Sexual Violence Advocacy Service (IDSVA) in Barking and Dagenham provided a co-located support service for victims operating from the hospital and other BHRUT sites, offering easy and fast referral for victims. This was however re-commissioned in 2014, and the co-location is no longer in place. The commissioner has outlined that the new provider will be making contact with named consultants in Emergency Medicine and Obstetrics/Gynaecology, and senior nursing and midwifery staff in order to introduce themselves as the new provider of IDSVA services in Barking and Dagenham, and to offer regular training/presentations on DV and SV indicators for A&E and maternity staff. They will establish joint-working protocols with the A&E departments, including rapid referral routes in order that the IDSVA team can be quickly alerted to DV & SV cases in key crisis moments, and to sign information-sharing protocols with the maternity services to ensure referrals will be handled sensitively and promptly.

147. Given this change, a recommendation is included for the partnership to be reassured by the provider, BHRUT and commissioner that this will not have a detrimental impact on the pathways of support for victims.

148. NELFT

149. All information in the IMR related to contact by the Health Visiting service with AA in relation to her child.

150. Opportunities were missed to ask AA about her family situation, most significantly about the father of her child, and to potentially therefore explore the issue of domestic violence.

151. Opportunities were also missed to follow up when AA did not attend appointments, and to follow up with her after she attended A&E with her child.

152. Recommendations are identified by NELFT to address the above issues:
   - Failure to attend appointments should be followed up by liaison with other services and pre-CAF assessment carried out.
   - A&E attendances should be followed up by a health visiting service contact.
   - Details of males within households should be documented within the records and it should be indicated where there are no males present.

153. There is also learning with regard to the uploading of information to the electronic system when the Health Visiting service is informed of a child's attendance at A&E. The issue of not following up on A&E attendances has already been dealt with.

154. Additional information provided by NELFT states that questions relating to domestic violence are routinely asked if safe to do so. It is not clear if this was in place at the time AA was in contact with the service, and if it was, whether it was carried out / considered. It is also not clear what developments have taken place to ensure staff are trained; nor whether processes are in place to ensure that enquiry takes place and is recorded.

155. An additional recommendation is therefore made in this Overview Report for NELFT to report on the enquiry that is taking place, its effectiveness and the pathways and training in place to support this.

156. Domestic Violence Disclosure Scheme

157. The Panel discussed whether the new Domestic Violence Disclosure Scheme (also known as "Clare's Law"[1]), had it been in place at the time of AA's relationship with BB, could have been used. The scheme allows the police to disclose information about a partner's previous history of domestic violence or violent acts – either following a request from the current partner / concerned third party, or as a proactive action taken by the police.

158. In the case of AA, other steps would have had to take place for the Disclosure Scheme to be applicable (had it been in place at the time). Either:

a. AA (or a family member or friend) would have had to approach the police due to concerns over BB's behaviour. Despite his violence and abuse against his previous partner, BB did not appear to show anything sufficiently of concern towards AA that may have prompted this action. Or
b. An agency involved with AA, for example the maternity service, health visiting service or her GP, would had to have taken the opportunities they had to explore with AA her relationship with BB, and then would have had to be sufficiently concerned over BB's behaviour to contact the police to ask them to investigate BB's violent history and consider a disclosure to AA.

159. Had either (a) or (b) taken place, opportunities would have been created to support AA, as well as possible safeguarding routes being created in relation to her child. However, it is the view of the Panel that, even were the Disclosure Scheme in place at the time of AA's relationship with BB, the likelihood of it being used is small.

160. Recommendations have however been agreed to ensure that this important new support option for victims is promoted and used locally, and integrated into existing practice.

[1] https://www.gov.uk/government/news/clares-law-rolled-out-nationally-on-international-womens-day

161. <u>Diversity</u>

162. Both AA and BB were Black British / Black Caribbean ethnicity.

163. The IMRs provided give no indication that their involvement was in any way impacted by their ethnicity.

164. The only point that was raised in the review relating to diversity was the issue of thalassemia screening during AA's pregnancy. Maternity services recommend that both mother and father undertake blood tests to screen for this; AA was advised of this but there was no follow up with BB, who did not undertake the test. This was not pursued by maternity services as, according to the CCG Panel member, the majority of fathers do not do this and so it caused no concerns.

165. Although this has no bearing on the case, the Panel felt it important to raise this lack of response to an important screening test as a separate point.

166. Conclusions and Recommendations

167. **Preventability**

168. Given the minimal contact AA had with agencies in the time prior to her death, and the lack of identifiable warning signs in BB's behaviour in the context of AA's family, it is not possible to state that the murder was preventable or predictable.

169. **Issues raised by the review**

Missed Opportunities to ask about AA's relationship

170. There were missed opportunities in 2010 (maternity service) and 2010-11 (health visiting service) to proactively enquire with AA about her relationship situation, to explore issues of domestic violence, and potentially to offer her support; this is especially important in light of the fact that AA, and her family, did not recognise BB's behaviour as abusive. However the IMRs from these services, and this review, show that significant changes have been made since that suggest these opportunities would no longer be missed. Recommendations are detailed below to audit and review the impact of these changes.

Missed Opportunities to hold BB accountable / offer support

171. There were also missed opportunities from 2005-2009 in holding BB to account for his abusive and violent behaviour towards the partner he had before AA (by the Police, albeit not Barking and Dagenham Police). For example, had she been offered some immediate support that may have helped her to support prosecutions; or had evidence been gathered that could have allowed a prosecution to proceed without her involvement. The Police IMR outlines improvements that have been implemented across the

MPS since this time in responding to domestic violence perpetrators and victims. A recommendation is detailed below to audit and review the impact of these changes locally.

172. These were also missed opportunities to offer support to BB to address his behaviours. This is raised through the feedback provided by BB as part of the review, in which he states that, given the number of times he was arrested, he could have been offered support. There are options in place for men concerned about their behaviour towards a partner, it is not clear what would have been available to BB or what information is provided by the Police to perpetrators, particularly repeat perpetrators.

Awareness of the range of behaviours that constitute domestic violence

173. It is clear from the information provided by AA's mother as part of this review that none of the behaviours displayed by BB towards her daughter were perceived as domestic violence, either at the time or in hindsight. Given AA's lack of fear, the chair has sympathy with this position.

174. However, it does raise the question of what public awareness raising campaigns or information has been available that may have alerted AA, or her family, to the unacceptability of BB's behaviour and the support available. It is key for these campaigns to be carried out, and that they emphasise the non-physical violence aspects of domestic violence.

175. **Recommendations**

176. *Recommendation 1*

177. The recommendations below should be acted on, in addition to the actions identified in individual IMRs. Initial reports on progress should be made to the Community Safety Partnership within six months of the Review being approved by the CSP.

178. *Recommendation 2*

179. Community Safety Partnership to undertake a review of victimless prosecutions, working with the local criminal justice agencies (Police, CPS and HMCTS) looking at interactions between agencies, barriers and areas of learning and development. Also to include seeking the views of victims/survivors in relation to victimless prosecutions.
NB: the police involvement in this case was not by Barking and Dagenham Police; however the Panel felt that this recommendation was appropriate given the ongoing MPS-wide issues around victimless prosecutions highlighted by the findings of this case and Panel discussions.

180. *Recommendation 3*

181. BHRUT to conduct an audit of case files in Maternity Services to establish: the percentage of women routinely asked about domestic violence; the percentage of women who disclose; how this latter figure compares with

what research would suggest the disclosure rate should be; and to identify any development needs in relation to when, how and how often the question is being asked. The audit should aim to establish whether the routine enquiry / response is improved compared to the findings of the IMR and this Review.

182. *Recommendation 4*

183. BHRUT, IDSVA service commissioner and provider to monitor and report to the CSP on the development of the new IDSVA service, and any impact on the response/support to victims following the end of the co-location with health providers.

184. *Recommendation 5*

185. NELFT to conduct an audit of the enquiry that is taking place in the Health Visiting service, to establish the extent to which it is taking place, the number of disclosures and what the response is. NELFT should also report on the training available for and taken up by the Service.

186. *Recommendation 6*

187. BHRUT & NELFT to reflect on current policy and training in the light of the introduction of the Domestic Violence Disclosure Scheme and report back to the Community Safety Partnership on any developments to be made.

188. *Recommendation 7*

189. Community Safety Partnership to review its recent public awareness raising campaigns and information to ensure that they draw attention to non-physically violent behaviours from domestic violence perpetrators. The CSP should consider approaching AA's family, via the Police Family Liaison Officer or other trusted agency (e.g. Victim Support Homicide Service), to explore whether they would like to be part of future awareness raising[1]. The CSP should also ensure that plans are in place to promote the new Domestic Violence Disclosure Scheme.

190. *Recommendation 8*

191. The Community Safety Partnership should nominate an agency (e.g. the Police Family Liaison Officer, or Victim Support Homicide Service) to update AA's mother on the local roll out of the Domestic Violence Disclosure Scheme (reference paragraph 164).
http://content.met.police.uk/Article/Domestic-Violence-Disclosure-Scheme---Clares-Law/1400022792812/1400022792812

192. *Recommendation 9*

193. The Community Safety Partnership to review and report on the support and pathways available and offered to perpetrators of domestic violence, particularly where repeat arrests are being made with no or few charges

[1] NB: AA's mother reviewed this Overview Report prior to submission, and indicated that she would be interested in being part of future awareness raising

following.

194. *Recommendation 10*

195. The CCG to raise awareness of the new Domestic Violence Disclosure Scheme to all health providers.

196. *Recommendation 11*

197. The GP practice to review its policy and procedures for identifying and responding to domestic abuse and ensure all staff receive appropriate training to support contemporary practice for healthcare practitioners, and to report to the Community Safety Partnership on this.

198. *Recommendation 12*

199. NHS England to ensure identifying and responding to domestic abuse is discussed with General Practitioners from this Practice during Appraisal and Revalidation

200. *Recommendation 13*

201. In light of the lack of involvement of the CPS in this review, for the Home Office to review nationally and regionally CPS engagement with Domestic Homicide Reviews, and improve consistency.

Annex 1 – Terms of Reference

This Domestic Homicide Review has been commissioned by Barking and Dagenham Community Safety partnership in response to the death of AA following her death on 18 March 2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

This domestic Homicide Review will consider agency involvement with AA, her ex-partner BB, and her child.

Purpose

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

2. To review the involvement of each individual agency, statutory and non-statutory, with AA and BB during the relevant period of time: 1 January 2007 – the date of the homicide.

3. To summarise agency involvement prior to 1 January 2007.

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

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

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

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

    a) chair the Domestic Homicide Review Panel;
    b) co-ordinate the review process;
    c) quality assure the approach and challenge agencies where necessary; and
    d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Barking and Dagenham CSP.

Membership

9. The following agencies are to be involved:
   a) London Borough of Barking and Dagenham
   b) Metropolitan Police Service
   c) London Probation Trust
   d) Voluntary Sector
   e) NHS (CCG; NHS England)

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

11. If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

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

13. Each agency must provide a chronology of their involvement with the AA and BB during the relevant time period.

14. Each agency is to prepare an Individual Management Review (IMR), which:
    a) sets out the facts of their involvement with AA, BB and Jamila*;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

15. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought AA or BB in contact with their agency.

Analysis of findings

16. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.

c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations access to specialist domestic abuse agencies.
f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and alleged perpetrator's family

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

18. Coordinate with any other review process concerned with Jamila* (child of victim and perpetrator).

Development of an action plan

19. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.
20. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.
21. To ensure that the appropriate support (including debriefing) for those staff directly involved in the case and the review process
22. To provide all those involved with the review equal an equal and fair opportunity to express their views. This includes ensuring compliance with the Mental Capacity act 2005 and the Equality Act 2010.
23. To conduct the process as swiftly as possible, to comply with any disclosure requirements, and on completion, present the full report to the Barking and Dagenham Community Safety Partnership.

Media handling

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

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

Confidentiality

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative.

That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

27. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

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

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*Not her real name but chosen as it carries the same meaning

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Annex 2 – Panel Members and Agencies Represented

Anthony Wills, Chair	Standing Together Against Domestic Violence
Althea Cribb, Chair (replacement)	Standing Together Against Domestic Violence
DS Helen Flanagan	Metropolitan Police Service, Specialist Crime Review Group
Helen Oliver	London Borough of Barking and Dagenham
Diane Jones	Barking and Dagenham Clinical Commissioning Group
Lucy Satchell-Day	London Probation Trust
Nicola Clark	NHS England
Chief Inspector Richard Goodwin	Partnership and Safer Neighbourhoods, MET Police, Haringey
Jan Scott	Victim Support