



Safer Kensington and Chelsea Partnership
Domestic Homicide Review
Overview report into the death of Robert and Clare
4 January 2017

Independent Chair: Deborah Jeremiah

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Tribute to Robert from his sister

Robert was man who loved his children and was involved in their lives. He was well known in the local community and many in that community turned out to pay their last respects to him at his funeral. He was my younger brother but in later years he said he would be the one to look after me. He was tall, handsome and liked to socialise and have fun with his family and friends. He is very much missed in our family.

Tribute to Clare from her Aunty

Clare was a pretty, sweet little girl and was a Daddy's girl. She would be reluctant to go to bed if her dad was not around to settle her down for the night. She loved going to the park and to be with her cousins such as at Christmas. It is still hard for us as family to believe that she and her Dad are no longer with us.

1 Preface

1.1 This domestic homicide review (DHR) examines the circumstances surrounding the death of Robert and his young daughter Clare in February 2015. The deaths occurred in the Royal Borough of Kensington and Chelsea (RBKC). Pseudonyms are used throughout in this report. The family lived in a social housing flat. The tenancy was in Joan's name.

1.2 Both were murdered by Robert's partner and Clare's mother, Joan. It is unclear exactly when Robert and Clare died but there is a time window as set out in the timeline for this report. Clare was aged 4 when she died.

1.3 Joan also seriously harmed their youngest child Ann, aged 18 months. Ann survived but is now in foster care. At the time of the homicides and significant harm to the youngest child Joan was experiencing a serious mental breakdown resulting in a psychotic episode.

1.4 The family had been known to local statutory agencies but did not meet the criteria for any formal child protection measures. Joan and Robert had also come to the attention of the police during arguments between the couple. The relationship between Robert and Joan was volatile and lacked trust from both sides. Joan told us for this review that the relationship difficulties which she viewed as abusive and the stress of caring for two young children each played a part in the deterioration of her mental health. Tragically, in her psychotic state she lost touch with reality and committed the acts she did.

1.5 The review has been led by an Independent Chair who has no association with the agencies or organisations concerned and one who has been trained in the process prescribed by the Home Office to conduct Domestic Homicide Reviews. There is a conjoined Serious Case Review (SCR) on which the Independent Chair for this review was a co-lead reviewer.

1.6 The Independent Chair and panel would like to express deepest and heartfelt condolences to Robert and Joan's families and friends for their loss. It is hard to comprehend the pain and distress caused by the deaths which also includes the death of a child of the family. What has emanated from this review has been a deep reflection by all concerned for the SCR and DHR on how we work with families where relationships are challenging and the ways in which mental health problems may develop, particularly when those stressors may not be totally apparent or disclosed to professionals.

1.7 The panel would also like to thank frontline professionals from a range of organisations and agencies who have cooperated and assisted with the review as well as those staff who supported the review from an administrative perspective. As Chair I would also like to formally record and thank the Review Panel for the patience, time commitment and thoughtful consideration. This was in the face of having a dual role as part of the review panel for this DHR and also as part of the review team for the parallel SCR. The interface between the two processes will be outlined later in the report.

1.8 A glossary of terms used is at **Appendix One**

2 Executive Summary

2.1 Robert was born in Jamaica in 1972. He moved to the UK in approximately 2001. Both Robert's parents live in the USA now but are not together. Others in Robert's family have also come to live in the UK from Jamaica and there are siblings in the UK. Robert worked as a painter and decorator and at times on the local market. Robert had the most contact with his sister, Alison and also his cousin Jane. Robert had two significant relationships before he met Joan. One was with a woman with whom he had a daughter who is now aged 12. After that relationship ended the woman moved away and he lost touch with that child. Robert told his sister losing touch with that child was something he regretted.

2.2 Robert then entered another relationship for some years with a woman who had a young son and she said that Robert was supportive of her and the child. At times Robert would use the surname of that family rather than his own. Neither past relationships featured violence or coercive control. After a long spell of no contact, Robert made contact with the woman in the previous relationship a few months before his death asking her about legalities on having contact with children when a relationship ends, as this woman had previously worked in social services. It has become apparent now that in the months leading up to his death he was planning to separate from Joan but wanted some way to see and be involved with Clare and Ann.

2.3 As the second relationship broke down Robert met and started a relationship with Joan. After being together for some time Joan became pregnant with Clare. There are in fact links between Joan and Robert's families going back a generation. Robert was pleased he was going to be a father again but his family describe Robert drinking more heavily in the relationship with Joan and that concerned them particularly as they considered Joan to have a problem with alcohol. Alcohol was feature in their relationship throughout.

2.4 After Clare was born Robert lived with Joan but the relationship was argumentative and on occasions he would leave the home for periods of time. The pattern was one of drunken arguments and then Joan throwing Robert out of the house. At times she would call the police if he refused to leave. Robert's family describe Joan as jealous and controlling and that Joan was struggling to adapt to a life as a mother and was unable to be out and socialising with Robert all the time because of their child but he was still able to do so. Robert kept up that lifestyle and that caused a great deal of conflict and resentment. Their second child, Ann was born in July 2013. It would seem that after point the relationship became even more strained. Both children are identified as Black British.

2.5 Clare and Ann lived with their parents throughout their lives prior to the deaths but it was never entirely clear to any of the professionals or agencies involved with the family if Robert lived in the family home all the time. Robert's family state he did, but Joan told professionals on many occasions that he did not live with her and that in fact she did not know a great deal about Robert including his real name or birthday. She often referred to him as her ex- partner and yet the relationship was clearly on-going and in regular conflict emanating from both sides.

2.6 Robert's family who have inputted into this review and also audio recordings retrieved from Robert's mobile phone by the police after his death indicates he was in the family home more than was appreciated at the time and in the run up to the homicides. The problems in the relationship escalated after the birth of their second child Ann in July 2013. Robert was not keen to have another child and had concerns he expressed to his family whether Joan could cope with another child. Joan was low in mood and constantly accusing Robert that he was unfaithful. Agencies identified that Joan needed additional support but did not see domestic abuse as a major feature of concern as Joan repeatedly told professionals that the abuse was in the past and that she was effectively separated from Robert.

2.7 However, Robert was involved in both children's lives. He was observed taking Clare to school and out and about more generally. He also had sole care of them in the family home on occasions. The family were known in their community and would be seen out and about. Joan's mother, Mary lived nearby and was Joan's main family support. Joan described Robert as a 'son in law' when we met her for this review.

2.8 The Police and Children's Social Care (CSC) became involved with the family following low level allegations of drinking and domestic abuse. Two assessments were undertaken by CSC in 2013 and for a brief period in 2014 a Child In Need¹ plan was put in place. This will be explored in more detail later in this report. Of note is that Mary also contacted the police stating that her daughter was in an abusive relationship with Robert. Mary knew Robert before he was in relationship with Joan and she had a poor view of him as a drinker and womaniser.

2.9 The children were also seen regularly by a Health Visitor who became involved with the family after Ann was born. That Health Visitor was able to obtain extended nursery care support for Joan because she was saying she was exhausted and needed more help. Joan stated to the Health Visitor that Robert was not living with her or providing any support looking after the children. Again, Joan maintained that she did not know Robert's true name and background even though he was the father of her two children. Joan denied he lived with them throughout.

2.10 Joan described herself to professionals as being of mixed heritage of Afro-Caribbean and Irish descent. Mary states that she brought Joan up alone and that Joan had panic attacks as a child. Joan had an uneventful education and attended college but dropped out after a year. Joan had some problems with anxiety into adulthood and in all a 17-year history of panic attacks, anxiety, and feelings of paranoia. She had had two admissions to an acute psychiatric facility in 2004 and at least one suicide attempt in 2007. She was provided with psychological support for anxiety in 2008 but disengaged with services in 2009. There is also some history around alcohol and substance misuse.

¹ Section 17 of the Children Act 1989 defines a child as being in need if s/he is under 18 and either

- s/he needs extra help from Children's Services to be safe and healthy or to develop properly; or
- s/he has a disability

Children's Services are required to assess these needs and draw up a plan to support the child and family.

2.11 Joan had previously worked in various retail stores. After the birth of Clare and Ann she did not work and stayed at home to look after the children.

2.12 There were also some historic agency contacts. In March 2011 Children Social Care (CSC) received an anonymous referral from a neighbour regarding alcohol use and care of a young child (Clare).

2.13 In July 2012, a referral was made by the police who had been called when Robert has refused to leave the house. Joan told police he was an ex- partner. CSC considered their involvement was not required. The contact points with agencies will be detailed further later in this report lifting information and analysis from the IMR's and all other sources of information before the review panel.

2.14 During the pregnancy with Ann, in 2012/2013 Joan did refer to a history of domestic violence from Robert but that this had not been repeated and she was no longer with him. This was considered by CSC but following checks with the Health Visitor it was concluded that the concerns did not warrant further involvement by CSC at that time. Because the domestic abuse was presented by Joan as historic the risk was seen as low. CSC state in the review that the closure record notes that Joan was resistant to further support from Early Help and Advance which indicates CSC did discuss the option of Advance, a domestic abuse support service with her. Further concerns were raised in early 2014 around the police needing to attend the home address. CSC became involved again. A more comprehensive social care assessment was conducted by a new social worker to the family. This social worker conducting the review discovered that Clare had made some significant disclosures 6 months previously at school describing conflict and violence at home between her parents. This is considered fully later in this report.

2.15 Mary, says that after the birth of the second child in July 2013, Joan was struggling to cope and became depressed and the relationship with Robert was worse with lots of arguments. Mary believes that Robert was unfaithful with other women and this distressed Joan hugely. She describes Joan as trying to put a "brave face on" and trying to stay jolly and care for the children. Mary witnessed the poor relationship between Robert and Joan.

2.16 Robert was also discussing with his family that he wanted to separate from Joan for good but wanted to keep in touch with his children. He was particularly close to Clare. Robert's family said they would support him and also offered to take the children on holiday to give Joan a break. They describe Joan as being paranoid, jealous and controlling and had concerns about her mental health after Ann was born. Robert told them he would sort it out as Joan had said that he involved social care she would kill him. That is further evidenced by audio on Robert's mobile phone.

2.17 A full timeline is included in this report but prior to the deaths, Joan visited her GP with symptoms of anxiety and distress. The GP referred Joan to mental health services for a full assessment as she was expressing some strange views such as believing aliens were around her. While waiting for the mental health appointment to be confirmed Joan left home and attended the mental health 'walk in centre' at the local hospital displaying much greater anxiety and symptoms of psychosis. She arrived there at approximately 8pm. This service was

not a formally commissioned as a walk in service but it had developed to permit people to walk in and seek help and staff would seek to accommodate that.

2.18 Joan was seen by a nurse and doctor with a preliminary assessment. While the doctor was seeking advice about the next steps to take, Joan left the hospital. This was around 2am. She had been there for around five hours and CCTV footage shows her behaviour becoming increasingly bizarre. Joan also rang the police several times while waiting at the hospital for help and audio of those calls were considered in this review. She was extremely fearful for her safety but could not be drawn on what or whom she was fearful about. When Joan left the hospital the nurse contacted the police requesting a welfare check. The hospital work closely with the police and would sometimes need their assistance in this way. The police initially said that would conduct a welfare check but then rang back to say they would not as it was now against policy. There had recently been a change of policy in police procedures on when and in what circumstances they would execute a welfare check. The welfare check was for Joan as she had told the nurse she had children but they were safe in the care of her mother. Joan said nothing about Robert. The contacts with health services, the police and welfare checks are considered more fully later in the report.

2.19 When Joan left the hospital she wandered the nearby streets and was acting bizarrely such as surrounding herself with orange cones in a street as she believed that orange was a protective colour. Her pathway is captured on CCTV. She also covered herself in dirt and hid as she believed that she was being pursued by vampires and that she had a to find a way to save the world.

2.20 At a time which is not entirely clear Joan returned to her home. Robert and the children were present. On a date believed to be between 18th and 22nd February 2015 she fatally injured both Robert and Clare. Joan's movements and contacts thereafter are set out in the timeline. Joan took Ann and stayed at her grandmother's, Vera from 22nd to 26th February but they had no idea all was not well. Joan's half-brother was also present and neither had any indication that Joan was seriously mentally unwell or that Ann has already been injured.

2.21 On 26th February 2015 Joan attended A&E with Ann, who had a number of infected wounds to her chest. The assessment was that the wounds had been present for some time. Joan told the doctors Ann had fallen through a glass coffee table but that explanation raised suspicion. Concern grew around Clare and CSC became involved. Subsequently the police forced entry to the family home where Clare and Robert were both found dead. Joan was arrested and assessed under the Mental Health Act and detained. Evidence accepted by the prosecution is that Joan was seriously psychotic when she murdered Robert and Clare and significantly injured Ann. Joan believed them at the time to be vampires and felt she was under an imperative to save the world.

2.22 Joan pleaded insanity for the murders and this was accepted by the prosecution and obviated the need for a full trial. Therefore, this DHR does not have the richness of trial evidence to rely upon for this review. The matter was dealt with in one short hearing and Joan was detained in a secure mental health unit where she remains.

2.23 Ann has survived her injuries and is currently in foster care. The harm sustained by this child has been considered primarily within the remit of the SCR along with the death of Clare.

2.24. During the preparation of this report the DHR Chair and SCR reviewer met with Joan. It has also been possible to meet with some members of Robert's family though for legitimate reasons it was not possible to do so until August 2016. Joan's family decline being involved and information from Mary is from contemporaneous information she gave to police at the time.

3 Purpose, Scope and Terms of Reference

3.1 The review process follows the Home Office Multi-Agency Statutory Guidance on the Conduct of Domestic Homicide Reviews (as amended in August 2013). Domestic Homicide Reviews came into force on the 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 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 was or had been in an intimate personal relationship or;
- b. A member of the same household as him/herself; held with a view to identifying the lessons to be learnt from the death.

3.2 The purpose of a DHR and the panel is to:

- 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;
- Identify clearly what those lessons are both within and between agencies, how and within what time scales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses, including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

3.3 Scope of the review

The review places a particular focus on the period from July 2013 to the date the bodies were discovered on 26th February 2015. That is not to say that earlier information will not be included where this might provide important context for the review and this context is included.

A timeline of events is included to produce a chronology of events and responses. This timeline marries up with the SCR timeline.

3.4 Terms of Reference

The specific terms of reference for this review are at **Appendix Two**.

The terms of reference were shared with Robert's family. Joan's family declined to meet or correspond.

3.5 Statement of ethos

The DHR was conducted in the spirit of openness and fairness that avoids hindsight bias and any bias toward any one agency or individual involved. The DHR also sought Robert and Joan's family's perspectives and those of significant others and managed this with compassion and sensitivity.

3.6 Equality and Diversity

The review adheres to the Equality Act 2010. All nine protected characteristics were considered by the panel. None were of concern or relevance to the circumstances of the deaths. The practices of agencies were carefully considered to ascertain if they were sensitive to the nine protected characteristics of the Equality Act 2010, i.e. age, disability, gender re-assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation. In line with the Terms of Reference, the IMR authors detailed how these were considered.

The fact that the family were of mixed heritage, was not a relevant factor either to the circumstances of the homicide or to the way they or their children were treated by any of the agencies with whom they had any contact. Equality was maintained throughout.

There is no information or inference in police records to indicate that any incidents were motivated or aggravated by, ethnicity, faith, sexual orientation, gender, linguistic or other diversity factors. Where this family had contact with the police, or in any of the joint working that took place, there is nothing to infer that any of these factors were relevant in the decision-making or how they were treated. This was tested out across the agencies and with the panel throughout the review.

One of the main features of the review is how professionals and agencies understand domestic abuse and how this may emerge and in what form. The couple concerned had a difficult relationship and Joan said this had included physical aggression and control. Joan states the relationship was a major factor to her stress and a contributory factor to her mental illness. Conversely Robert's family state that Joan sought to exert control over Robert and that at times she was an aggressor.

3.7 Domestic abuse can take many forms:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

As our national understanding of domestic abuse has grown a feature of controlling behaviours has emerged which we now term nationally as “coercive control”. This can include a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacity for personal gain, depriving them of means needed for independence, resistance and escape and regulating their everyday behaviour.

The core elements of ‘power and coercive control’ have long been recognised by those working in the domestic abuse field. However, it is only in more recent years that coercive control has taken prominence in the law. This feature of coercive control is considered to be so serious that this is now an offence in its own right. The law was enacted to make this a criminal offence in January 2016. This is under the Serious Crime Act 2015.

3.8 Warning signs and behavioural techniques of abuse considered to be components of coercive control include:

- Unpredictable mood swings- switching from charm to rage
- Excessive jealousy and possessiveness
- Isolation-preventing partner from seeing family or friends
- Constant criticism including putting the partner down in public
- Control of the partner’s money
- Control over what the partner wears, who they see, where they go, what they think
- Exerting pressure on the partner to have sex against their will
- Random and unexpected use of violence to frighten and subdue partner

4 Domestic Homicide Review Panel

4.1 The DHR review panel is set out below:

Independent Chair
VAWG strategic lead- RBKC Community Safety

Specialist crime review group - Metropolitan Police.
Head of Safeguarding- Central London Community Healthcare NHS Trust
Named Midwife for Safeguarding- Imperial College Healthcare NHS Trust
Tri Borough Safeguarding and Child Protection - Schools and Education
Associate Director of Quality, Safeguarding and Safety- Central and North West London NHS Foundation Trust.
Senior Service Delivery Manager- West Area Victim Support
CEO - Standing Together
DHR regional lead -NHS England
Domestic Violence services- Angelou Partnership Manager
Tri Borough Quality Assurance Manager- Royal Borough of Kensington and Chelsea (RBKC) Family Services.
Designated nurse- Central and West London CCG.
Area Manager- Catalyst Housing LTD.
Named GP for Safeguarding- Children in West London CCG
Consultant Paediatrician- Imperial College Healthcare NHS Trust
Housing Option and Allocation Manager - RBKC

4.2 The panel consisted both of agencies that had involvement with the family but also those who have wider knowledge of working in the field of domestic abuse and have specific responsibilities around this. Individual Management Reviews (IMR's) were also provided from those agencies who had involvement with the family:

Imperial College Healthcare NHS Trust
Specialist crime review group- Metropolitan Police Service
Catalyst Housing Ltd
Central London Community Healthcare NHS Trust.
Royal Borough of Kensington and Chelsea Family Services.
RBKC Housing Needs Group.

Central and North West London NHS Foundation Trust.
Central and West London CCG.
Tri borough safeguarding and child protection schools and education- RBKC

4.3 The chronologies were shared with an aligned SCR and an integrated chronology produced and used for both processes. It is from this integrated chronology that the timeline in this report emanates.

4.4 The IMR's were produced as requested and the Chair and Panel wish to thank the authors for these and for attending the panel meetings to present the IMR's and answer questions from the panel. On request some authors produced further information to sit behind the IMR's and to clarify where necessary. The timing of requesting the IMR's was set to also allow the SCR process to progress.

5 Parallel Processes

5.1 Given the circumstances also of a child death, and another with significant harm, the Local Safeguarding Children Board for Hammersmith and Fulham, Kensington, Chelsea, and Westminster (the LSCB) concluded that the criteria for undertaking a Serious Case Review had been met. The criteria, which are set out in *Working Together to Safeguard Children 2013* are as follows:

- (a) *abuse or neglect of a child is known or suspected; and*
- (b) *either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. (Working Together to Safeguard Children, (2015:75)*

5.2 There was some deliberation and communication with the Department of Education (who oversee SCR's) and the Home Office (who oversee DHR's) as to whether one review and report would suffice. However, the Independent Chair of the LSCB was informed that two reports would be required particularly as the selected methodology for the SCR differed in nature and process to that used for a DHR. It was therefore agreed that two reviews and reports would be necessary, each following their own prescribed process but closely aligned. It should be noted that since that the commissioning of these reviews where both an SCR and DHR are required the Home Office now agree that a joint report can be produced within certain parameters.

5.3 The SCR started at the same time as the DHR and both reviews commenced after the criminal matter was concluded. There has been a close interface between the reviews in

terms of sharing a review team/ review panel, and the independent Chair of the DHR also co- led the SCR.

5.4 To seek to enhance both reviews information and data has been shared across both reviews as much as possible. There is also a strong commonality for the review in that the main objective for both reviews is to learn lessons and to prevent further violence and deaths in the future.

5.5 An inquest has not been heard as yet for either Robert or Clare but is currently being considered by the Coroner and the next pre inquest review is in January 2017.

5.6 The IPCC has concluded its investigation into the police contact with Joan and Robert prior to the deaths.

5.7 The Associate Director of Quality, Safeguarding and Safety at Central and North West London NHS Foundation Trust has also produced a single agency report under the remit of a Mental Health Homicide Review as Joan was being cared for by mental health services at the time of the index event. This is required by the Department of Health and for the organisational learning there. This report has been shared within the DHR process but is also reflected in that organisation's IMR in any event.

6 Timescales

6.1 The Home Office Statutory Guidance advises that where practically possible the Domestic Homicide Review should be completed within 6 months of the decision made to proceed with the Review. In this case, this has not been possible for several reasons relating to the fact that there were two reviews sharing a panel, the criminal matter needed to take primacy with assessments around Joan's mental state and fitness to participate and family involvement was not possible until relatively recently. The SCR report was initially finalised in July 2016 but given further and significant information from Robert's family was amended. The SCR and DHR report were simultaneously published.

6.2 The DHR was formally notified to the Community Safety Partnership Board on 27 February 2015. The Home Office were notified in March 2015.

6.4 The criminal proceedings concluded in October 2015. This was a short hearing as the insanity plea was accepted.

6.5 The IMR's were requested after the process of conversations with frontline professionals was concluded for the SCR. This was in an attempt to avoid duplication in seeing frontline professionals.

6.6 The DHR panel met on 8 occasions specifically for the DHR and the final meeting was on 19th September 2016.

6.7 The review team for the SCR were also the review panel for the DHR with a few additions to the review panel to reflect domestic abuse professionals. The SCR took primacy.

6.8 This DHR has therefore been concluded later than the 6 months' timescale. As both the SCR and DHR has progressed, the learning has become apparent and the agencies have captured this and have worked to make changes and improvements where necessary prior to the reviews' conclusion. Real progress has been achieved in the interim rather than waiting for either report to be concluded and published.

6.9 The Community Safety Partnership has been kept updated as to progress throughout and has sound links with the LSCB.

6.10 It has taken time for other family members to be able to input into the review but this was achieved in August 2016. The family information presents a very different perspective on the relationship and subsequent events which had not been aired previously as would normally have been the case as there was no full trial. The panel and Independent Chair are most grateful to Robert's family for coming forward albeit this was toward the very end of the process and the panel have needed to revisit some of the analysis work and correct factual inaccuracies.

7 Methodology

7.1 This review is guided by:

- The processes outlined in the Home Office multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- Learning from other Domestic Homicides Reviews and Serious Case Reviews of child death/vulnerability across the UK
- The cross government definition of domestic abuse (April 2013).

7.2 This report emanates from various sources of information gathered from sources detailed at **Appendix Four** which also includes research references.

7.3 Contributors to this review include the review panel with their consideration and deliberations on the information being brought forward to the review which includes IMR's and supporting documentation. The review panel also has the added benefit and fullest information from the frontline professionals involved with the family from the SCR. Conversation notes from the serious case review were shared. This meant that the review panel had rich information from these frontline professionals directly as well as the content of IMR's.

7.4 The review panel did not seek the expert advice or opinion of any other specialist during the review as all questions were answered by members of the review panel, IMR authors or frontline professionals. While this review concerns one victim under 18, there was expertise on the panel well able to consider the interface of domestic abuse in the context of children

safeguarding systems. There were also some members on the review panel whose roles revolve around the management of domestic abuse and the development of local and regional strategies in the national context.

7.5 The IMR authors were provided with and followed the IMR template from the Home Office guidance as well as a checklist of what makes a good quality IMR. There was also a presentation delivered on the overarching process for the DHR and support around IMR's.

7.6 Arrangements were made to promptly secure documents at the start of the review and to commence with the collation of the chronology. Participating agencies were advised to ensure that actions were taken to address lessons learnt as early as possible. Some of the meetings have been joint meetings to avoid duplication and share information as much as possible.

7.7 The review panel found obtaining Robert's confidential information, (particularly medical records) very difficult. It transpired he used numerous aliases and was not registered with a General Practitioner nor are there any medical records on all searched systems under the various names he used and yet we know from police records that he did sustain injuries in the past. Initially it presented as if he lived his life out of sight of public services concealing his name. It was not until later in the review process that it has been possible to speak to family members for Robert and gain a much clearer understanding of him as person in the community, father and his relationship with Joan. The review panel were still however unable to find any medical records for him. What is known about previous medical history and past physical injuries is very limited. The police have some information about non family related contacts but these are low level incidents and he has never been in custody or prison. Joan also had some level of non-family related police contact when she was younger but not any serious offences and certainly nothing within the timeline of this review.

7.8 There was close liaison between the criminal proceedings and the review via the Senior Investigating Officer. The forensic psychiatric medical report assessing Joan was agreed by the defence and prosecution at the court hearing. The report clearly states that it is considered medically that when Joan committed the homicides she was not of sound mind. The police also explored if harmful practices featured in this case as a result of how the bodies were presented but this has been discounted after expert opinion was obtained.

8 Confidentiality and Dissemination

8.1 Prior to publication details of the review and findings have been kept confidential. A great deal of confidential data has been considered and shared during the course of this review but with the appropriate agreements and understandings as to the security and confidentiality of that information. This has taken into account that some information has concerned a victim under 18.

8.2 The findings of this review are restricted to only participating officers/professionals, their line managers, the family of the victim and the perpetrator, until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

8.3 Each of the panel members the Chair and members of the Community Safety Partnership have received copies of this report. The report will also be discussed in full with Robert and Joan. Joan's family decline to meet.

8.4 Before publication but after the conclusion of the Home Office Quality Assurance process the Community Safety Partnership will share the final report with all members of the review panel, the Chief Executives of their agencies; and the families and others who have contributed to the review. Joan, will have the opportunity see the report.

8.5 Until such time as the report is deemed adequate within the Home Office quality assurance process the report will remain restricted.

8.6 The content of the overview report and executive summary has been anonymised to protect the identity of the victim, perpetrator, relevant family members and all others involved in this review. Both families will be pre-warned as to the publication date of this review. It should also be recognised that there is a young surviving sibling who has experienced significant harm from her mother and lost a sibling and father.

9 Family involvement

9.1 A genogram was provided for the DHR but has not been replicated to maintain confidentiality. It will be apparent from this report who the main family members are.

9.2 Family composition and pseudonyms used.

- Victim – Robert
- Victim- Clare
- Surviving victim -Ann
- Perpetrator, Joan-mother to Clare and Ann and partner to Robert
- Joan's mother – Mary
- Robert's sister - Alison
- Robert's cousin, Jane
- Joan's grandmother- Vera
- Joan's Half sibling - John

9.3 Information from the families was gathered after a careful introduction to the various family members explaining the process and encouraging them the participate. Regard was given to the very helpful advice and guidance contained in the Advocacy After Fatal Domestic

Abuse² and Home Office leaflet for families and this was provided to further aid the family's understanding and inform them of this support.

9.4 This review also used the principles of family involvement as contained in the research³ for involving families to ensure a sensitive, structured and well prepared approach for initial contact, negotiation, information gathering and feedback throughout. In this review the Chair and review panel maintained an on-going dialogue with the family and also with those supporting them. The accounts around Robert are so different from his family and Joan that a decision was made to present both perspectives in more detail than is perhaps usual to support learning. The review also had the benefit of mobile phone recordings Robert made.

9.5 Information from Robert and his family

As part of the review, the police shared recorded phone messages from Robert's phone. These are various dates that range from two months to two weeks before the time that Joan presented to the GP unwell. These are of various duration and record arguments between Joan and Robert which it appears has been recorded by Robert covertly. Most of the content is from Joan but this must be seen in the context that apart from one recording where Joan discovered Robert was recording them at all other times it would appear that the recordings were made without Joan's knowledge. On a number of the recordings the older child is heard to be intervening in the conflict and argument between Joan and Robert. It is also possible to hear the younger child crying in some recordings. In one recording others are present possibly Joan's mother but they are talking in normal tone. The recordings indicate a great deal of conflict between the couple. Joan is challenging Robert around his lack of support around the children and allegations that he is unfaithful and is living with other women. At times Joan is tearful and pleading with Robert and at others she sounds very angry and is ranting at him for periods of time. On one recording Joan threatens to kill Robert. When Robert does respond he speaks in a different language. Joan indicates clearly to Robert what stress she is under, the impact is a perceived lack of commitment to the relationship is having upon her and her frustration that he is not in her view supporting her emotionally, or practically. She refers to him coming in and out of the home as he pleases and not respecting her. There is one call where she appears to be packing his possessions to throw him out. Voices are raised and Joan sounds in a distressed state and sobbing. From what is being said it would appear that Robert would spend some time with Joan for an intense period and then not be in contact for some weeks raising suspicion for her that he was with another woman and family also. One of the aliases he used was the name of a woman with whom he has been known to associated with historically according to police information but whether he was living a "double life" as such is not possible to ascertain with any surety.

² www.aafda.org.uk

³ Morris, K., Brandon, M and Tudor, P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN ISBN 13 978 085358 287 8

9.6 Robert's family fed into this review and believed that Robert and Joan lived together throughout their relationship and up until his death. They say that Robert did not live anywhere else and the family considers the suggestion that Robert was in any way leading a "double life" a fiction. They are also perplexed around the perception that Robert was not known or visible. They say Robert was big character in the community where he and Joan lived. He sometimes ran a stall in a local market but his main source of income had been painting and decorating. He also did some small contracts for the Council.

9.7 The family say that he had other little jobs here and there but he always provided for Joan and the children and was a generous person. They describe Robert as "showy" and was always full of banter with a cheeky sense of humour and could be very charming. Robert would visit her Alison at her home rather than she to him and they did not live near to each other.

9.8 The family describe Joan and Robert as having a difficult relationship and on occasion Robert would stay with Alison for a few days for things to calm down after rows. During these times Joan would disbelieve that Robert was at Alison's and Joan would constantly contact Robert and Alison would have to go on the phone and assure Joan Robert was with her.

9.9 The family say Joan was highly suspicious and insecure, not trusting Robert throughout their relationship. They explain that Robert was not sure about having another child with Joan as he felt that Joan did not cope well with the demands of being a mother. She would get very stressed and there were regular arguments. Joan had also liked to go out drinking and socialising a lot and that was difficult when caring for young children. Robert told his family that Joan was drinking a great deal at home and he would take the girls to school as there were occasions where Joan drank in the morning. Robert also said that the older child would not go to bed if he was not there. Robert was a good cook and he did most of the cooking for the family. He also tidied the house. He liked things just so and would like the toys all put away at the end of the day rather than left all strewn around.

9.10 On the weekends, Robert and Joan would socialise with family and friends at their home having a drink. The family describe Joan as "living on alcohol." The children would be present and also Joan's mother who spent quite some time at the flat. She remembers that the relationship with Joan and her mother could be difficult at time. Once during a very heated and loud argument, Robert rang Alison and held up the phone so she could hear what was going on. Joan was ranting and very angry and drunk in the presence of children and Joan's mother. Joan was screaming and accusing Robert of having an affair with her mother.

9.11 In the year before he died Robert told Alison that he was recording rows with Joan on his mobile phone and that Joan was threatening him including death threats. (this is verified by phone records and transcripts obtained from the police.) Alison also wonders if there was physical violence as Robert had been injured a few times.

9.12 The family are adamant that Robert would not physically harm a woman or the children. It was just not who he was she said. The arguments escalated with Joan constantly accusing Robert of being unfaithful and there did not seem to be any trust there. Robert liked a drink too. There are no records indicating that Robert or Joan presented at health services with physical injuries that could be attributed to domestic violence.

9.13 Robert's family say said that Joan was very difficult and threw Robert out of the home but he loved the children and they loved him and he would return when things calmed. Robert did talk about leaving but he was reluctant to leave the children. Robert would take himself off for a few days. Things became more difficult after the birth of the second child, Ann, Robert's family explained. Joan was not coping well and was really angry at Robert. They offered to speak with Joan and also offered for one or both of the children to come and stay to give Joan a break but she would not agree. Joan seemed paranoid. Robert's family said they were going to take the children away for short holiday and it all seemed agreed. The children would have been with their cousins but Joan said no.

9.15 In the 6 months leading up the deaths, Alison knew from Robert that the relationship was very difficult indeed and Robert was wanting to leave the relationship. Joan was paranoid about him and defensive toward any help from Robert's family. Robert was saying she was not coping with two children and had "social services on her back" (Joan's words). Robert told Alison that Joan told him if he said anything to social services she would kill him.

9.16 Robert was however asked later to attend a CSC meeting and he told his family he had to pretend that all was well as he did not want the children taken into care.

9.19 Alison was informed by a family member of Robert's death by phone. Her son had seen on the news there had been a death in the road in question and had commented. It came as a shock it was Robert and their cousin had been looking for him that previous week. It transpired that the cousin had been around to the flat. There was no answer to the door. Alison found out that Joan had also contacted her sister who is studying at University during that week and had asked if she could visit but that was not possible.

9.20 The family say that they could not have predicted any harm to the children but Robert told her things about Joan's rages and drinking and Joan had threatened him. Joan is tall, and big but Robert was very strong and she does not think Joan could have overpowered him. The family believe Robert was stabbed in his sleep. The family's view is that they may never learn the whole truth of what happened and that has not been tested out in court with a trial. The family feel very confused how Joan could have behaved normally to others the week during which she apparently killed Robert and Clare. Joan had been outside the home and yet did not raise the alarm of what she had done.

9.21 Robert's family thinks that Joan misinformed services about Robert, hid her drinking problem and anger issues, and painted Robert as a poor father. Robert was on the verge of disclosing things to social care on several occasions but was scared what would happen to his children and also Joan's reaction. She had already threatened him if he said anything. They think Robert was trapped in an abusive relationship and that Joan suppressed what was happening and masked her mental state to services.

9.22 Alison arranged Robert's funeral and many in the community attended. Robert's family is no doubt the relationship was stressful for both Robert and Joan and believes that if it had not been for the children Robert would have left the relationship some time ago.

9.23 Information from Joan

9.24 Joan was seen with appropriate support some months into the review and she had expressed a wish to participate but it was vital to ensure that she had made sufficient recovery for this to happen safely. Joan has also been visited again with support and this report shared with her.

9.25 Joan was invited to tell us about her experience of services she received but also what would have helped her. Joan referred to her first social worker (SW1) as being very helpful and was like part of the family. However, she found the relationship with the last SW (SW2) more difficult and she felt she was under pressure for some months. She believed this SW to be less experienced. Joan states she felt the responsibility was all on her and that the SW2 should have found out more about Robert. Joan thinks that SW2 should have dug much deeper about him instead of applying so much pressure on her. Joan knows that SW2 was doing her job but the level of scrutiny on her personally felt stressful.

9.26 Joan told the review that she found out that Robert lied a lot to her and maintains she did not know his true name, age or even his birthday. The police were involved trying to get him out but he always came back and she admits she would let him back in.

9.27 Joan thinks the police and SW2 could have been more joined up. Joan felt she couldn't be open with SW2 as she had to protect her family and was very stressed. She was trying to do the best she could to keep the family together.

9.28 Joan said that she had very good relationship with the health visitor. (HV). She found the HV very friendly, helpful and supportive and easy to talk to. She kept Joan up to date on how the family were doing. She was also fairly new but seem to learn very quickly. The HV worked with others to help Joan and they would see the HV in the street and she would also chat. The HV was less intrusive.

9.29 Joan said what she needed was help with her young children. She needed the older child to go to nursery more and perhaps other help with the younger child so she would have some time to herself and be able to have some time out and go out and socialise more. Joan recalls that she became exhausted and was not sleeping well. She had not slept for 5 nights before the events took place that led to the deaths.

9.30 Joan did not talk to nursery/school about her problems as she did not see that as a place for support as schools are all about performance and attendance she thinks. They had however just opened a crèche and she was hoping to use that.

9.31 Joan said that she registered with her GP surgery some years ago. About a week before the events she was on the school run and felt odd. She was drawn to the colour orange in things around her and didn't understand why she had to seek out this colour but that this colour was protective. She started to feel she was in "survival mode". She went to the GP. The GP prescribed her anti-depressants but she only took one as she was worried as she was still breastfeeding. Joan states that the GP told her that she would ring Joan the next day but the GP did not. Joan said she was not aware of any referral being made to mental health services.

She just recalls the medication and the GP saying she would call Joan the next day. She said if she would have known about a referral she would have attended the appointment.

9.32 Joan explained that she had been to the GP before with strange thoughts. This had been in the previous November so months earlier. Her daughter was learning phonics and she kept getting the phonics rhyming repetition into her head and she could not stop it. Joan told her GP about this but she was not assessed on that occasion.

9.33 For about a week before the deaths, Joan became mentally unwell with thoughts the nature of which she had never experienced before. She recalls became very scared. She went to a number of churches in the immediate area. She would go to church fairly regularly. She sought holy water from one priest and she was in a distressed state. She was convinced that vampires were chasing her and she ate and covered herself in garlic so they could not smell her. She remembers eating garlic in front of one priest. Some churches were receptive and others said come back tomorrow. She sought blessings and felt extremely frightened. She had written to another priest explaining things and put her bank statements and a bible into a post box.

9.34 Joan had told her mother when she had had strange thoughts in the November that she did not feel right. Her mother's view was that she was very rundown and that the poor relationship with Robert was "bringing her down" and her mother said Robert was "disrespecting" her. The family got through Xmas and she had plans to take the children on holiday and set up a business with her mother.

9.35 Joan explained that she took herself to the hospital in the end as she was very frightened. She had never experienced the thoughts or fear like it before. She went to Urgent Care Centre first. She recalls having panic attacks there and asking the nurse if she was she in the right place. She was advised to go the mental health unit on the same site but was too scared to go alone. The nurse walked her down and helped her speak to someone there. Joan describes screaming and being hysterical at St Charles. She was left waiting for a long time so she started to ring the police begging for help. She recalls the police being at the hospital but ignoring her, some were on foot and others in cars. She could not understand why they were ignoring her at the time but now realises that they might have been there for other patients. She was scared and constantly looking around as she felt there were vampires after her. She went outside and a nurse came out for a cigarette and spoke to her. There was also a doctor who spoke to her but then went away again and she was left for a long time. The receptionist was asleep and at 2am another patient came in to use the phone to order pizza as his mobile phone was out of charge. Joan tried to get the attention of the staff and was very distressed. She reflects on this now and understands that there was a wait but she needed help quickly and as time passed became more and more anxious. She did not feel safe in the hospital but was also scared to leave.

9.36 There is objective evidence that Joan was left in the reception area for some hours. CCTV footage also shows her holding out an orange plastic bag in front of her. A police officer who was bringing in another patient approached her and asked if she was ok. She would not speak. The police officer asked the receptionist and a nurse if someone was attending to Joan and

they said yes. Joan left the hospital at 2am. There was no further action that night after the police declined a welfare check.

9.37 Joan said she ran from the hospital in the end as she needed to get somewhere safe. She hid in a garden and covered herself with mud as she was convinced that the vampires could smell her. She buried her shoes and then saw some orange traffic cones nearby. She surrounded herself with these in a circle for protection in street. She thinks all this is captured in CCTV from Barclay Bank. Her view now is that perhaps she should have been sectioned or sedated at the hospital to calm her down. She was running around in the street and she wonders if people thought she was on drugs.

9.38 Joan wandered the streets initially trying to hide and told a member of the public who happened to be a psychiatrist that she was trying to make her way to the spaceship. This person advised her to go back to St Charles before getting on the bus. Joan was covered in mud with no shoes and was distressed. It was raining and she recalls sitting outside a church on the ground. The priest told her to come back the next day. It was the early hours of the morning. She eventually managed to get home. Her mother had been with the children but had returned them and they were at home with Robert. (NB. the actual events were not discussed with Joan on medical advice.)

9.39 Joan shared with the review that her relationship with Robert was sometime violent. They would drink and fight. She is sure he was also with other women despite having two children with her. Joan agreed that Robert was fine about the first child but not so keen to have the second. Joan lived in a close community where everyone knows everyone else and she had some friends in the community. Joan was very clear that she did not want her mother to be involved in the review. She said her mother has been through a lot- losing a granddaughter, son in law (Robert) and also Joan's younger half sibling was doing GCSE's. She did not suggest anyone further who may be able to assist in the reviews.

10 Timeline.

10.1 The timeline below sets out key dates lifted from the chronology and where the DHR had focussed its consideration around learning points. This timeline is shared with the SCR. It commences when the second child, Ann is born as the evidence before the panel indicates that this is the point when the relationship becomes more challenging. This timespan was agreed by the panel to marry up with the Serious Case Review timespan and to accord with systems learning principles but this report does of course view this period in the historic context of the family and relationship.

Date	Event
1.07.13	Ann (second child) born.
Key event 1	

26-31.07.13 Key event 2	Police undertake a welfare visit following an anonymous call from a neighbour. Children both safe and well. Notification sent to Children's Social Care (CSC). Child and Family Assessment initiated. Joan requested extended nursery placement for older child, Clare.
02.08.13	Further referral from police received by Children's Social Care. Checks undertaken, Health Visitor (HV) informed
05.08.13	(HV) is notified that the extended nursery place has been approved.
09.08.13 Key event 3	Social Worker (SW1) undertakes home visit, assessment recommended.
21.09.13	Robert reports to the Police that he has been assaulted by a stranger. No further action taken.
23.09.13 Key event 4	Clare starts nursery. Disclosure by Clare to her teacher of domestic abuse at home in November 2013. No action taken and social services are not informed for six months.
09.10.13	Social Work assessment completed. HV continuing to work with family. Case closed but social care not aware of Clare's disclosure.
16.01.14 Key event 5	Mary called the police while drunk, saying her daughter is in an abusive relationship with Robert. Police attend. Welfare Check is undertaken and the children are seen as well/asleep. Notification made to CSC. Enquiries made by CSC. No further action.
08.05.14 Key event 6	Joan calls police. Robert would not leave the house. Police attended, Robert left. Recorded as non-crime domestic incident. Children asleep and well. Notification made to CSC who decide to visit and undertake a full assessment.
18.07.14	Child in Need assessment completed by SW2.
06.08.14 Key event 7	Network meeting takes place (as part of the Child in Need plan) with parents, children, HV and SW2. This is the first time professionals meet Robert.
08.09.14	Clare starts at reception class at school
10.09.14	Robert cautioned for possession of cannabis with intent to supply.

29.09.14	Joan attends 'Strengthening Families programme'. Only attends one session.
03.10.14	Robert stopped by police for drinking alcohol. No further action taken.
10.11.14 Key event 8	Review network meeting held for Child in Need plan. Positive feedback about care of the children and no new concerns. All agencies agree to close the case.
25.01.15	Hospital doctor contacts police about Robert who had been admitted with eye injury following an assault by a stranger.
05.02.15	Community nursery nurse undertakes home visit to advise mother about breast feeding.
09.02.15	School meeting with Joan about Clare's dropping attendance (91%)
12.02.15 Key event 9	Joan attends the surgery and is seen by her GP. She is anxious, low and depressed. The GP does not identify any immediate risk or current psychosis and makes a referral to the primary care mental health team, marked urgent.
13/02.15	Clare not in school. Message left for Joan (last day before half term)
23.02.15	Primary care mental health team triages the GP referral (3 working days is the norm)
17.02.15 20.30 hours Key event 10	Joan presents at the Urgent Care Centre ⁴ at St Charles Hospital with symptoms of anxiety and is taken to the Mental Health Unit by one of the nurses. She says she her children are with her mother. Joan becomes increasingly distressed and is expressing paranoid thoughts. She makes a number of calls to 999 and the out of hours GP service. Joan is seen initially by a nurse, later by a doctor but leaves the unit in the early hours and after five hours at the hospital while the doctor is taking advice re next steps.

⁴ Urgent Care Centre – direct access health facility providing assessment and treatment of minor illnesses and injuries provided by the CLCH NHS trust within St Charles Hospital.

18.02.15 02.08 hours Key event 11	<p>The nurse contacts the police to undertake a welfare check The police initially say they will do the check, but later phone back to say they will not.</p> <p>Joan walks the street behaving bizarrely but eventually goes home.</p> <p>Children had been with Mary but she brought them back and were now at home with Robert.</p>
18.02.15 Key event 12	<p>Primary Care team make an unsuccessful attempt to contact Joan by phone.</p> <p>Robert's cousin, Jane tries to visit but no answer at the family home.</p> <p>Deaths probable between 18 and 22nd February. It is believed that Clare may not have died immediately.</p>
22.02.15 to 26.02.15	Joan went to stay with her maternal grandmother, Vera and half brother, John. Joan has Ann with her.
23.02.15	<p>Primary Care Liaison nurse attempts to undertake a home visit twice in response to the GP referral. No response.</p> <p>Clare is absent from school again. This is the first day after return from half term. Joan said in a short telephone call with school that Clare was with Robert.</p>
24.02.15	Further attempts to contact Joan including Second home visit attempted by Primary Care Liaison nurse and Consultant Psychiatrist. No response. No further action taken.
26.02.15 8.40pm Key event 13	Joan leaves her maternal grandmother's telling her she is taking Ann to the hospital. Joan brings Ann into St Mary's A&E with chest wounds stating she fell through a glass coffee table. Staff concerned about circumstances. Duty Social work team informed. Same day school contact a social worker due to non attendance of Clare since 12th February.
27.02.15 am	Hospital inform CSC about Ann and concerns about Clare's whereabouts. SW visits Joan on ward and agree to have strategy meeting on Monday re Clare.
5pm	<p>Paediatrician calls the police due to increasing concern re Clare.</p> <p>Police attend house and discover bodies of Clare and Robert. Robert found in the bath with stab wounds and Clare on the bed with fatal injuries to the chest.</p>

10.2 At post mortem it was noted that Robert had twenty-nine roughly corresponding stab wound defects. A 10cm long fragment of what appeared to be a paintbrush was recovered from within the right pleural cavity of his chest. A cause of death was not recorded. For Clare, it was noted that there were six stab penetrations to the chest including insertion of a broken pencil which required surgical removal.

10.3 An inquest was opened and adjourned at Westminster Coroner's Court on the 10th March 2015 for both Deceased. It is anticipated that the inquest will be heard in Spring 2017.

11 Analysis

11.1 Agencies were asked to provide chronologies and IMR's of their involvement with Joan, Robert and their children and this will be considered through the key events as set out in the timeline. Particular learning points are in bold.

11.2 The focus for this section of the report therefore will be an analysis of the response of the agencies involved with the family and why decisions were made and actions taken or not taken as indicated by the IMR's but also from further information within the review.

11.3 The review panel has made every effort to avoid hindsight bias and has viewed the case and its circumstances as it would have been seen by the individuals at the time. Where relevant learning points were identified by services and agencies these are highlighted in bold.

11.4 Three agencies responded as having had no relevant contact with either Joan or Robert They are:

- RBKC Housing
- National Probation Services
- Domestic Violence agencies

11.5 KEY EVENT 1 – Ann born July 2013

There was consensus in the review panel that the birth the couple's second child Ann marked a turning point in her Joan's health, stress levels and in her relationship with Robert.

Midwives at Imperial Hospital had contact with Joan during her pregnancy with Ann but these records have been lost and were not available for analysis.

The safeguarding summary which could be found includes reference to the safeguarding lead in midwifery being copied in to emails about Joan on 4 occasions (where the subject matter related to reference to a history of domestic violence). The midwifery supervision record which was also available and relates to a history of domestic violence although there is no detail in these summary records of what the domestic violence actually consisted of – i.e.

whether it was physical, verbal, psychological, controlling or coercive as indicated in the LSCB London Child Protection Procedures. (Details about the nature of the violence may be in the missing records) No risk tool such as the DASH- Domestic Abuse, Stalking and Honour Based Violence risk assessment was used. This is a risk tool used in assessing levels of risk to domestic violence. The purpose of the checklist is to give a consistent and practical tool to practitioners working with victims of domestic abuse to help them identify those who are at high risk of harm and whose cases should be referred to a Multi-Agency Risk Assessment Conference (MARAC) meeting in order to manage the risk.

In April 2013, while pregnant Joan was reported to have disclosed physical and verbal abuse but further clarity was required and therefore the case was allocated for an initial contact. Two home visits were completed as a result of this and agency checks reflected positively on the family. Joan admitted that there had been some pushing previously with Robert during and just post her pregnancy with Clare but denied any current domestic abuse. A DASH risk tool was not completed with Joan. Joan referred to Robert as her ex- partner. Her previous alcohol use was also explored with her and she admitted to drinking prior to her pregnancy with Clare and it was noted she appeared to be casual, possibly minimising this. However, Joan denied any current violence with whom she called her ex-partner and stated they had limited contact and her second pregnancy was a one off reconciliation. No further action was taken at this point and it was agreed that universal services would continue to support the family as required.

The lack of a risk assessment tool such as the DASH being used is surprising given that Joan was informing midwives that there had been domestic violence though it should be emphasised that she was stating that she was no longer in a relationship with Robert. There were also no current concerns as to her care of Clare and on the face of it Joan had support from Mary. Without the records it is difficult to ascertain how much midwives knew about other risks such as Joan's previous mental health problems though she had been seen to a degree for that aspect of her health within the same Trust. There does not appear to have been mental health indicators to raise concerns in the ante natal period.

When discussing the use of a DASH with midwifery, it is apparent that the DASH is more commonly used by the police rather than health services though through this review the hospital has reflected upon this. It is standard practice to enquire about domestic abuse in the ante natal assessments. It was acknowledged that pregnancy can present as a high risk factor in a difficult relationship even where there is minimal contact between the couple.

After Ann's birth, Joan stated to her health visitor (HV) that Robert was abusive and alcoholic and had been physically abusive towards her in the past. She stated that she did not want contact or any relationship with Robert and knew how to contact police if he came to the family address.

11.6 KEY EVENT 2- 26th to 31.07.13

The Health Visitor (HV) initiates a CAF⁵ and welfare checks were required by the police.

On 26th July 2013, Joan's neighbour made an anonymous call to police stating that Joan had been playing loud music and she was concerned for the two children. Ann was just under one month old. She also stated that she had previously seen Joan drinking beer while breast feeding. She was advised to call environmental health regarding the noise nuisance.

In July 2013, another police report was received around possible neglect of the children. When police attended, they had no immediate concerns for the children but a male was present they recognised as a local street drinker; they were unable to obtain his details for further checks. It is believed that this was Robert. This referral did lead to an initial contact with CSC where the main concerns highlighted were the parental relationship, Joan's alcohol use and low mood. The Social Worker, SW1 proceeded to complete a Child and Family Assessment. The Health Visitor assisted in that process. Joan would not provide details of 'Robert' for him to be included in the assessment process and in discussion with SW1, and she also refused to consent to Mary being spoken to as part of this process.

Joan's refusal to involve Mary in the assessment was not challenged at the time. A reflection in this review was how contact with Robert and Mary at this point would have added to the assessment and provided more information around Robert and his relationship with Joan and level of involvement with the family. On reviewing information provided to the police after the deaths it is clear that Mary would have been able to provide a great deal more information which would have assisted those working with the family understand that Robert was in fact at the family home a great deal more than Joan was indicating. He was living there at points and was in fact involved with the children particularly Clare with whom he had a strong attachment. This is in stark contrast to the information Joan was giving professionals about Robert and contact with him as well as the ongoing challenging nature of their relationship. **Therefore, the CAF was somewhat limited by this dynamic and could not detect the full scale of the relationship between Joan and Robert or any risk attached to it.**

SW1 felt that this did leave grey areas but that Joan was adamant there was no current domestic abuse and that contact between Clare and Robert was facilitated by Mary and this was limited. The home condition, children's presentation and relationship between Joan and her children was always very positive. Feedback from agencies was also positive and therefore, SW1 closed the case with the Health Visitor as the lead professional continuing to support and monitor. SW1 did recall when inputting into this review that Joan was a physical presence, tall, broad, dominating and loud and did not come across as someone that would not stand up for herself. SW1 did not view her as a victim.

⁵ The CAF is a shared assessment and planning framework used by all children's services in England. It is used when it is believed that a child has additional needs. The assessment identifies what those needs are and co-ordinates services who can work to meet the needs. The process is a voluntary one which requires the consent of the child's parents or guardian.

The neighbourhood manager for the housing provider (Catalyst Ltd) where Joan lived did not receive any complaints about Joan. It is reasonable to expect that the neighbourhood manager was knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator.

During 2012-2013. Catalyst reviewed its anti-social behaviour policies, including domestic abuse policy; introduced a new risk assessment matrix and tool kit for its neighbourhood managers. Training was provided to all housing staff. It also introduced a new IT system (Orchard) as a case management tool for neighbourhood managers. At the end of 2014, policies were updated to reflect legislative changes including the reference to coercive control to recognize it as a criminal offence.

No risk assessment was undertaken by Catalyst for Joan however, as no indicators of domestic violence were recognised. However, no record of this incident or later concerns were made on Catalyst's case management system. This should have been done. **It is recognised that the system at that time was over complex and acted as a deterrent to record 'minor' issues.**

Joan had also asked for a larger property after the birth of Ann but this was not possible. Between February 2012 and 1st July 2013, Catalyst contractors attended on 14 occasions for day to day repairs, none of which were relating to property damage.

RBKC housing department did not have any involvement during the salient time.

11.7 KEY EVENT 3-09.08.13

Social Worker (SW1) undertakes home visit, assessment recommended.

On 8th August 2013 police received an abandoned call, whereby the male caller requested help from the police before the line cleared. No disturbance was heard. Due to the nature of the call the police completed intelligence checks on the phone number and ascertained it was linked to Joan's address. Police called the number back which went to voicemail. A text was sent to the number requesting they call police back if their attendance was required. As there was no disturbance heard and no return call, the incident was closed.

A further social care assessment was conducted. SW1's assessment at this time was that Robert and Joan's relationship issues did not reach the threshold for a domestic abuse risk assessment. The team do use and complete the DASH risk assessment with parents where domestic abuse is of concern and likely requires a referral to MARAC. However, this was not completed with Joan or Robert. Joan denied domestic abuse and minimised it and it would have not reached threshold for a MARAC referral. Joan was adamant they were not together. Therefore, the risk level was not deemed to require a specific risk assessment beyond the child and family assessment. The health visitor has also obtained an extended nursery place for Clare which was a positive. **However, as a learning point CSC accept the need to consider risk assessment and approaches with families where the concerns are lower level but still evident. Also completing a DASH should be considered whether a MARAC is likely to be the outcome or not.**

11.8 KEY EVENT 4- 11.13

Clare started nursery and made a disclosure to staff of domestic abuse at home. No action taken and social services are not informed for six months.

Clare started nursery in September 2013. At the beginning of October 2013 Social Services contacted the school to advise that if they should have any child protection concerns, particularly around the presence of Robert that the school should contact Social Services. The school had some contact with Robert when he collected Clare from school and the school observed that their relationship was appropriate and she was happy to be collected by him. He was consistently polite to school staff. In mid-October 2013 Social Services advised the school that the case was now closed and this was confirmed to the school via e-mail.

In November 2013 it was noted in an "Areas of Concern Book" maintained by the nursery teacher that Clare said in late November 2013 *"my Mummy does not like my Daddy and my Daddy doesn't like my Mummy. They are not friends"* on being asked why Clare said this, she replied *"cause my Daddy wants to kill my Mummy "..." Daddy kicked Mummy and Mummy had blood on her head. I had to look after her cause she said to Daddy get out of here!"* This exchange between the teacher and child was not shared by the member of staff in the school with the Designated Safeguarding Lead in a timely way. The rationale for this as explained much later was that Clare at this point of time had been observed saying things that were not true about other children and therefore, they had noted the information but not moved further than this. This was addressed at the time by the Head Teacher with the member of staff concerned as this was not in line with the expected standard of practice in sharing and logging this information with the Designated Safeguarding Lead.

The disclosure by Clare at nursery therefore did not lead to a referral to Family Services in November 2013 by the nursery teacher or Head. The case had closed to CSC in October 2013. Family Services were only made aware of this disclosure during a later 2014 assessment approximately 6 months later, at which point Clare did not repeat herself and the parents were able to minimise the concern. **A more timely response to disclosures such as this is good basic practice and would have given further information to Family Services where there were already concerns emerging. Clare's disclosure in conjunction with the 'grey areas' that remained present at the time of case closure, in terms of Family Service's understanding of the relationships at home, in all likelihood would have triggered further assessment. This may have escalated into the child protection arena, and an appropriate domestic violence response from agencies such as using a risk assessment tool such as the DASH with Joan.**

The panel consider the poor sharing of information by the school as inappropriate management of a significant disclosure from a child. The school has since revised its safeguarding policy and procedures accordingly.

11.9 KEY EVENT 5-16.01.14

Mary called the Police while drunk, saying Joan was in an abusive relationship. A welfare check is undertaken and the children are seen safe and asleep. A notification is made to CSC. Enquiries are made by CSC. No further action required.

On 16th January 2014 at 2311hrs a female called Police requesting if they could attend her address. The call was inaudible and the address could not be established. An argument was heard in the background before the caller disconnected. Police called the number back and a male answered advising that there was no need for police to attend. Due to the circumstances, police decided to attend and commenced intelligence checks to identify the address. However, the calling number was linked to Robert and the address was unidentified.

This incident also linked to a call from Joan's mother the same day where she raised concern for the well-being of Joan and the children. Mary advised that Joan was in an abusive relationship. Police saw Joan and the children who were asleep in bed. Joan advised that she and Robert had argued and she wanted him to leave.

Police noted that it was very unusual that Joan only knew Robert by the name of 'Robert', despite him being the father of their two children. Again alcohol was involved during this incident and a relevant factor of their lifestyle. The incident was recorded as a non-crime domestic and the report closed. A police Merlin was created and appropriately shared with CSC.

It was only when Mary called them with concerns, that police were able to identify the actual name of Robert. In this police report further information showed that in 2012 he had been arrested in possession of a knife and in 2009 he had been arrested for being drunk and disorderly.

There was now a building picture of discord between the couple drawing in the police and CSC but seen as low level and the children as safe. The matter was managed as a non-crime incident despite the information from Mary and she raising concerns. There was no consideration to see Joan alone or complete a DASH risk assessment.

11.10 KEY EVENT 6- 08.05.14

Joan called the police. Robert would not leave the house. The Police attended, and Robert left. This was recorded as a non-crime domestic incident. The children were noted to be asleep and well. Notification was made to CSC who decide to conduct a home visit and undertake another assessment.

In May 2014, Joan contacted the police to report that Robert was at the address, was drunk and would not leave. It was at this point the case was allocated to a new Social Worker (SW2). It was during this assessment period that there were further indicators of domestic abuse and SW2, despite a continuing barrier from Joan, sought to include Robert in the assessment. SW2 had to be very persistent but was able to meet with Robert and observe him with the children. It is important to note that of significance at this time, was information from Clare. At the

start of the assessment with SW2 she referred to being frightened of her daddy and told SW2 that he shouts which led SW2 to feel concerned about contact. During the assessment, as the school was part of the process, it became apparent what Clare had said at nursery the previous November. The nursery provided details from Clare as she had referred to a knife, "that daddy kills mummy, that mummy and daddy do not like each other and that daddy had kicked mummy ...". Clare did not make such disclosures to SW2 during the assessment or during the period of time post assessment, whilst subject to the 'Child in Need' plan. During the assessment, Clare drew a picture of her daddy where he had a smiling face and through observations of the children with their father (one during a network meeting and one in the park) the children seemed happy and excited to see him. **Of more concern for SW2 at the time was Joan's apparent depression and that despite being advised to attend the GP, she did not go although the Health Visitor was monitoring this. When the case closed, all professionals were in agreement with this decision.**

SW2 was a fresh pair of eyes to this family and reviewed past contacts and noted the family had been known to the Royal Borough of Kensington and Chelsea CSC since an initial Police notification in 2011. From this point forward, there have been three key themes that have been evident during points of contact with the family. These were:

- Maternal Depression
- Alcohol use of both parents
- Domestic Abuse

Joan did suffer with depression but as we understand it now, this was a precursor to an acute psychotic episode during which the tragic events unfolded. The psychotic episode could not have been appreciated at the time by the professionals working with Joan. CSC reflect that the above three aspects form what agencies refer to as the 'toxic trio' or "multiple risk" as they have been identified as common features in households where harm comes to children. This is supported by the **2014 publication by CAADA 'In plain sight: Effective help for children exposed to domestic abuse'** which comments on the relationship between these risk factors. However, when reviewing the chronology, each theme was not always a factor in each contact with this household and there were many strengths evident in relation to the parenting and attachments observed. The risks were often denied or minimised by Joan. **It is clear, that the extent of each of these risk areas was minimised by the family impeding the understanding of agencies in learning the full extent of risk in the household. Therefore, understanding the approach to assessments and interventions with this family is essential to consider whether there were opportunities that may have enabled us to get a clearer picture of these risk factors.**

Focusing on the parental relationship at this stage, when considering referrals for the family, it is Joan who comes across as the victim up until the point Robert was murdered i.e. she was calling the police and disclosing to the midwife concerns regarding the relationship. This was confirmed when discussing the case with SW2 who confirmed Joan was not perceived as the victim. Joan did admit to some mutual pushing during arguments to the Social Worker detailing them as historical and not of current concern. Furthermore, the disclosure by Clare paints her mother in more of a victim role. **It is essential that mutual domestic abuse is**

considered. This is important to note given that the extent of the domestic abuse remains unknown given both parents being reluctant to be open with professionals regarding the relationship.

In discussion with SW1 and SW2 independently of one another, the question was asked regarding specific domestic violence risk assessments. **Risk assessment tools such as the DASH were not used by CSC at the time but now it is used on a case by case basis though it is not mandatory. There are now specialist practitioners working with families where domestic abuse features.**

Up until the child and family assessment completed by SW2 in 2014, Joan had told agencies that she did not even know how to contact Robert. Professionals were sceptical regarding this, but it left them in a difficult position to try and work with both parents. The threshold was not deemed at a child protection level in 2013 and decisions needed to be reached regarding further action. **The persistence of SW2 in 2014 in terms of including Robert should be commended as it was only at the point Joan was advised the case would not be closed until he participated, that he made himself available. However, this persistence should be the norm in terms of including fathers in assessments.**

The approach to working with Robert is not an isolated occurrence when considering the challenges of working with fathers generally. Had he been included at an earlier stage, it may have been possible to learn more about him as there would have been increased time building that professional relationship. Whilst Joan's reluctance to involve him was problematic, as evidenced in the 2014 assessment, this was a hurdle that was overcome and leads to the next key event.

11.11 KEY EVENT 7-06.08.14

A network meeting takes place as part of the Child in Need plan with parents, children, the HV and SW2. This is the first time professionals meet Robert.

Robert attended the child in need meeting, which is a formal meeting. CSC advised in the review that there are efforts to be inclusive to fathers but engaging fathers can be challenging and generally mothers take the lead with services and are the main contact point. Consequently, there is more of a bias toward working with mothers as they tend to be the primary carer and more accessible.

Robert cooperated with the meeting but continued to refuse to provide an address of where he lived. SW2 described him as having 'a wall around him' in terms of sharing with her and whilst the issues were explored with him, he was very resistant to being completely open. This did impact on SW2's ability to really get a sense of his background. SW2 noted that when she observed the parents together to discuss contact, they both reported the communication between them had improved and they denied on-going difficulties. It does appear that he was a perpetrator of domestic abuse but he was also a victim. Based on the information provided, whilst it is clear the level domestic abuse was minimised, there were indicators and inconsistencies that were picked up by agencies.

It is important to consider the weight CSC and other agencies give to the child's voice. When we consider Clare's journey, it is recognised she was young but there were three occasions in which she made comments to professionals that indicated there was an unhealthy relationship and complex dynamics in the home. These were during the 2013 initial assessment (May 2013) in which it was reported Clare (then 3 years old) said daddy had curled his fists up and was banging them together; there is then the disclosure in November 2013 (then 4 yrs. old) to the nursery which gave a deeper insight to the level of domestic abuse in the home; and in the 2014 assessment, Clare (4 yrs. old) does state that she gets frightened and daddy does shout sometimes. The concerns were then denied/minimised by parents and observations between the children and both their parents were deemed very positive which in my view, appears to have reduced the anxiety of professionals along with Robert's eventual engagement with CSC. **This demonstrates the complexity of gathering evidence and balancing this to inform practice, the importance of timely responses to disclosures as well as the need to understand the different ways children may try to express their feelings about life at home and how practitioners interpret this.**

The Health Visiting service was involved with the family as a matter of routine and the only concerns at this stage were to support the mother to access an extension to the nursery place for 3-year-old Clare. There had been a recent change of HV, but this had been managed well, and the new Health Visitor quickly established a good relationship with the family that was appreciated by Joan. Although the HV was new in this role, she was an experienced health professional, who herself was well supported, and demonstrated strong skills in working with families.

From the outset the HV observed good care of the children and good attachment to Joan. She followed expected professional practice in regularly checking Joan's mood which was at times low, but not unduly concerning given the stresses of being a single parent. The HV saw that as the primary stressor. It is evident that the HV offered a good level of support to the family throughout her involvement. Any signposting around domestic abuse or relationship conflict was not considered as it was something presented as being in the past and contact with an abusive partner not conveyed as every day a part of family life. This painted a picture however that we know from information into this review is inaccurate. The HV service does not routinely use domestic abuse risk assessment tools. **Joan nor Robert was open with professionals as to their true relationship with Robert and the impact that was having upon her. This presented professionals with no real opportunity to signpost them for relationship support or those agencies who work with those who are victims or perpetrators of domestic abuse.**

11.12 KEY EVENT 8-12.02.15

Joan attended her GP surgery feeling anxious, low and depressed. The GP does not identify any immediate risk or current psychosis and makes a referral to the primary care mental health team, marked urgent.

Historic GP records indicate the Joan had some problems with anxiety and low mood as far back as 1996 but this was contained in old records that were not accessed by the GP she was registered with at the time of the deaths. No GP records or GP contacts could be found for Robert.

On 14/11/2014 Joan had had an appointment with her GP. She discussed feeling stressed and having difficulties with her ex-partner. She had difficulties managing with two children but said her mother and sister help out. She denied being depressed. After a discussion, Joan decided to ask her family to help out more. The GP advised some relaxation strategies.

On 12/02/2015 Joan presented to the GP with symptoms of dizziness, tiredness and feeling unwell over the previous 10 months. She felt anxious and depressed with clear symptoms of depression that were getting worse. She was finding it difficult coping with her 2 young children, both under 5. Particularly over the previous week she had felt some hopelessness and also that she was surrounded by aliens. At this appointment though she did not exhibit any psychotic features. Risk for self-harm or suicide was elicited and none was identified. She was asked about her alcohol consumption this was within recommended weekly limits with no binge drinking.

Joan requested medication to help her cope and agreed to start an antidepressant. The GP felt she was vulnerable, being a single parent with poor social support and 2 children under 5. She advised that she would refer Joan to a Primary Care Liaison Service who could offer her additional support with her depression. It should be noted that the GP acted on this immediately and referred Joan to this service using the usual electronic referral form, marking the referral as 'urgent'. Urgent is to be seen within three days. The GP also discussed a crisis plan with Joan including what to do out of hours e.g. call 111, attend an out of hours' service or weekend surgery. She requested Joan to attend for a review in 10 days. Joan advised the GP that she would ask her mother to come and stay to help her out. At this appointment, Joan had brought Ann with her. The GP noted a good rapport between Joan and Ann and considered Ann was being cared for appropriately. There was no further contact with the family after this.

The GP was sensitive to Joan's needs particularly in relation to her vulnerability as a single parent with 2 children under age 5, and to her mental health. Whilst difficulties with her ex-partner were discussed, domestic violence was not asked about explicitly nor risk assessed. Feeling generally unwell with non-specific symptoms together with feeling depressed may also have been a sign of domestic violence, particularly psychological or emotional abuse. **It is possible that opportunities to undertake assessment of domestic violence may have been missed at this stage. There are no specific policies in the surgery regarding domestic violence as identification and action is done on a case-by-case basis.** All GPs are trained to Level 3 in safeguarding children, which includes domestic abuse and potential indicators for this. However, during discussion with Joan in the course of the consultation, risk of domestic abuse to her as a victim may not have been indicated and the GP states it may have been mentioned. The GP advised it is not possible to document everything that has been said in consultations so a brief summary is usually made, especially when consultations are lengthy

and significantly longer than the 12 minute allocated slots. The GP spent a long time with Joan consultation demonstrating good medical practice and a patient-centred approach.

Joan described anxiety and feeling low for several months as well as a lack of sleep due to breast feeding which meant she was struggling to cope. The GP assessed her depression using the correct assessment tool which confirmed her view that Joan did need further help and support, but that there was no evidence of serious mental health problems or psychosis Joan did refer to having had thoughts about aliens, but in the context in which this was said, it was not something that gave the GP particular concern. The GP was familiar with working with patients with mental health problems and anxiety and stated in the review that it is not uncommon for people to express what might seem odd beliefs or thoughts, but that this in itself would not indicate a serious mental health problem or reason to consider they might present a risk.

The GP explicitly assessed how Joan's feelings might be impacting on the children. She observed that Joan was very responsive to Ann's needs and safety while in the surgery, despite her own distress. Joan was also explicit that while she sometimes had thoughts about 'giving up' she had no active plans to do anything and indeed would not because of the children. The GP identified no evidence of hallucinations or psychosis and also that there were social and personal factors that would explain Joan's anxiety and low mood. She prescribed anti-depressants and completed a referral to the Mental Health Primary Care Liaison Team marked urgent, as from experience she believed that this was the quickest way to access support for mother.

By marking the referral via the Primary Care Mental Health service as 'Urgent', the GP felt that Joan needed to be seen quickly. **It may have been more beneficial to refer to the Assessment and Brief Intervention Team (ABT), whose remit is to see patients quickly as they are deemed at greater risk. At the time of the incident, specific inclusion and exclusion criteria for both services were not available, which may have caused confusion as to which service to refer to for a faster assessment. During the review it was noted that the map of such services was complex.** The GP Surgery were aware that the health visiting team had been involved with the family but it is not explicitly documented in the notes when these conversations occurred. There is no information on Robert apart from mention of an ex-partner by Joan. **The father(s) of the children or who had parental responsibility was not documented. The details of other significant people in the children's lives e.g. grandmother and aunt were not documented.**

At that time there was no formally commissioned crisis mental health service to which the GP could have referred Joan the same day that he saw her. If a patient needed to be sectioned under the Mental Health Act there is an urgent process for that but the GP did not at that time consider that Joan was detainable under that Act. There has now been a service redesign of the urgent mental health pathway.

On the 9th February 2015 there was a routine meeting with Joan and whilst Clare was not at that point of compulsory school age the school discussed Clare's attendance as it was low (91%) and below the school's expectation of 93%. It was a constructive meeting where Joan

shared aspirations for her daughter going to university referring to her own half -sister who had started university around that time. The professional who saw her then picked up no concerns in Joan's demeanour or communications.

Soon after this meeting Clare was absent from school on Friday 13th February and efforts to contact Joan that day were not successful. Half Term was from Monday 16th to Friday 20th February inclusive.

11.13 KEY EVENT 11-17.02.15

20.30 hours

Joan presented at the Urgent Care Centre⁶ at St Charles Hospital with symptoms of anxiety and is taken to the Mental Health Unit on the same site by one of the nurses. She becomes increasingly distressed and is expressing paranoid thoughts. She makes a number of calls to 999 and the out of hours GP service. Joan is seen initially by a nurse, later by a doctor but leaves the unit in the early hours and after five hours at the hospital while the doctor is taking advice re next steps.

On 17th February 2015 Joan called police to say that she had left her children with her mother and instead of going to buy food she had attended St Charles Mental Health Unit and was waiting to be seen by doctors. It would appear that she advised police of her whereabouts in case her mother subsequently reported her missing. On the same day she called police again asking them to attend the hospital as she was suffering anxiety attacks and was 'not mad'. This was the first time Joan's mental health came to the attention of the police.

The health services relevant to this episode are based at St Charles Hospital in North Kensington. There is a large mental health service on the site which includes community services and in-patient services. In the building where the in-patient services are located there is a 24hr 136 suite for adults who are detained by police and believed to be suffering from mental illness and present a danger to themselves or others. The police can take individuals meeting these criteria to the s136 suite as a place of safety. The Trust responsible for this service is Central and North West London NHS Foundation Trust. (CNWL)

CNWL had contact with Joan in two earlier periods. The first occasion was in 2008 when Joan was seen by the Adult Psychology department to address moderate anxiety presenting as 1-2 panic attacks per week when avoiding triggers. Joan was misusing alcohol to address social interactions. She had general worries about her health and wellbeing and was unemployed wanting to go back to work.

The second was in early February 2015 when Joan presented to her GP as a single mother of two children and the GP referred her for an urgent assessment by the Primary Care Liaison team. When they eventually received this referral and it passed through the relevant stepped

⁶ Urgent Care Centre – direct access health facility providing assessment and treatment of minor illnesses and injuries provided by the CLCH NHS trust within St Charles Hospital.

approach so that they could offer to see her, unbeknown to them Joan had already presented at the Mental Health Unit at St Charles.

On 16th February 2015, the referral was “paper triaged” and it was recommended that Joan be offered a telephone triage by the Step 3 CBT team.

Before this could be done and on 17th February, Joan presented to St Charles Hospital Mental Health Unit after being brought there by a member of staff from the Urgent Care Centre which is on the same site complaining of dizziness and anxiety. She arrived at the unit at 20:00 according to the CCTV, but there is no entry in the log book until 21:00. The bed management log book records arrival as 22:30hrs. At the time of her arrival, there was another patient who had been brought in by the police presenting as manic and who was waiting for a bed. The area was described as being particularly busy with lots of police and others coming to deal with other patients.

This very busy facility is not formally commissioned or resourced for the purpose of assessing patients urgently as a walk in patients unless they are brought in under s136 by the police as a place of safety. However, a convention had existed for some years that the service would accept patients as a walk in. CNWL closed the “walk in service” in July 2015.

Joan was seen and assessed by a senior nurse in the team. This was in the waiting area as she refused to enter the assessment room, where Joan expressed ideas that “Something is out to get her”. Joan could not tell the nurse anything further on this as she was “afraid if she talks about it something bad will happen”. It is believed that this assessment took place between 11pm and 11.30pm. The Duty Doctor went to assess Joan and she was waiting in the area between the two sliding doors leading to outside the building and reception. She refused to come back into the assessment area. She was seen in the reception area and was asked to come in. She stated that she couldn’t come in as she was “Worried that staff would attack her”. She appeared suspicious of both the Duty Doctor and the nurse, and told them not to come forward, and appeared tearful at times. She was attempting to look through the reception window at the security camera in the reception office. The Duty Doctor and the nurse attempted to complete an initial assessment in the waiting area. The assessment is summarized as follows.

Joan states she has had anxiety for 3 days. She reported feeling generally overwhelmed, she reported feeling suspicious of others but could not be more specific. Joan was afraid if she tells the nurse or the doctor what she is thinking they will think she is “Mad”. They asked Joan what kind of help she is expecting from services; she did not know but kept asking the nurses opinion.

Joan remained in the hospital for nearly five hours. During this time she makes 999 calls to the police and also to out of hours. Joan starts off the calls pressured in expression but seeks to explain calmly that she is very scared that she is going to be hurt but was unable to articulate by whom. No questions were asked if this was in relation to any other individual including Robert. One call handler on the third call sounds frustrated that Joan will not tell him who or what she is scared about. Joan tells him he would not believe her if she said. **It was ascertained by the call handler that she was already at the mental health unit and she**

was advised she was in safe place. This is a reasonable assumption. Joan persisted through a number of later calls that she was not safe and then asked for the army or navy as she had to save the universe.

During the time she was at the mental health unit, CCTV at the hospital shows Joan acting bizarrely holding out an orange carrier bag in front of her. Joan has since explained that the bag which was orange she believed this colour to be safe and protective. A police officer who was attended another patient into the unit did approach Joan but she said she was waiting for the doctor and do not want him to come closer.

No one saw Joan leave the hospital. There was a receptionist on duty but he had fallen asleep. This member of staff was subsequently dismissed. Joan left the hospital as she felt unsafe there. She believed she was being pursued. She walked the streets for some time in a confused state. Her path is captured on CCTV and at one point she surrounds herself with orange traffic cones as “orange was the protective colour”. She also covered herself in dirt and hid so vampires could not smell her. She visited a number of churches for safety also. In the middle of the night she went home. Her time of departure is believed to be 2am.

11.14 KEY EVENT 10 -18.02.15

02.08 hours

Request for a police welfare check

After it was discovered that Joan had left at 02.08hrs the duty nurse at St Charles Hospital called the Police, concerned for Joan’s welfare, as she was experiencing mental health issues and had left the hospital. She described Joan as *‘unwell, paranoid and convinced that someone was going to attack her.’* The duty nurse advised that Joan needed to return to hospital. It was noted by hospital staff that Joan *‘may attack people as she very much believed she was going to be attacked’*. It was established by police that Joan had not been sectioned under the Mental Health Act. The police initially said they would do the welfare check but then rang back and said they would not.

Police decided not to carry out a welfare check on behalf of the hospital to locate Joan. This decision was based on a Metropolitan Police Service (MPS) policy instructing that *‘it is not part of police core duties to carry out general welfare checks on behalf of another non-police agency’*. As Joan was not sectioned under the Mental Health Act, they had no power to detain her. The police do however have powers to remove someone from a public place under s136 criteria and take to a place of safety such as a s136 suite.

The caller was advised of Police New Instructions which are as follows:

“It is not part of the core duties of police to carry out general welfare checks on behalf of another non-police agency. When a request is made, the IMMEDIATE risk of the situation must be established.

The request must be about an individual.

It is an EMERGENCY.

There is REAL CONCERN that something SERIOUS is ABOUT to happened (or already happened) to the relevant individual on those premises. Police will respond if an individual is in need of immediate assistance due to a health condition, injury or some other life threatening situation.

Unless this threshold is reached, police have no duty and therefore NO POWER to take action once outside those premises.”

It has been apparent in this review that the police’s change of policy for welfare checks was not understood or appreciated by other agencies and there was some question whether the new policy had been adequately shared with all agencies and cascaded to relevant frontline professionals. The review panel were able to see the rationale of reviewing welfare checks given the significant burden they were placing on the police. However, the implications of this across the agencies is so significant that without serious planning to manage such a change the review panel see this as a unilateral rather than partner based decision. There was and to a degree still is, confusion around what exactly a welfare check means in ethos and practical terms. In the context of this review it was read to mean the police to identify and physically check the wellbeing of an individual to protect them and others. The nurse ringing the police that night was clear that she thought Joan may attack another as she was paranoid and believed she could be attacked. No specific checks were made for the children as they were believed to be with their maternal grandmother.

The panel concluded that while it would have been highly unusual to seek to use police powers to take an individual into a s136 suite from the reception of a mental health unit had Joan been picked up by police later as part of a welfare check or when she was acted bizarrely in the street s136 would have been the likely consequence and she would have been assessed under those powers for possible detainment under the Mental Health Act. As it was, in the in the hours Joan was waiting at the hospital her mental health deteriorated further and rapidly and she left the hospital. No member of public alerted police when she was acting bizarrely in the street and she eventually went home where Robert and the children were together. By then she had deteriorated further into psychosis and at some point believed Robert and her two children to be a threat.

The nurse had an address for Joan’s mother, but no phone number and therefore was not in a position to contact her herself. The nurse therefore left information for the morning staff. What neither the nurse nor subsequently the morning staff considered, was that they could or should contact Children’s Services. The following morning daytime staff attempted unsuccessfully to speak to the GP to inform her of Joan’s presentation. There was no formal requirement for them to do so, but best practice would have been to ensure that the GP was provided with the information. There was a lack of clarity about follow up when individuals came into the walk in service voluntarily and a lack of clear protocols. The staff also made a referral for Joan to the Assessment and Brief Treatment Service, the secondary mental health service provided by CNWL for those needing more urgent assessment. However due to a problem with how the referral was logged onto the patient information system, Joan’s details did not appear and no action was taken.

In considering whether the team could have used the Mental Health to keep Joan on the site and to make sure she had a more comprehensive assessment CNWL states that was not appropriate because Joan had presented voluntarily to the service. She did not say anything in the assessment which indicated she was likely to harm herself or others, indeed she described her children as a strong protective factor. Joan's presentation was around anxiety. She did talk about feeling that something bad would happen. This would be a common idea in people with acute anxiety and would not necessarily lead to someone causing harm to anybody. She had not come into the building fully and was hovering near the doors so a holding power may have been unlawful. The panel considered whether the staff could have used the police who were onsite but they were dealing with another patient and it is unlikely that they would have been able to compel her stay in the site for a more detailed assessment. It was also unclear if she had mental capacity to consent. The duty doctor was unsure what to do so he called a more senior doctor for advice which is good practice. The issue of domestic abuse did not arise during the contact at St Charles where the staff were unable to complete a full assessment. Joan did not say who or what was making her fearful. No professional was aware of Joan's past mental health history or the recent urgent referral. The health information systems did not connect together.

One of the key aspects was this was a service seeking to assist an acutely ill individual as a walk in patient, with a rapid mental health deterioration while on site and inadequate resource and experience to assess her quickly and plan care. This would have included a full consideration of Joan's vulnerability and risk she may pose to others including verifying the location of her children. This service has since reviewed its remit and commissioning parameters as stated with a service redesign that has included a closure of the service to walk in patients. Matters were compounded in that information that Joan had been referred urgently by her GP to another part of the service was not accessible.

While one of the barriers to effective communication and information sharing in this case was the fact that the IAPT (Improving Access to Psychological Therapies) service uses one set of clinical records and the secondary mental health services use a different system. This is the same in all Trusts in the UK but it would have been useful for both the primary service and the walk in staff to be aware of each other's involvement in the case.

11.15 Key event 12-18.02.15

Unsuccessful attempts to follow up on Joan by health services, and Clare by education.

On 18th February 2015, an email was sent to the Kensington Assessment & Brief Treatment team at 09:30 by the Patient Flow Co-ordinator at St Charles, referring Joan to ABT (Assessment and Brief Treatment Team) after her presentation the previous night. The nurse also called the GP at 09:20 on 18th February, but there was no response. It is reported that the GP telephone rang but did not get answered and there was no voicemail facility.

On the 19th to 20th February the PCLN service discussed the case and attempted to complete a telephone triage in accordance with their procedures. They couldn't make contact with Joan

and it was agreed that the consultant psychiatrist in the team would see her the following week for a full assessment and that the nurse would continue to try and make contact. The nurse left a message on Joan's mobile to make contact. The Nurse repeated the attempt on the 20th but again got no response and left a message.

As a result of being unable to make contact with Joan a home visit was made on 23/02/2015. There was no response at the home address. The liaison service then contacted the referring GP to establish if they had further concerns, which they did not. Then the team completed a further home visit on 24/02/2015 when Joan did not attend her assessment appointment, and, again gained no response.

The GP was not aware that Joan had attended unwell at the "walk in centre" and so would not have been alerted to a deterioration. CNWL state that GP's are usually informed but accept that as this was not a commissioned service there was no specific protocol or standard detailing expected communication with the GP and timeframes were not set by the Clinical Commissioning Group.

11.16 KEY EVENT 13 -26.02.15

Joan left her grandmother's home and takes Ann to the hospital. Joan brings Ann into St Mary's A&E with chest and abdominal wounds. Staff are concerned about circumstances. Duty Social work team informed. On the same day school contact social worker due to non attendance of Clare since 12th February.

Clare did not return to school after half term and efforts were made to contact her on Monday 23rd February but there was no response. On Tuesday 24th February Joan was phoned again as Clare was not in school and Joan did return the call to ask if Clare was in school saying that she was staying with her father. The school reminded Joan that they had tried to reach her the previous day leaving a message as Clare was not in school at which point Joan hung up. The school was not able to contact Robert as they had no phone contact details for him. Further efforts were made to contact Joan by phone on 25th and 26th February. The School Administrative highlighted to the head teacher that in taking account of Clare's absence on Friday 13th February this was her 5th day of absence from school. The school through the head teacher contacted duty Social Services at 9.15am on 26th February. On Saturday 28th February the head teacher was contacted by the Tri Borough Director of School Support and Commissioning to advise of the tragic event.

At the point of admission to the school there was a lack of clarity/knowledge about Robert. There was however vigilance and conscientious approach by the head teacher and staff in recognising the broader context of safeguarding and addressing a low attendance pattern at an early stage albeit the child was not yet of compulsory school age. There was also persistence and perseverance on the part of the school in trying to contact Joan and other members of the family when the child was absent from school including administrative colleagues.

The response of all the agencies when Ann was taken into hospital by Joan in the evening on was of a good, often excellent standard. Her medical needs were responded to immediately and to good clinical standards. From the outset staff identified concerns about: Joan's explanation as to how the injuries had been received; the delay in seeking treatment and the mother and child's unusual presentation. The on call Registrar contacted the Duty Social Work Team during the night and was given information that the family was known, but there were no serious concerns. The following day the Consultant Paediatrician who was responsible throughout the day for Ann's care immediately identified the need for background checks and as a result information about mother's presentation at the GP and the Mental Health 'Walk In' centre came to light. The locality social work team was informed first thing in the morning and the social worker who had previously been allocated came with a colleague to make further enquiries and attempt to locate Clare. A Strategy meeting was arranged for the next working day and was in line with required standards when there are concerns about an injury to a child. Arrangements were also made for a psychiatric assessment for Joan later that day.

Joan had told the professionals that Clare was with Robert but attempts to locate them by CSC and the police during the day were unsuccessful. By 5pm the Consultant Paediatrician had become increasingly concerned about Clare's whereabouts given the vagueness of Joan's explanations and contacted the police Child Abuse Investigation Unit direct, who agreed to treat Clare as a missing person. The police attended the family address in the early evening and on breaking into the flat found Clare and Robert dead. Immediate arrangements were made to secure Ann's safety and initiate the required Rapid Response procedure.

12 Predictability and Preventability

The Panel consider in this case is that the degree of the risk posed by the mother to Robert or her children could not have been anticipated by those who had contact with her at the time. Nor does the case raise a general issue about the identification of psychosis and any risk to children more widely. This is a conclusion that has been explored in some depth during this Review, supported by psychiatric opinion and is unanimously shared by the Review Panel.

In terms of preventability it has to be accepted that there were points such as at the "walk in centre" or during a welfare check if the police had been able to locate Joan that intervention and treatment may have been possible. That however cannot be said with certainty.

13 Good Practice

There were a number of examples of good practice that were apparent in this review.

1. The rapport the HV developed with Joan and additional assistance she obtained for help with the children.
2. SW2's persistence and professional curiosity to achieve Robert's input and draw him out from the shadows.

3. Police reliability in informing CSC of attendances upon the family and concerns they were receiving.
4. The school's ability to act upon the decreasing school attendance with Clare.
5. The school seeking to verify Clare's absence after half term.
6. The clinician's management of Ann on being brought into hospital with suspicious injuries.

14 Conclusions and DHR Recommendations

14.1 Two psychiatric assessments in relation to the mother were undertaken for the criminal proceedings. Both independently concluded that the mother was suffering from an abnormality of mind, paranoid psychosis, at the time she killed Clare and Robert. A central question for this Review has therefore been whether the professionals involved gave proper consideration to the mother's mental health needs in the context of a history of domestic abuse and on-going relationship problems both of which Joan minimised, and whether or not they could have identified that she was developing a serious disorder of this nature. The catastrophic and highly distressing outcome for this family has presented a particular challenge to the Review.

14.2 All reviews are required to take into account the risks of hindsight bias when making judgements regarding standards of practice. In this Review it has also been especially important to be aware of the risk of 'outcome bias'. That is: knowing the outcome of a case, particularly when that outcome is so devastating, can affect our judgement of the practice at the time as well as our judgements about what should be done differently in the future.

14.3 Guidance from the National Institute for Health and Care Excellence, NICE⁷ summarises the approach to recognition and treatment of Psychosis and Schizophrenia in adults. It identifies that the initial symptoms which may occur prior to a first psychotic episode can last for anything from a few days to 18 months. These can include '*positive symptoms*' such as hallucinations and delusions, and '*negative symptoms*' such as emotional and social withdrawal. These symptoms will be unique to each individual and, for some, the first acute episode of psychosis may take place without any obvious symptoms. What is apparent is that identification of the early onset of psychosis is far from straightforward and ultimately requires a full psychiatric assessment. '*The prepsychotic phase is often prolonged and characterised by subtle and confusing symptoms*'.⁸

14.4 Research in relation to whether there is a correlation between psychosis and increased risks of dangerousness has identified there are some statistical links⁹. However, it is crucial to note that even at the point at which the possibility of a psychotic episode is identified, this does not in itself mean that a particular individual presents a serious and immediate risk or that accurately assessing the level of that risk can be guaranteed. It is well recognised that in

⁷ NICE (2014:4)

⁸ McGorry, P et al (2005)

⁹ Maden, T (in Kemshall and Wilson, 2011) & Walsh et al (2002)

risk assessment the *'past is the best guide to the future'* and that *'...it is almost impossible for a patient to be rated as presenting a high risk of violence without a history of actual or threatened violence'*¹⁰. Research regarding filicide and maternal ill health also presents a complex picture and identifies that *"few studies have been able adequately to assess the relationship between filicide and mental health"*¹¹. The authors further identified that *'understanding the risk factors for filicide....is far from complete'* .

14.5 The Learning points set below are a culmination of all the information placed before the DHR review panel and are the key conclusions after a great deal of deliberation in this highly unusual case.

14.6 Learning Point 1- The commitment to providing a proactive service at the point of referral in children's social work within RBKC optimises early intervention and assessment.

The ability of the safeguarding system to respond effectively and proportionately when there are low level repeating concerns about children, including conflict in parental relationships which may amount to domestic abuse is recognised as a pressure point and is frequently a feature of Serious Case Reviews. Children's Social Care have established thresholds that need to be met for them to become involved, with those thresholds being higher if there is no parental consent. Such thresholds are intended to ensure that the involvement of a statutory body in families' lives is proportionate to the degree of concern about children. This includes where domestic abuse is a feature.

Referrals to CSC raising low level concerns about the care of Clare and Ann were raised on three occasions during the 18-month period subject to this review. Individually none of these referrals identified concerns that would meet Children's Social Care's established thresholds for significant harm, which could have triggered a statutory intervention, such as a Child Protection Plan or Care proceedings. Despite the comparatively low level of concern the first of these referrals in July 2013 led to an initial contact and assessment and the third, in May 2014 also resulted in the decision to undertake a full assessment.

Both the Multi-agency Safeguarding Hub (MASH) team and the practice manager on receiving the third referral reached the conclusion that despite the superficially low level concerns which led to the referral a more comprehensive assessment was justified. This was one of a series of referrals and in the Practice Manager's words *"there was the risk of ongoing exposure for the children to bickering parents"*. At both points in the entry into the system it was recognised that such a pattern of behaviour required serious consideration irrespective of the seriousness of individual events. **RBKC housing had no direct contact with this family but inputted as a panel member. What transpired in this review is that they can hold helpful historic information around individuals as tenancies are not agreed unless tenants agree to share information. This is source of information that is not obvious to multi-agency professionals and was an immediate learning point the panel identified early on in the review and took back to their agencies.**

¹⁰ Maden, T (p107)

¹¹ Flynn, S et al (2013)

The practice approach in this case was described by all the social work professionals as being typical of the way in which their team worked and part of a sustained approach to best practice not only within their team, but across the borough. Both the social workers and their managers described a very stable team, with low staff turnover, access to good reflective supervision and peer support and a commitment to achieving best practice. Staff talked knowledgeably about the significance of issues such as domestic abuse and family conflict on children's development and the importance of intervening early in families where there were problems.

However, the 'revolving door' syndrome, whereby families come in and out of service on a number of occasions before being identified as needing more intensive support or assessment, is a recognised feature of referrals to Children's Social Care. A recent report to ADCS identified that 23% of all referrals to CSC are 're-referrals' (second or subsequent referrals on a closed case within 12 months of the previous referral).¹² This is of concern because it highlights that for many of these families their needs are not being fully recognised and opportunities for early intervention therefore may be missed. It is also important in managing limited resources to avoid the increased likelihood of expensive long term interventions with families in the future.

This should also recognise that working with families can feel very threatening to them and that their challenges may be minimised to professionals, as in this case which then draws the professional away from an accurate risk assessment on all factors including domestic abuse, parental health problems and alcohol/substance misuse.

14.7 Recommendations

- 1. Frontline professionals should be reminded of the perceived threat families can feel when they are being assessed and how parents can guard responses to professionals in sharing the true family dynamic; domestic abuse or health problems.**
- 2. Professionals should not be thwarted in obtaining wider information from extended family members who may have key perspectives to share, particularly where parental relationships are volatile. The child's welfare must be paramount.**
- 3. Fathers should always be included in assessments unless there is a legitimate reason why this is not possible. This should be monitored via supervision and audit.**
- 4. Multi-agency professionals, in RBKC including professionals in schools should receive updating training around domestic abuse and coercive control and how to respond to disclosures made by children to gain a more sophisticated understanding and ensure children are heard.**

¹² ADCS, (Nov 2014:65)

14.8 Learning Point 2

There was a lack of shared understanding across the partner agencies in RBKC about the purpose and processes for undertaking welfare checks on children or adults at risk.

A wide range of professionals have historically looked to the police to respond on their behalf when they are significantly concerned about an individual's welfare or safety. This may be because the individual is thought to be missing, or in some way at risk and the professional concerned believes that a face to face check on their welfare is necessary. Statutory agencies have for many years been reliant on the police to undertake what are known as '*welfare checks*' to identify whether an individual adult or child is 'safe and well'. However, changes in the Metropolitan Police Policy to welfare checks has led to a significant reduction in the number of such checks and a lack of clarity as to how agencies who have concerns should respond.

After Joan left the hospital in the early hours of the morning, the duty doctor agreed with the nurse that she should contact the police to raise their concerns. The nurse did so and was explicit in identifying their concerns for the mother's welfare, their fears that she could attack someone if she felt threatened and she stated that Joan needed to be brought back to hospital. She provided the mother's address and phone number but specifically stated that the mother had not been willing to give her own mother's phone number so that they could make checks on the children. The Review has been given access to the recording of this call which confirmed that the nurse was clear and explicit during the call. The call handler's response was a clear commitment to getting '*someone looking around the houses, as soon as*'. Twenty minutes later the police called the nurse and she relates that they told her they '*no longer do welfare checks on mental health patients*'.

The nurse's expectation that a check would be undertaken was based on previous experience, reinforced by the response of the call handler that evening. In fact, the police had, in December 2014, issued an operational instruction tightening their approach to undertaking welfare checks, but this information does not appear to have been disseminated to front line practitioners or to all the relevant agencies. The combination of factors leading up to this point appears to have contributed to a sense that there was little else that could be done during the night and a loss of the sense of urgency about the degree of risk that might exist. Unknown to the nurse the referral to Assessment and Brief Treatment (ABT), which was made as she had requested the following morning, was logged incorrectly on receipt and therefore not identified within the ABT as a referral.

During 2014 the Metropolitan Police undertook a review of the way that '*welfare checks*' were being responded to. That review identified that these checks were significantly increasing and creating a demand on police resources that could not be justified. What is therefore apparent is that there is believed by partners to be a need for such checks, although the Police have produced evidence that in the majority of these cases the need is not one that justifies their involvement.

The Police had discussed the development of their new approach with mental health partners and adult social care in a wide range of meetings across London both prior to and after the

implementation of the new policy. However, the information was not formally communicated with the LSCB by the Police or by those partners in adult social care who had been briefed by the police. As a result, the new police policy briefing regarding welfare checks was not known to the LSCB until April 2015. No evidence has been presented to this review as to whether the safeguarding children implications of this policy were assessed by partner agencies or whether new guidance and advice was put in place for staff by the relevant agencies.

Given the established nature of referring to the Police for welfare checks and the lack of clarity amongst partners as to the change and any implications it might lead to, it is reasonable to assume that this is not a case specific concern, but has wider implication.

The Metropolitan Police's briefing on welfare checks (initially created March 2014, updated March 2015) identified that in one month across London they received over 12,700 requests for welfare or 'safe and well' checks. Dip sampling suggested that only 4% of these actually justified police attendance. What is evident from these figures is that there is a widespread and high demand for such checks across London. No figures for the Borough have been provided, but there is no reason known to this review to suggest that the Borough's experience would be fundamentally different to this.

The Police's analysis identifies a considerable mismatch between the requests for checks and their policing responsibilities. They have identified that there is no general responsibility for the safety or welfare of the public, only as part of their core duties to:

- Prevent and detect crime.
- Keep the Queen's peace
- Protect life and property

The Police have therefore asserted that they will only carry out such checks if there is an emergency and when there is a real and immediate concern about serious risk¹³

What is not known is the numbers of welfare checks where there may be a legitimate challenge by the referrer to a police decision not to take action.

The level of welfare checks requested, even taking into account that a number of these may by any reasonable judgement be inappropriate, identifies that there is felt to be a need by a variety of agencies for some means of reassurance about the welfare or safety of individuals. The Metropolitan Police's decision to review their role is of itself a reasonable one. However, it raises questions both about the way in which it has been managed and communicated and the way in which key services have, or have not, responded.

Whilst it is reasonable to draw the conclusion that a proportion of the referrals in fact did not require any urgent response, it is equally reasonable to conclude that whether or not the Police was the right agency to take action, there was adequate reason for the referrer to have believed that an urgent response of some description was necessary. If good systems are in

¹³ Further details are laid out in the Metropolitan Police External Briefing Note – welfare Checks.

place to identify an alternative response or to escalate a challenge to the police then there is minimal cause for concern. However, this remains an unknown and as such represents a vulnerability for the child and adult at risk protection system.

Following the commissioning of this DHR, (and the SCR) Kensington & Chelsea Borough Commander requested a review of the Welfare Check Policy.

This has since been completed and the following extra guidance has been added:

‘To remind individuals that other policies may apply such as; missing people. Also where appropriate to carry out intelligence checks to ensure the correct decision is made whether or not to carry out the welfare check.’

This has been shared and the updated version has been put onto the Police Intranet page. As and when briefings are delivered the new version is being shared. It will become a toolkit in due course.

The Metropolitan Police service have produced a new MPS policy. This is particularly important in terms of partners understanding the need to reach the threshold for such checks to be carried out. This further work is captured in the MPS action plan appended to this report.

14.9 RECOMMENDATIONS

- 1. The most recent policy around conducting welfare checks requires further consideration and clarity for frontline professionals in relation to the threshold for welfare checks.**
- 2. All agencies need to cascade this to their frontline staff to promote a common understanding and mutual expectation as to when and how such checks would be executed.**
- 3. The Community Safety Partnership needs to have a monitoring and audit role to assess the impact and wider implications that restricted welfare checks are having on public safety.**

14.10 Learning Point 3

The inability of health professionals in RBKC to access records in a timely way can undermine their capacity to effectively assess patients and any risk they might present.

Parental mental health and domestic abuse and its impact upon the family is assessed at a number of different points throughout the contact that health services and other professionals have with the individual. This takes place at a variety of levels, starting from non-health professionals who draw on their general practice knowledge in order to identify unresolved concerns through to specialist psychiatric assessments undertaken under the remit of mental health legislation and domestic abuse thresholds. The quality of assessment is likely to be significantly reduced where historical information is not available to the

assessor. Effective record keeping systems which can be accessed quickly when required are therefore a crucial tool in achieving quality assessments.

Missing obstetric records from the antenatal period meant that information Joan shared there around domestic abuse could not be shared going forward on any consideration of risk. Imperial Hospitals conducted an extensive search and they could not be found. The details of what Joan disclosed around domestic abuse is not clear.

During the course of this review it also became apparent that there were historical and current mental health records relating to Joan which for a variety of reasons was either unknown to key professionals or where those records were inaccessible in a timely way. It is not the contention of this Review that access to these records would in itself have resulted in a change in outcome, however, it meant that professionals were not able to undertake assessments with the full information that should have been available to them. This issue was highlighted in 2 different ways:

Health records held by Imperial College Healthcare Trust identified that the mother had a history of depression and panic attacks dating back to 1992. She had also attended A&E in 2007 following an overdose, as a result of which she was seen by the Psychiatric liaison nurse and referred to her GP for follow up in the community. It is further recorded that she was seen by the CNWL Adult Psychology department in 2008 for anxiety and panic attacks. However, this information was not known to the Health Visitor, and as it was stored within previous paper records, was not readily accessible to the GP who would have needed to specifically request old records. This impeded the professionals working with Joan as to the possible impact of the stressors she was experiencing in her relationship with Robert which was very unhappy and also the demands of looking after two young children.

When Joan attended at the Urgent Care Centre¹⁴ and from there the 'walk in' centre at the mental health unit in St Charles Hospital, there was no means for staff to access any other health records for her, either from within their own Trust or the GP Records, and as a result they were completely reliant on her own self reporting. CNWL, which is commissioned to provide mental health services in the borough, does not currently have one shared recording system. Staff in the Primary Care Liaison Team use a different electronic recording system (IAPTUS) to CNWL staff in the secondary mental health services who use a system called JADE. The duty nurse and doctor at St Charles, who are also CNWL staff, did not have access to the IAPTUS system, which would have alerted them to the fact that the mother had recently been referred to Primary Care Liaison by her GP. The JADE system alerted the duty nurse and duty doctor at St Charles that there was an old paper file, but this is not available on site and the doctor's experience was that it could take up to a week to order it.

The difficulties experienced in this case over accessing records and recording systems that are unable to communicate with each other are a widely recognised problem within health services.

¹⁴ Urgent Care Centre – direct access health facility providing assessment and treatment of minor illnesses and injuries provided by the CLCH NHS trust within St Charles Hospital.

This is a pattern that features widely within health services both at a national level and specifically in relation to CNWL NHS trust which uses JADE, a system not widely adopted within the NHS.

In this family's case the nature of the historical information regarding Joan meant that although it may well have heightened awareness, it would have been unlikely to have significantly changed the clinical care provided by the primary mental health practitioners. However, in general terms the absence of such information limits the capacity of health practitioners to contribute to multi-agency assessments of children, or risk assess parents which in some situations could be of crucial significance. We know that most parents with mental health problems do not present a risk of harm or neglect to their children. However the risk increases when ***'parental mental illness coexists with other problems such as substance misuse, domestic violence or childhood abuse'***¹⁵. Absence of key information regarding historical mental ill health therefore is likely to undermine both good assessment and the quality of any interventions to support a family and protect children.

For very similar reasons a significant risk exists in assessing the quality of parenting capacity when systems prevent good information sharing between health specialisms. It is particularly of concern if services providing a crisis response are unable to access all the information as this increases risks both to staff, but also to the assessment of risk to adults and children. While this does seem a mammoth task for the NHS it would not be correct to restrain from raising this in reviews as information sharing is cornerstone to all safeguarding systems be this for children or adults and certainly in the domestic abuse arena.

14.11 Recommendations

- 1. Achievable means should be explored of enabling primary health practitioners to have access to historic records that could contribute to a holistic assessment of an adult or child who may be at risk.**
- 2. Information sharing should extend to considering risks wider than health such as domestic abuse.**
- 3. The service redesign of crisis mental health services should include a robust information sharing system.**
- 4. Where a patient is being seen in the same health organisation but in different parts of the service each part of the service should be able to practically information share what is held on that patient by each part of the service.**

14.12 Learning Point 4

The use of a DASH risk assessment or similar tool may have assisted professionals understanding of the degree and nature of discord in the relationship and its impact upon the family individually and collectively.

¹⁵ Cleaver et al (2011:31)

While these deaths were as a result of Joan's extreme mental illness and not as an act of domestic abuse it is a fact that the nature of the relationship was a significant factor in Joan's mental health deteriorating. It is notable in the review that no agency conducted a domestic abuse risk assessment when domestic abuse was a feature throughout. The rationale for this by the agencies was that the abuse was being described by Joan as historic and yet it was very clear to agencies that the relationship was ongoing at least in part and was resulting in drunken arguments, alerts to neighbours and Mary resulting in police call outs. Clare also made three disclosures of violence in the home over an 18-month period.

The DASH form is a nationwide tool created in 2009. The DASH checklist was created by Laura Richards, BSc, MSc, FRSA on behalf of the Association of Chief Police Officers and in partnership with Safe Lives, a national charity dedicated to ending domestic abuse. Its purpose is to capture information and to assess level of risk around incidents of domestic abuse, stalking, harassment and honour based violence.

High risk DASH forms will be sent into the Multi-agency Risk Assessment Conference (MARAC) Administrator for processing; sharing information, referring to the independent domestic abuse advisory service, safety planning and arranging multi-agency meetings where necessary to discuss interventions. Medium or standard risk DASH forms cannot be shared, without the victim's consent.

The DASH form can be completed by any professional who believes their service user is a victim of one of these forms of abuse. It is best practice that a professional completes a DASH if someone is believed to be a victim of domestic abuse. There are two enhanced sections of the form which must be completed if there is a positive answer to the question "Is there any other person that has threatened you or that you are afraid of?" This enhanced section has a further ten questions and goes into much greater detail of the victim's circumstances. The other enhanced section is with reference to stalking and honour-based crimes.

The quality of the risk assessment is determined by the comprehensive collection of information attached to each question and on the summary page at the rear of the form. The risk management framework of the DASH is based on there being three levels of risk to the victim.

Standard – current evidence does not indicate likelihood of causing serious harm

Medium – There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

High – There are identifiable indicators of risk of serious harm. The potential event could

happen at any time and the impact would be risk of serious harm (Home Office 2002 and Offender Assessment System 2006): “A risk which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible”.

The majority of DASH forms are completed by the police and health services in this review confirmed that it is not widely used in health. It does rely upon the cooperation of the individual to be open and cooperate and we know that Joan and Robert both accused each other of abuse and control tactics but also sought to minimise the problems in their relationship when under scrutiny by CSC. No professional can compel an individual to agree to this risk assessment but it would have served as structured method to capture information about this relationship. The police often complete these with the individual face to face and this assists in capturing information even when the evidence does not indicate any likelihood of serious harm. It therefore merits inclusion in this review as a learning point.

14.13 Recommendation

- 1. All agencies and frontline professionals should consider the use of a DASH risk assessment where domestic abuse is featured even if it appears at a low threshold level.**
- 2. It should particularly be used in the face of high risk factors such as pregnancy, separation, disclosures being made by children or by other family members that their parent/relative is in an abusive relationship.**

15 Postscript

This DHR involves an unusual set of circumstances and a very rare outcome. It does however highlight the challenges that professionals face in understanding risk and what is really happening within the dynamic of an unstable relationship where children are also involved and there are multiple risk factors.

APPENDIX ONE: Glossary

CAF- Core Assessment Framework

CAADA – Co-ordinated Action Against Domestic Abuse. A national domestic abuse charity that has now been renamed Safe Lives.

Child in need - Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Child protection – Section 47(1) of the Children Act 1989 states that: Where a local authority have reasonable cause to suspect that a child who lives, or is found, in the area and is suffering, or is likely to suffer, significant harm, the authority shall make 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.

Child protection procedures - the system in place to protect children, which include policies, procedures, training and resources.

Coercive control - “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 means needed for independence resistance and escape and regulating their everyday behaviour”

DASH - Domestic Abuse, Stalking and Honour Based Violence

Domestic abuse - 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

- Emotional

LSCB – Local Safeguarding Children Board

MARAC – Multi-agency risk assessment conference. A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (IDVA), police, children’s social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential¹⁶

SCR – serious case review

Working Together to Safeguard Children, 2013. The statutory guidance for inter-agency working to safeguard and promote the welfare of children.

¹⁶ <http://www.safelives.org.uk/practice-support/resources-marac-meetings>

APPENDIX TWO

TERMS OF REFERENCE

. The purpose of the statutory Domestic Homicide Review is to:

- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.
- 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.
- Apply these lessons to service responses including changing policies and procedures as appropriate.
- Prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The Domestic Homicide Review will consider:

a) Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented the deaths.

b) Review current responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened to support the victims and review national best practice in respect of protection of individuals from domestic abuse.

c) Examine the roles of the organisations involved in this case; the extent to which the victims or perpetrators had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case to draw out the strengths and weaknesses and to assess whether there are any gaps in support.

d). Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard the wellbeing of the individuals within the immediate family unit.

e) Identify clearly what those lessons are.

f) Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in order to improve our work to better safeguard victims of domestic abuse.

The Review panel will also consider other factors for agencies or individuals to guide future work:

1. How do agencies best work with and respond to with family members who may be experiencing domestic abuse?
2. How should agencies work with a family and respond when a young child discloses they have witnessed domestic abuse?
3. How can agencies identify, assess and manage the risk of harmful practices within the family? **NB Though agreed as term of reference, expert evidence discounted this as a factor**
4. How can professionals best understand the culture of the family and the dynamic this brings to the relationship within the family?
5. How can agencies best assess the risk to the family and individual where a parent has a mental health problem?
6. How can agencies best share information around a parent who may have an escalating mental health problem?
7. How can agencies involved and support fathers so they do not become invisible?

APPENDIX THREE

ACTION PLANS

1. EDUCATION –ACTIONS

All learning points as stated in the report and associated actions for education achieved.

2. CNWL

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Review if any services provided by CNWL are not commissioned and ensure these have an agreed set of operational procedures referring to Safeguarding	CNWL only	Review of services commissioned in comparison with services provided	CNWL – Contracts Department	Minutes of meeting with Contracts Department	End June 2016	Shared understanding where the Trust is providing a service that is not commissioned and that appropriate procedures are in place to safeguard children. Achieved.

Develop shared understanding across the partner agencies about the purpose and processes for Police undertaking urgent checks on children whose carers present with significant concerns	Across Triborough LSCB/LSAB	A briefing note needs to be provided to all frontline managers Advice and above note to be on LSCB /LSAB website and disseminated widely	All LSCB agencies	Briefing note cascaded to frontline and their managers Training for On call Nurses and Managers adapted to reinforce this learning	End June 2016 End June 2016	Calls requesting Police assistance provide the necessary risk information so that these are followed up by Police Achieved
The Trust should set up a Single Point of Access (SPA) for all referrals for mental health so that GPs and other stakeholders are clear about referral routes and to ensure that systems are in place so that referrals are not lost or not acted upon	CNWL & WL	SPA established 24 Hour Home Treatment Teams (HTT) and Rapid Response (RR)	CNWL & WL service transformation	Communication to stakeholders on SPA SPA launch in K&C,W Communication to stakeholders on HTT and RR HTT and RR launch in K&C,W	September/ October 2015 November 2015 November/ December 2015 January 2016	Clear referral routes to mental health services in and out of hours Achieved.
All staff working directly with parents should be reminded of the role of social care when there are potential concerns about children	CNWL	Training for staff refreshing on referral to Emergency Duty team out of hours if there are any safeguarding children concerns or a lack of certainty about the whereabouts of children	CNWL operational services	Training for mental health staff and instruction that they must refer to MASH in hours and Emergency Duty Team out of hours if there are any safeguarding children concerns or a lack of certainty about the whereabouts of children Dissemination of learning from this SCR	Immediately undertaken for Hospital concerned June 16 July 16 September 16	Children's Social Care appraised in timely way of any safeguarding children concerns Ongoing

				Audit of compliance Report to LSCB	October 16	
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3. Catalyst Home Provider

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Catalyst risk assessment and domestic violence policies refers to coercive control. The training that followed the introduction of the policies did not explore this concept with the neighbourhood managers.	Local	Further training as stated	Catalyst		June 2016	Achieved

<p>The recording of all issues must be systematic and not ad-hoc. This is being addressed with the review of the ASB Procedures.</p>	<p>Local</p>	<p>Review of anti social behaviour procedures</p>	<p>Catalyst</p>		<p>June 2016</p>	<p>Achieved</p>
<p>Based on staff interviews, it is unlikely that the repairs operatives would have observed 'anything of concern'. But this is an opportunity to ensure that a formalised feedback mechanism is introduced for both contractors and any staff member, not just neighbourhood managers.</p>	<p>Local</p>	<p>Devise formalised feedback mechanism</p>	<p>Catalyst</p>		<p>January 2016</p>	<p>Achieved</p>

4. Children's Social Care ACTIONS

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
1. The involvement of fathers in assessments and interventions to be strengthened and viewed as essential to the process.	Local	<p>1.An LSCB audit has been completed which is focused on domestic abuse risk assessments and will also considered the involvement of fathers.</p> <p>2.Further to this, bi-annual practice weeks offer another level of scrutiny where cases are audited and observations completed which</p>	Children and Family Services and the LSCB	1.Quality Assurance Manager in conjunction with the LSCB planned and completed a single agency audit looking at 15 cases within Family Services. This included a file review and interviews with the allocated Social Workers to gain further understanding of practice.	<p>1.November 2015</p> <p>2.Practice Weeks are a rolling programme</p>	<p>1. November 2015</p> <p>A total of 15 cases were reviewed across the tri-borough. Out of the 15, 13 of these had included fathers in the assessments. The other two had reasonable explanations as to why this had not occurred and it was clearly identified on file.</p>

		will quality assure relationships built during assessment and intervention periods.		2.Auditors are Senior Managers and this practice week is an established and robust quality assurance mechanism across the boroughs.		In conclusion it6 does appear that fathers are generally included within assessments completed in current practice where possible. 2. Rolling programme
2. The working relationship between partner agencies to be improved with specific focus on threshold and referral pathways.	Local	An LSCB audit was completed which focused on multiagency working where a parent is experiencing mental health difficulties.	LSCB	Quality Assurance Manager in conjunction with Adult Mental Health Services completed this audit for the LSCB. This considered 30 cases, 15 not open to Family Services but known to IAPT (Improving Access to Psychological Services) and 15	January 2016	January 2016 The findings were analysed and presented at the LSCB Board Meeting to all members for consideration of how the learning will impact on them. The audit demonstrated good practice but also key areas for development that will now

				known to Family Services; agencies were asked to audit the cases from their perspectives. Agencies included were Family Services, IAPT, Adult Mental Health provisions, Education, Advance (domestic abuse support service), GP's, Drug and alcohol service and Health Visitors/School Health.		contribute to the LSCB Short Life Working Group currently in progress.
3. An audit to be completed in order to ascertain the use of domestic abuse risk assessment tools in Family Services.	Local	An LSCB audit has been completed focussed on domestic abuse risk assessments considering the use of Barnardo's and DASH	Children and Family Services and the LSCB	Quality Assurance Manager in conjunction with the LSCB planned and completed a single agency audit looking at	November 2015	November 2015 This review highlighted that although the Barnardo's RIM and DASH was not routinely

		assessments as well as wider practice learning.		15 cases within Family Services. This included a file review and interviews with the allocated Social Workers to gain further understanding of practice.		used in all cases where Domestic abuse featured, the risk assessment and interventions with families were still of good quality and identifying risk. Cases were being presented at MARAC although Children' Services were not necessarily the ones who referred although the minutes were provided. This was shared with Standing Together and the Family Services Directors.
4. Consideration of specific training needs for	Local	LSCB to identify from the SCR and DHR the key	All involved agencies	The January LSCB Board meeting was themed	May 2016	

<p>agencies/individuals involved in this case where identified as part of the IMR's. For example, referral pathways, shared thresholds etc.</p>		<p>training needs of agencies and plan to address these areas.</p>		<p>around parental mental health hearing the findings of the SCR and multiagency audit to share the findings with all relevant agencies.</p>		
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5. Imperial Hospitals NHS Trust

No recommendations or action plan. St Mary's Hospital was where Joan attended with Ann after the deaths and the good practice there is captured in the report. The loss of the main medical records pertaining to the ante-natal period where Joan was pregnant with Ann was investigated and it has not been established who removed the records and they have not been located. Information Governance at the Trust have managed that accordingly. Safeguarding and supervision records held by the Trust were accessible and are discussed in the body of the report.

6. Police (MPS)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
<p>1. To ensure that the external police 'welfare check' policy is disseminated to all agencies.</p> <p>2)To ensure that the external police 'welfare check' policy is disseminated to all police staff.</p> <p>2. Policy to be added to policy CCC quick link reference.</p>	<p>Service Level (MPS wide)</p>	<p>1)Policy to be disseminated to external partners. (Complete)</p> <p>2)Policy to be disseminated to all police staff. This is currently been rolled out to all operational staff.</p> <p>3).The policy to be added as a quick reference link on the Central Communications Command (CCC)Intranet page. (Complete)</p>	<p>Metropolitan Police</p>	<p>1.The policy although in existence was revised as a result of this DHR.</p>	<p>1.March 2015 Policy revised and disseminated.</p>	<p>1). Complete</p> <p>2) Ongoing - rolling programme</p> <p>3)Complete</p>

9. LEARNING POINT 1 ACTION PLAN

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Guidance statements						
Frontline professionals should be reminded of the perceived threat families can feel when they are being assessed and how parents can guard responses to professionals in sharing the true family dynamic;	Local	Direct toward LSCB	Multi agency across health, social services and housing	Conjoin this recommendation with the SCR	March 2017	

domestic abuse or health problems.						
Professionals should not be thwarted in obtaining wider information from extended family members who may have key perspectives to share, particularly where parental relationships are volatile. The child's welfare must be paramount.	Local	Direct to LSCB	Multi agency	Conjoin this recommendation with the other action plans and SCR	March 2017	
Fathers should always be included in assessments unless there is a legitimate reason why this is not possible. This should be monitored via	Local	Direct toward LSCB	Multi-agency	Conjoin this recommendation with the other action plans and SCR	March 2017	

supervision and audit.						
Multi-agency professionals, in RBKC including professionals in schools should receive updating training around domestic abuse/coercive control and how to respond to disclosures made by children to gain a more sophisticated understanding and ensure children are heard.	Local		Multi-agency	Conjoin this recommendation with the other action plans and SCR	March 2017	

10. LEARNING POINT 2 ACTION PLAN

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Guidance statements -						
The most recent policy around conducting welfare checks requires further consideration and clarity for frontline professionals in relation to when the threshold for welfare checks.	Tri Borough	All core statutory agencies to agree how this will be achieved.	Multi-agency	Conjoin this action with the MPS action plan	June 2017	
All agencies need to cascade this to their frontline staff to promote a common understanding and mutual expectation as to when and how such checks would be executed.	Tri borough	All core statutory agencies to agree how this will be achieved	Multi-agency	Conjoin this action with the MPS action plan	June 2017	

The Community Safety Partnership needs to have a monitoring and audit role to assess the impact and wider implications that restricted welfare checks are having on public safety.	Tri Borough	All core statutory agencies to agree how this will be achieved	Multi-agency	Conjoin this action with the MPS action plan		
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11. LEARNING POINT 3- ACTION PLAN

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Guidance statements -						
Achievable means should be explored of enabling primary health practitioners	National	NHS England and West London Clinical Commissioning Group to form	NHSE		July 2017	

to have access to historic records that could contribute to an holistic assessment of an adult or child who may be at risk.		working group to consider				
The service redesign of crisis mental health services should include a robust information sharing system.	Pan London	NHS England	NHS England	Conjoin with CNWL action plan	October 2017	
Where a patient is being seen in the same health organisation but in different parts of the service each part of the service should be able to practically information share what is held on that	Local	See CNWL action plan above	CNWL		See CNWL action plan	

patient by each part of the service.						
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12 LEARNING POINT 4- ACTION PLAN

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
Guidance statements -						
All agencies and frontline professionals should consider the use of a DASH risk assessment where domestic abuse is featured even if it appears at a low threshold level. It should particularly be used	Tri borough	Conjoin with single agency action plans on relating to domestic abuse and consider consistent risk assessment tool across agencies and clarity of when to use.	Multi-agency but directed by CSP		July 2017	

in the face of high risk factors such as pregnancy, separation, disclosures being made by children or by other family members that their parent/relative is in an abusive relationship.						

APPENDIX FOUR

Source documents and Research

This report is an anthology of information and facts gathered from:

- The Individual Management Reviews (IMR'S) of participating agencies;
- Policy documents and other materials in support of the IMR's
- The Senior Investigating Officer;
- Psychiatric report prepared for the criminal proceedings
- Relevant statements from the criminal proceedings
- Associated press articles;
- The perpetrator;
- Family members
- Discussions and analysis during SCR/DHR Review Panel Meetings;
- Conversation notes of discussions with frontline professional who had involvement with the family
- Audio and transcripts of phone calls Joan made on the day and night she attended St Charles Hospital
- CCTV and stills of Joan at the mental health "walk in" centre
- Phone audio from Robert's personal mobile phone
- Relevant policies and protocols across the agencies

Relevant research and references

ADCS (Association of Directors of Children's Services) : Safeguarding Pressures, Phase 4. Nov 2014

DfE: Keeping Children Safe in Education, 2014 & 2015

Flynn, S et al: Filicide: Mental Illness in those who kill their children. April 2013 PLOS online.

HM Government, 2015. Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children:

McGorry, P et al: International clinical practice guidelines for early psychosis The British Journal of Psychiatry Aug 2005, 187 (48) s120-s124

National Institute For Health And Care Excellence (NICE)_Psychosis and Schizophrenia in Adults: prevention and management 2014.

OFSTED: Inspection of safeguarding and looked after children services

Royal Borough of Kensington and Chelsea 2012

OFSTED: What about the Children? 2013

Statham, J and Smith, M: Issues in Earlier Intervention: identifying and supporting children with additional needs. DCSF RB205 March 2010

Walsh, E, et al Violence and schizophrenia: examining the evidence. The British Journal of Psychiatry Jun 2002, 180 (6) 490-495

www.womensaid.gov.uk: Home/Domestic Violence A-Z/Children

Policing Domestic Abuse: How To? 12th June 2015

University of Bristol. Who does what to whom: gender and domestic violence perpetrators- 2013

Research report 55. Supporting high risk victims of domestic violence; a review of Multi-Agency Risk Assessment Conferences (MARACs) -July 2011

Responding to domestic abuse: Guidance for General Practice- 2012

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office -2011

Domestic Abuse risk factors and risk assessment: Summary of findings from a Rapid Evidence Assessment Levin Wheller and Julia Wire December 2014

Domestic Violence and abuse: how health services, social care and organisations can respond effectively. NICE (National Institute for Health and Care Excellence) 2014

APPENDIX FIVE - Letter from Home Office DHR QA panel

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Stuart Priestley
Chief Community Safety Officer
Royal Borough of Kensington and Chelsea
The Town Hall
Hornton Street
London
W8 7NX

23 December 2016

Dear Mr Priestley,

Thank you for submitting the Domestic Homicide Review report for Kensington and Chelsea to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 13 December 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a clear, easy to follow report in which useful lessons have been identified and which is evidence based. The Panel particularly liked the opening tributes to the victims from the family which helps humanise the report.

There were some other aspects of the report which the Panel felt could be revised, which you will wish to consider:

- The Panel felt it was important that the report makes a distinction between coercive and controlling behaviour and mutual domestic abuse ;
- You may wish to review the language in the report. The Panel thought terms such as “volatile” and “relationship conflict” could perhaps be softened;

- The report would benefit from a brief explanation as to why the period under review was determined as two years;
- The Panel would welcome clarity in the report on what factors determined the conclusion reached in paragraph 3.6;
- It would be helpful if the medical term set out in paragraph 2.21 could be defined, perhaps in a footnote;
- Although housing issues are considered in the report, the Panel was unable to establish the housing tenure of the adult victim;
- Please proof read for typing errors.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for London for information.

You may wish to be aware that the Home Office has published updated Statutory Guidance on the Conduct of Domestic Homicide Reviews which can be found using the following link: <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>. We have also published key findings from analysis undertaken by Home Office researchers on a sample of 40 DHRs from across England and Wales completed between 2013 and 2016. The report can be found here: <https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned>.

Yours sincerely

Christian Papaleontiou

Chair of the Home Office DHR Quality Assurance Panel