HARINGEY COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Louise

December 2013

Independent Chair and Author of Report: Laura Croom

Associate Standing Together Against Domestic Violence

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Executive Summary

1. The Review Process

1.1 Immediately after Louise's death, Haringey Council undertook an internal review that concluded in February 2014 with an action plan for key council agencies.

1.2 There was a delay in identifying that a Domestic Homicide Review (DHR) would be required, due to the development of the criminal case. This summary outlines the process undertaken by Haringey DHR panel in reviewing the murder of Louise.

1.3 The Metropolitan Police Service (MPS) notified Haringey Community Safety Partnership (CSP) that the case should be considered for a DHR. Haringey CSP determined to conduct a DHR and notified the Home Office and commissioned Standing Together Against Domestic Violence (STADV) to provide a chair for this process in June 2015. There have been several changes of Strategic Lead since these processes and the dates on which these processes were started are not known to the current lead.

1.4 This DHR process began with an initial meeting on 13 July 2015 of all agencies that potentially had had contact with Louise and Damien prior to the point of death.

1.5 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 10 February 2005 to the date of the homicide.

1.6 As the incidents between Louise and Damien took place in Hertfordshire too, Hertfordshire CSP was asked to circulate services there to discover what information they had. As a result, the Hertfordshire services noted below were added to the panel and those that had had contact provided Independent Management Reviews (IMRs). Refuge, newly commissioned to provide the IDVA service in Hertfordshire, joined the panel for the final meeting where the panel reviewed the draft report.

1.7 Enfield CSP also joined the panel, as Louise had been discussed at the Multi-Agency Risk Assessment Conference (MARAC) there.

1.8 The Review Panel for this DHR comprised the following from Haringey, Hertfordshire, Enfield and from national organisations. The Chair was grateful for their contributions and support.

1.9 London Borough of Haringey

- Haringey Community Safety, Eubert Malcolm (In Haringey, responsibility for VAWG moved from Community Safety to Public Health during the course of this DHR)
- Haringey Public Health, Sarah Hart, Victoria Hill and then Fiona Dwyer
- Metropolitan Police Service, DS Pam Chisholm
- Haringey Police, DCI Marco Bardetti, then DI Ian Watson
- Haringey Children and Young People Service, Jon Abbey
- Homes for Haringey, Sharon Morgan, then Chinyere Ugwu

- Haringey Housing Related Support, Claire Drummond, Commissioning Lead, then Nick Smith
- Haringey Council, Anti-Social Behaviour Team, Stephen McDonnell, delegated to Gareth Llywelynn- Roberts
- Haringey Council, Human Relations, Tina Ohagwa, then Tricia Howarth
- Haringey Council, Adult Services, Jeni Plumber
- Haringey Advisory Group on Alcohol/Rise (HAGA), Gail Priddy, then Elizabeth Balgobin
- Barnet Enfield Haringey Mental Health Trust, Mary Sexton then Colin Chapman
- Solace Women's Aid, Mary Mason
- Nia, Karen Ingala Smith, then Rahni Binjie
- Haringey Clinical Commissioning Group, Hazel Ashworth
- NHS England, London, Angela Middleton
- North Middlesex University Hospital Trust, Julie Firth then Eve McGrath and then Nicole Booty
- London Community Rehabilitation Company, Cassie Newman
- Victim Support London, Caroline Birkett

1.10 Enfield Community Safety

- Community Safety Unit, Shan Kilby

1.11 Hertfordshire County Council

- Hertfordshire Constabulary, Alan Postawa, then Ruth Dodsworth, then Tracy Pemberton
- Hertfordshire Clinical Commissioning Group, Tracey Cooper (also representing Hertfordshire County Council's Domestic Abuse Partnership
- NHS England, Central Midlands, Anneliese Hillyer-Thake
- Victim Support, Hertfordshire, Christine Duala
- Refuge, Sharon Erdman joined when Refuge gained the IDVA contract in Hertfordshire during this review and Christina Duala withdrew

1.12 National level organisations

- Crown Prosecution Service, Malcolm McHaffie
- Her Majesty's Prison Service, Louise Tuhill, then Barbara White
- National Probation Service, Andrew Blight and then Folini Tsiouprador

1.13 Agencies that had had contact were asked to complete Individual Management Reviews (IMRs) and chronologies of their contact with the Louise, Louise's daughter (who was under 18 at the beginning of the timeframe reviewed), and Damien prior to Louise's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- A chronology of interaction with the Louise, Jade and Damien; what was done or agreed;
- Whether internal procedures were followed; and conclusions and recommendations from the agency's point of view.

1.14 Twenty-eight agencies responded and, having reviewed their files, 11 reported having had no contact. These were:

- Nia, a domestic abuse service
- Whittington Hospital
- East and North Hertfordshire NHS Trust
- Hertfordshire Probation Service
- BeNCH CRC
- Hertfordshire Community NHS Trust
- Hertfordshire County Council
- Hertfordshire Partnership University
- Hertfordshire County Council Children's Services
- Hertfordshire Specialist Domestic Violence Service

1.15 The Pupil Referral Unit, where Louise worked, reported having sent all their information to Haringey Council in the aftermath of Louise's death.

1.16 Brief information was supplied in the course of this review by the East of England Ambulance Service, but was outside the Terms of Reference for this review.

1.17 IMRs and chronologies were requested from 20 agencies and processes:

1.18 IMRs were provided by these services and processes in Haringey:

- Metropolitan Police Service
- Haringey Council – Human Relations department
- Homes for Haringey
- HAGA and Rise
- Solace Women's Aid
- Victim Support Service in Haringey
- Haringey Anti-Social Behaviour Service
- London Community Rehabilitation Company
- London Ambulance Service
- North Middlesex University Hospital Trust
- The Grove

- MAPPA
- Haringey Integrated Offender Management
- GP for Damien

1.19 IMRs were provided by these services in Hertfordshire:

- Hertfordshire GP for Louise and Jade
- Hertfordshire Victim Support
- Hertfordshire Constabulary

1.20 IMRs were provided by these national organisations

- Crown Prosecution Service
- HM Prison Service

1.21 Given their very limited involvement, the Review Panel agreed that the Enfield Multi-Agency Risk Assessment Conference (MARAC) would be asked to supply information about its meeting(s) that dealt with Louise and/or Damien.

2. Outline of circumstances that led to a DHR

2.1 *Brief Synopsis of Homicide*: In December 2013, in the early hours of the morning, the body of Louise was discovered by a member of the public face down, in a pool of blood at the foot of a tall block of flats. The MPS and London Ambulance Service (LAS) attended and her life was pronounced extinct at the site.

2.2 Enquiries revealed a history of domestic abuse of Louise by Damien who lived on the fourteenth floor in the block of flats. CCTV captured him walking past Louise's body that morning and several witnesses reported having heard a disturbance.

2.3 The MPS circulated Damien as 'Wanted' and he surrendered later that day. He was arrested, interviewed and bailed pending an investigation. Because of the way Louise died, the police investigation took some time to find the evidence necessary to meet the threshold for charging Damien.

2.4 *Post Mortem*: In December 2013, the Haringey Mortuary conducted a Special Post Mortem and found the cause of death to be multiple injuries, consistent with a fall from a height of fourteen storeys. The pathologist was not able to exclude the possibility that some of the injuries were caused by other means.

2.5 *Criminal trial outcome:* In February 2015, Damien was charged with murder. He pleaded not guilty and was convicted in August 2015. He was sentenced to life imprisonment with a minimum tariff of 17 years.

2.6 *Synopsis of relationship with the perpetrator:* Louise and Damien were both 43 when Damien killed Louise. They had known each other since school. The nature of their relationship changed over the course of the period covered in this review. Louise appeared to live with Damien for periods, but in

her own place and with family members at other times. Damien said that Louise owed him money for looking after his 'business' when he was in prison, but this review found no firm evidence of this.

2.7 *Members of the family and the household*: Louise's daughter was 17 and living with her the first time that the relationship between Louise and Damien came to the attention of services.

2.8 The Review Panel expresses its sympathy to the Louise's family and friends for their loss and thanks them for their contributions and support for this process.

3. Parallel Reviews

3.1 *Criminal trial.* The criminal trial was not completed when the first panel meeting took place. The MPS provided a list of proposed witnesses so that the IMR writers did not interview the potential witnesses until after the trial.

3.2 *Inquest.* An inquest into Louise's death was opened by the coroner in December 2013 at the North London Coroners Court and concluded upon Damien's conviction for murder.

3.3 *Haringey internal review.* The Haringey internal review was concluded several months after Louise's death. The action plan from that review has not been completed. The Chair of this Review had an email exchange with the Chair of the Internal Review to ensure that this review had access to all the information gained in that review.

3.4 *National Offender Management Service***.** The London Community Rehabilitation Company (LCRC) provided a serious further offence review for the National Offender Management Service (NOMS) after Louise's murder. This was requested for this review. The LCRC reported that this was not a publishable document and therefore could not be shared with this review. However, they also reported that the lessons from that review focussed on individual practice and are redundant in light of the re-organisation of probation services that have since occurred.

4. Chair of the DHR and author of the Overview Report

4.1 The Chair and Author of the Review was Laura Croom, an associate DHR Chair with STADV. Laura Croom is an independent consultant in the field of violence against women and girls. She completed the Home Office accredited training for DHR Chairs and has worked in domestic abuse for 14 years. She created the accreditation programme for independent domestic violence adviser (IDVAs) services for CAADA, now SafeLives, and reviewed domestic abuse partnerships for STADV's Home Office-funded guidance for such partnerships. This is the sixth DHR she has chaired.

4.2 STADV is a UK charity bringing communities together to end domestic abuse. STADV has been involved in the DHR process from its inception, chairing over 50 reviews between 2013 and mid-2016.

4.3 *Independence.* Laura Croom was commissioned to scope the domestic abuse provision in Haringey statutory services in early 2014, and she supported Solace Women's Aid's IDVA service through the early stages of Leading Lights accreditation in 2009 – 2010. She has no other connection with Haringey Council or any of the agencies involved in this case.

4.4 Authors of IMRs were independent of line management of the service.

5. Equality and Diversity

5.1 The Chair of the Review and the Review Panel bore in mind the protected characteristics during the DHR process.

5.2 Damien was a heterosexual black male who was 43 at the time of Louise's death. Louise was a 43-year-old heterosexual white woman. They were not married. The protected characteristics of disability, gender reassignment, religion/belief and sexual orientation do not pertain to this case in that neither party was disabled, nor was at any stage of transitioning from one gender to the other. They did not hold particular religious or other beliefs as far as we can tell from the records and Louise was not pregnant.

5.3 The protected characteristic that appears to have influenced events was the gender of the victim in that domestic abuse is a gendered crime with the overwhelming majority of victims being female and the perpetrators being overwhelmingly male.[1] Damien had a pattern of abusive behaviour, particularly towards women.

5.4 The panel had two specialist domestic abuse agencies on the Panel: Solace Women's Aid and Nia.

5.5 *Impact on agency responses.* The responses of agencies to Damien and Louise do not appear to be motivated or aggravated by their race, age, or marital or civil partnership status.

5.6 *Sex:* Louise's gender appears to have had an impact on the response she received from agencies. The response she received replicates Monckton Smith's finding[2] that a female victim of low-level domestic abuse who co-habits with her abuser has very low status with those agencies. That status would have been further reduced when she did not cooperate with interventions in a way that fitted the agenda of that agency.

5.7 *Age:* The information received from Louise's colleagues and the notes of MPS officers suggest that both Louise's father and mother were vulnerable through age. Further support might have been provided for them as they tried to protect and help Louise.

5.8 The protected characteristics do not appear to have had an impact on the response of agencies to Damien. His personal behaviour, particularly his threatening and manipulative approach to authorities, appears to have had more influence.

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[1] (1) '89% of those who had experienced 4 or more incidence of domestic abuse were women.' Walby, S and Allen, J, *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*, 2004.
(2) 'The intensity and severity of violence used by men is more extreme, men being more likely to use physical violence, threats, and harassment. From Hester, M *Who Does What to Whom: Gender and Domestic Violence Perpetrators*, 2009.
(3) Sharp-Jeffs, Nicola, and Kelly, Liz, 'Domestic Homicide Review (DHR) Case Analysis', June 2016, p. 11. The report can be found at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf. This shows a similar disproportionate experience of women (92% of victims in the DHRs it has chaired) as victims of domestic abuse.

[2] Monckton Smith, op cit., p. 21.

6. Involvement of family and work colleagues

6.1 The Chair of the Review provided a letter about this DHR, information about AAFDA and the Home Office leaflet for family members to Louise's daughter, Jade, through the police Family Liaison Officer. This was passed to Jade after the trial was over.

6.2 The Chair of the Review and the Review Panel acknowledged the important role Louise's family and colleagues could play in the review.

6.3 The Independent Chair of the Review successfully involved the following individuals in the review:

Known in the review as	Relationship to Louise or Damien	Means of involvement in review (e.g. TOR/Interview/ reviewed report)
Jade	Louise's daughter	Input on TOR Face to face interview Reviewed draft report
Jack and Clarissa	Work colleagues of Louise's	Face to face interview by SL for VAWG Reviewed the notes of the interview

6.4 *Summary of information from family.* Louise's daughter described her mother as a lover of life and a free spirit. She said she was a vibrant and happy woman, a forthright person. She described her mother's association with Damien as one more of ownership than a relationship. She thought Damien was obsessed with her mother, was controlling and manipulative. Jade said that she did not realise for some time that Damien was physically hurting her mother but said there were lots of injuries over time. Her mother did not talk about what was happening to her, perhaps because she was ashamed.

6.5 Louise was terrified of Damien, Jade reported, because he knew where her family lived and where she worked. She felt trapped and could not get away. At one point, Louise slept in her car parked on the forecourt of 24-hour petrol stations so that there was always someone there and CCTV in case Damien did anything. Louise did not feel anything could be done to stop Damien because the times that she did ring for help, it had made no difference.

6.6 Jade said that her mother had been evicted from a private rental because Damien continued to break in. Later, Louise was suspended from work 'because of him', Jade reported.

6.7 Jade said that her mother was given a lot of information from different agencies, but she needed someone to talk to her, not give her information to read. Jade said that she and her family felt that Damien never suffered any consequences for the harm that he caused.

6.8 *Summary of information from Louise's work colleagues.* Jack and Clarissa said that they had known Louise since she started working as a cleaner for the Pupil Referral Unit in about 2001. She worked full-time across the four sites initially and then three sites when one school closed. They found her good-hearted and amiable. They never really knew where she lived.

6.9 Jack and Clarissa said that Louise worked her hours at strange times and occasionally worked late at night and stayed over at one of the sites, using the school as a sort of refuge from Damien. They described her time-keeping as 'chaotic'.

6.10 Louise's father, in his mid-80s at the time they thought, often came with her and helped her complete her work. The staff were concerned about him doing the heavy work and suggested that he sit down occasionally, but he refused. The managers knew about Louise's father helping her.

6.11 They felt that Louise's father had been a stabilising influence on her and saw that she ran errands for him. When Louise's father got ill, Jack and Clarissa said that Louise's life got more difficult and she became unreliable about attendance at work.

6.12 Neither Jack nor Clarissa recall ever meeting Damien. They said that he'd left abusive messages on the school telephone, on their phones and on Louise's phone, obviously trying to get her in trouble. They recalled a phone message on the school phone in the spring of 2013 from Damien saying 'if I can't have you, nobody will, you don't know what you're getting into'.

6.13 Louise brought Damien to work on several occasions. Jack ignored this at first and then told her that she could not bring him to the premises, but she continued. Jack found her difficult to manage. Louise was suspended in 2013 for bringing a man onto the site – the school had child protection concerns – and her time-keeping had worsened. She was unable to complete her hours.

6.14 Jack and Clarissa described seeing injuries on Louise a number of times and noted that several times after she had missed work, she returned with faded bruising. They reported that the Pupil Referral Unit had been granted a 'barring order' against Damien across the several sites. (The review could find no evidence of this order.)

6.15 Jack talked to Louise several times about her injuries and tried to help. Jack and Clarissa knew that Louise had been given information about domestic abuse. They felt that she backed away when they talked about with her. She said she 'gave as good as she got', though Jack questioned that with her. They understood that the head teacher also offered to help, to vary Louise's hours but Louise refused their offers. Jack thought that Louise did not want to admit to being in a violent relationship and he felt at a loss as to how to help. He did not think that Louise believed that other people could help her. He also thought that she was secretive for her own purposes.

7. Involvement of perpetrator

7.1 The chair, in consultation with Haringey's Acting Strategic Lead on VAWG, decided not to incur the cost and delay of trying to talk to Damien as it was felt this would not advance Haringey's understanding. This decision was based on the information provided by agencies that showed that Damien had shown no insight into his own behaviour, made no attempt to seek help or change, had consistently confounded efforts to address his criminal behaviour and his substance misuse. The panel endorsed this view at the fifth panel meeting.

8. Overview of agency information

8.1 Throughout this review process, the services involved were working to improve their response to victims and perpetrators of domestic abuse. The abbreviated accounts below state the response at the time and are not necessarily indicative of current practice.

8.2 ***Metropolitan Police Service and Hertfordshire Constabulary***. Damien was well-known to the criminal justice services. He was convicted on 32 occasions before Louise's death for 47 crimes. He was a habitual user of cocaine and cannabis. The evidence of Damien's bad character requested by the chair from the MPS for this review ran to four pages. His criminal activities ran across five London boroughs and Hertfordshire.

8.3 Over the timeframe of this review the MPS dealt with 29 incidents regarding Damien and Louise and/or female family members and 11 regarding other women (partners, acquaintances and neighbours) and a police officer. Hertfordshire Constabulary had 23 reported incidents regarding Damien and Louise and/or female family members. These incidents were relentless and included threats to kill, threatening texts and messages left on the answer machine at her place of work, assaults, assaults with weapons, attempts to incriminate Louise, strangulation to unconsciousness, arguments, damaging and taking Louise's car, attending late at night to yell threats, threats and assaults on those around Louise, damage to her front door and her mobile phone, attempts to break into her flat, smashed windows, threats through other people. There were also allegations of kidnapping and holding her hostage, as well as silent emergency calls from family members' phones. Louise's daughter was also threatened and assaulted.

8.4 Damien was convicted for four offences against the person in the timeframe of this review. All were against women: ABH against a previous partner, common assault against Louise and then against her daughter, and common assault against a neighbour.

8.5 There were a further 23 cases taken to court for 27 offences that did not result in convictions. One was for rape of a previous partner, six were against Louise and one was against her daughter.

8.6 During the time period under review, Damien was in prison on ten separate occasions, including times on remand, and served between one day and two years during these periods of incarceration.

8.7 The response from the two police services was varied. Call-outs were always responded to and each incident addressed at the scene. The information-gathering and risk assessment were frequently weak with an incident-focus rather than an evaluation of the incident within the pattern of events. Supervision was frequently poor.

8.8 ***Homes for Haringey.*** Damien was a tenant of Haringey Council from August 1994 to 2006 and then a tenant of Homes for Haringey when the management of council's housing stock was transferred to Homes for Haringey.

8.9 There were letters of warning and successful injunctions taken out by Homes for Haringey who worked closely with the Anti-Social Behaviour Team (ASB Team) to manage Damien.

8.10 Damien was threatening to neighbours and was convicted of common assault against a neighbour when she complained about his dog. The neighbour was moved for her safety.

8.11 Damien was also abusive to staff who reported their concerns. A senior manager attended a Multi-Agency Public Protection Arrangements (MAPPA) meeting about Damien in 2008 and recorded that it was not appropriate for lone men or women to attend Damien's flat. On 25 September 2009 Homes for Haringey was granted a without notice injunction against Damien prohibiting him from assaulting, harassing, using or threatening to use violence against any employee, agency or contractor of the council. Staff reported feeling very vulnerable when they had contact with Damien. Several staff members were moved to other buildings following frightening encounters with Damien.

8.12 Homes for Haringey obtained a suspended possession order against Damien for rent arrears in June 2011.

8.13 Staff identified that Louise was Damien's girlfriend and visited him frequently. She tried to act for him regarding eviction proceedings and was seen to restrain him when he was threatening staff on one occasion. Louise spoke informally to one of the concierge staff, telling her that Damien had been in prison for assaulting her and she wanted to leave him.

8.14 ***Haringey ASB Team***. The ASB Team investigate complaints of anti-social behaviour and refer domestic abuse perpetrator activity to Homes for Haringey and victims to Hearthstone. The ASB team supported Homes for Haringey in their possession order case in June 2011.

8.15 The ASB Team investigated 2 complaints against Damien in April 2012: that he had threatened to kill another resident and returned with a machete and further threats, and another complaint from another neighbour that he threatened to her and her partner. Louise was convicted of the first offence.

8.16 The team also helped to obtain a warrant to execute the possession order in June 2012 as Damien had not paid off the rent arrears. Damien obtained a stay in February 2013.

8.17 The ASB Team acknowledged that there were improvements to be made in information exchange with the MPS and in their understanding of violence against women and girls and how their work fits into safeguarding procedures, etc.

8.18 ***Solace Women's Aid (WA)***. Solace WA provides VAWG services across 21 London boroughs. They found that Louise had been referred to Solace's Enfield IDVA service and the Enfield MARAC by MPS on 28 May 2011 as medium risk but with heightened risk factors and again on 12 October 2011 following an assault. On both occasions, contact was attempted within 24 hours. In May, the IDVA did not leave a message because she was not sure the phone was safe. Contact was attempted 8 times over several days and the case was closed and the police were informed. Following the October referral with safe contact details, the IDVA service texted and rang over the course of the next 16 days without success. When the case was closed, a final text was sent with contact details for Solace and other support services. The police were informed.

8.19 ***Victim Support Service, London***. The MPS referred Louise to Victim Support (VS) London on 12 occasions. On 7 of those 12 occasions, VS had no record of the referral. Discussions suggested that this may have been due to the referral processes which have changed since this time. Following the other 5 referrals, attempts were made to contact Louise and on 2 occasions, contact was made. On one successful call (in May 2011, after Damien assaulted her outside her probation work placement), Louise declined their support. On the other occasion, following harassment at work in

December 2011, completed a risk assessment with Louise that showed as 13. Louise requested a panic alarm and declined emotional support.

8.20 VS also received a referral for another woman in relation to Damien and for Damien himself following what appears to be a false allegation against Louise. VS were unsuccessful in contacting Damien on that occasion.

8.21 ***Haringey Council and the Pupil Referral Unit***. Though employed by Haringey Council from 2001 until her death, Louise was managed by the Pupil Referral Unit at the three sites where she worked. The Pupil Referral Unit said they had sent all the information they had to the council after Louise died. The council only had information about the disciplinary proceedings underway when Louise died.

8.22 Between 13 November 2007 and 15 December 2011, the police were called 7 times to Louise's workplaces as a result of the behaviour of Damien. Louise told the head teacher at the time that she had 'personal problems' but did not wish to discuss these further. She was suspended from work on 20 November for gross misconduct: failing to submit a Criminal Records Bureau check, allowing unauthorised persons onto the school premises and unauthorised absences.

8.23 Though staff had concerns about the abuse they saw Louise suffering, it appears that these concerns were never escalated in a formal way and the staff linked some of her absences to assaults as they could see faded bruising when she returned to work.

8.24 The review was not able to corroborate the information from staff about a 'barring order' that a court granted to protect the children at the site.

8.25 ***London Community Rehabilitation Company***. The LCRC provided an IMR though the probation services have been reorganised since Louise's murder and therefore the IMR addressed the involvement of the London Probation Trust.

8.26 Two of Damien's convictions in this time period involved probation. Following the ABH of a previous partner in 2005, the pre-sentence report identified Damien as presenting a risk of serious harm to known adults. Having been on remand for some time, he was released on licence following his conviction. Licence conditions were added that addressed the victim's safety and Damien's behaviour.

8.27 There were lapses in the expected practice when Damien was released on licence: there was no home visit within 10 days of his release, his attendance at weekly probation meetings was very poor but he was not recalled and the frequency of his meetings was reduced. There are no MAPPA notes in Damien's file. His risk was reduced to both the public and known individuals before his licence expired in August 2007. The pre-release risk assessment was not completed until November 2007.

8.28 Following conviction in December 2012 for a burglary, Damien received a suspended sentence requiring a Drug Rehabilitation Requirement (DRR) and 24 months supervision. The pre-sentence report noted Damien's stable relationship, yet also notes an angry exchange between him and Louise and fails to mention the indefinite restraining order that was made against Damien on 25 February 2012.

8.29 Damien's attendance at the DRR appointments began well but tailed off. Damien's engagement with the supervision order was very poor due to his reported ill-health. The assessment and sentence plan required within 20 days of the commencement of his sentence, was completed almost a year later and 6 weeks before Damien killed Louise. Though Damien referred to problems in his relationship, previous violence, and his unhappiness with his current partner (Louise), a Spousal Assault Risk Assessment (SARA) was not made to assess the risk to Louise and inform a strategy to manage the risk.

8.30 Damien's Offender Manager (OM) changed 4 times in the course of this supervision.

8.31 Damien was still subject to the supervision order when Louise was killed.

8.32 Louise was sentenced to 80 hours unpaid work under a community order for shoplifting. While attending her unpaid work commitment, she was assaulted by Damien on 14 May 2011. She was advised not to attend the following week. A senior manager tried to contact her later without success. Her safety was not addressed.

8.33 ***HAGA and Rise***. HAGA is an alcohol community treatment service in Haringey and Rise was a service devised by HAGA and Westminster Drugs Project (WDP) to provide after-care services for those with drug problems. (Rise dissolved in December 2013 as a result of legislative changes).

8.34 Damien had a drug rehabilitation requirement (DRR) (medium intensity) and 24-months supervision following his conviction on 7 December 2012 for burglary and theft. Damien was referred in January 2013 and an assessment and treatment plan made. No risk assessment was made, despite the DRR, and the worker was unaware of Damien's criminal history. Damien missed appointments due to his reports of ill-health and was discharged by Rise in June 2013.

8.35 ***The Grove***. At the time, The Grove provided most of the substance misuse service in the borough under the name of DASH (Drug Advisory Service Haringey) alongside other local agencies. DASH worked within the domestic abuse policies of the Barnet Enfield Haringey Mental Health Trust (BEHMHT) and had its own operational policies at the time.

8.36 At the end of Damien's DRR on 17 June 2013, he was concerned about his increasing drug use and was referred to DASH. The referral told of Damien's 15-year-old £80/day crack cocaine habit and £25/day cannabis use and his expressed interest in abstinence-based treatment. This assessment did not note any intravenous drug use, history of violence, restraining order, domestic abuse or Integrated Offender Management (IOM) oversight.

8.37 Damien did not attend a number of appointments and assessments. At one session he reported having been on remand for rape and kidnap charges and said he was eventually acquitted. The worker contacted the IOM and recorded Damien's risk history, including a harassment order [sic] prohibiting contact with an ex-partner, but no specific mention was made of domestic abuse or the victim's name. His mid-November discharge was deferred after the probation service asked that he be offered another chance to engage. He did not use this opportunity and was discharged on the day of Louise's death.

8.38 ***London Ambulance Service***. The LAS were called out 5 times to incidents related to Louise and Damien. In December 2007, the LAS attended what was described as a stabbing. Damien had a

small and superficial wound but was taken to North Middlesex University Hospital (NMUH) and handed over to staff there.

8.39 The MPS noted that Damien was conveyed to NMUH after he assaulted Louise and her ex-partner at their house in February 2008. LAS do not have information about this.

8.40 LAS were called out 3 times in 2011: in January 2011 in response to a 999 call, they attended Damien who said he'd been drinking and arguing with his girlfriend and fallen down the stairs. When he became agitated and stopped engaging with them, the ambulance staff suggested he make his way to the hospital. Police called an ambulance to Damien's address when he was on the roof and refusing to come down in April 2011 but then cancelled it.

8.41 In May 2011, the LAS responded to an emergency call to the same address. Louise had been assaulted by her boyfriend and was bleeding seriously from a head injury. The police were at the scene when LAS attended and took Louise to NMUH and handed her over to hospital staff, explaining the incident leading to the injury.

8.42 LAS were called to the scene of Louise's death in December 2013.

8.43 ***North Middlesex University Hospital Trust***. Louise attended the Emergency Department (ED) four times in the time period covered here. On two occasions, she was ill and on two occasions she had suffered injuries. In April 2010, Louise attended with her 'partner' (no name noted) with an anterior dislocation of her right shoulder. Louise said she had fallen. Her shoulder was re-located and she was given an appointment at the clinic the next day. No further questions were asked about the injury and Louise did not attend the follow-up appointment. In May 2011, the LAS brought Louise to the ED and explained that Louise had been assaulted by her boyfriend. The triage nurse took a history that corroborated the ambulance crew's information. Louise left the hospital when the nurse went to get pain relief.

8.44 Damien attended NMUH ED on four occasions for injuries. He was brought to the hospital after he had broken into the house Louise shared with her ex-partner and daughter in 2008. He had superficial cuts, and was suffering fits of shaking, was violent and uncooperative. In January 2011, he presented to the ED with rib pain saying that he'd fallen down steps at a train station (he told the LAS he'd fallen during a drunken argument with Louise). In August 2013, he presented with a broken bone in his hand following a fight he said he'd had with unnamed people when he was with Louise. His hand was strapped and pain relief given. He did not attend the fracture clinic as recommended. He also attended with a painful right knee that he said he'd twisted going downstairs in early December 2013.

8.45 ***Multi-Agency Public Protection Arrangements (MAPPA)***. MAPPA is a meeting of local criminal justice agencies to provide a platform to coordinate information and activities of agencies with responsibilities for public protection and sexual and violent offenders. Damien qualified for MAPPA following his conviction and sentence for 26 months for ABH on a previous partner and criminal damage in June 2006. His drug taking, prolific offending, violence, non-engagement and disregard for interventions suggest that he was difficult to manage. He was a category 2, level 2 offender as a reflection of his sentence for 12 or more months in custody and requiring multi-agency involvement.

He was discussed 3 times at MAPPA while under licence and plans were made and completed that addressed the safety of his victim and identified a new partner (the name not recorded).

8.46 Damien was re-referred in October 2008 following allegations of assault on another woman. The records of this MAPPA meeting show poor research that failed to identify 8 incidents between Damien and Louise. When police attended to notify Damien that he was a MAPPA subject, Louise was at his address. This was noted, as was her home address. But at the next MAPPA meeting about Damien, the assaults on Louise were not noted and the meeting focussed on Damien's treatment of the woman he'd assaulted. Louise's name was shared but no risk management plans were made for this relationship.

8.47 ***Haringey Integrated Offender Management (IOM)***. This approach brings together a number of stakeholders to change the behaviour of offenders at the highest risk of reoffending and/or harming the local community. The intensive package of intervention includes enforcement, persuasive compliance and supportive offender engagement. Damien was adopted as a 'Red' IOM nominal on 15 January 2013 following his sentencing for burglary and theft from a dwelling in December 2012. The 'Red' rating identified that he was at high risk of re-offending. The variety of his offending was notable.

8.48 Damien was supervised by an IOM probation officer and an IOM police officer. He was required to report for supervision twice a week: once to each of them. He also had to report twice a week to substance misuse services for the DDR: once to the drug intervention programme and once to the Recovery Services. There was no record of supervision by probation or police on the intelligence system, Crimint. There was no record of the information shared about Damien at the monthly IOM meetings.

8.49 Officers working with Damien at the time knew that he was in an unstable relationship with Louise and that there was a protection order in place. There were two notes about Louise on the file: when she attended a probation appointment with Damien and when they had an argument outside the probation office in August 2013. Louise was not spoken to directly either time and Damien's blatant breaches of the restraining order were not pursued.

8.50 Damien was discussed at monthly IOM meetings from 6 February 2013 until Louise's death. His behaviour and worsening compliance record were discussed. His deteriorating relationship with Louise was discussed, as was his increasing drug use. The officers would have known that these factors indicated an increasing risk of re-offending. He should have been subject to breach proceedings prior to Louise's death.

8.51 The last time Damien was seen by the officers was on 28 November 2013. An unknown male attended Damien's appointment on 2 December saying that Damien was 'not in a good place at present'. The IOM officers attended his address on 17 December (two days before Louise's murder) and did not find him there, despite his recent excuse that he was immobile through ill-health.

8.52 The IOM process has been substantially restructured since this time.

8.53 ***GP for Damien***. Damien used sick notes regularly to excuse him from activities and appointments designed to address his offending. As a result the panel was interested to learn what the GP knew

of Damien. The GP was a sole practitioner and retired in the course of this DHR. He provided some information himself, but did not provide an IMR as requested.

8.54 The GP reported that Damien had attended the GP surgery 35 times during the timeframe of this review. He was referred on for complaints regarding shortness of breath and abdominal pain. On 16 occasions, the GP provided a medical certificate.

8.55 Between 10 April 2012 and 23 November 2013, the GP provided 8 medical certificates for chest pain, depression and abdominal pain. There were no referrals on to secondary treatments during this time.

8.56 ***GP for Louise.*** Louise attended the GP surgery 15 times between 7 April 2009 and her last appointment there on 29 July 2013. Louise complained of tiredness a great deal and had a history of anaemia. There were no underlying chronic conditions identified through the GP's care.

8.57 Louise attended the GP surgery in July 2010 and reported that 'her husband' had assaulted her the previous night and tried to strangle her. The GP recorded the injuries, noted the police were involved and treated her. When one of the injuries formed an abscess, the GP provided further treatment and referred Louise for tests.

8.58 ***Victim Support (VS), Hertfordshire****.* Hertfordshire Constabulary noted two referrals of Louise to VS. VS had no record of these. The DV services in Hertfordshire have been newly commissioned so recommendations address the new services.

8.1 ***Crown Prosecution Service.*** The Review Panel wanted to review CPS decision-making in devising and requesting bail conditions, the case for harassment that was timed out and the disposal of the breach of restraining order that occurred in January 2013, and the cases that were discharged where no evidence was offered, in particular the strangulation case and an assault on the police officer.

8.2 The CPS did not have independent records for this review as the information they held had been destroyed in line with their policies. They were only able to provide information compiled to prosecute Damien for Louise's murder, which was primarily gained from the police systems.

8.3 ***HM Prison Service****.* Damien was in HMPS custody on 10 occasions during the period covered by this review. However, due to a change in computer systems and the destruction of records in line with the Data Protection Act, there is little information relating to Damien's time in prison. Few interventions were possible, including IDAP, the programme for domestic abuse offenders, as most of his time served he was on remand.

8.4 His violence was noted in prison: there are notes on his file flagging his risk to female prison staff in September 2012 and he was the subject of discussion at a Violence Reduction Board in November 2012 following an assault on a member of staff and on another prisoner. This Board addressed issues around managing Damien in prison. It determined that Damien represented a low risk of further violence despite his denials of the prison assault. Several assessments were poor from the point of view of addressing Damien's behaviour in the context of his overall offending: a post-conviction report showed no concerns in relation to breach of trust, despite 11 recorded breach convictions at the time; anger management was suggested, despite it being inappropriate in domestic abuse situations.

8.5 ***Enfield MARAC****.* Louise was referred to the Enfield MARAC following an assault and threats by Damien in June 2011. These multi-agency meetings are designed to provide an opportunity of agencies to share information and work together to keep domestic abuse victims safe. The only action here was to find out if Louise was visiting Damien in prison while he was on remand for assaulting her. Records do not show if this action was completed. The MARAC did not provide information about the second MARAC that Louise was referred to in October 2011, following an assault by Damien in September.

9. Analysis

9.1 *Poor understanding of domestic abuse.* There were three significant incidents that should have led to a step-change in the response to Damien's offending: (1) the shocking assault of P2 in 2006, (2) the strangulation of Louise to unconsciousness in July 2010, and (3) the indefinite restraining order in February 2012. All of these should have identified Damien as a violent high-risk perpetrator of domestic abuse thereafter requiring a suitably calibrated response.

9.2 The pattern of abuse was missed. Damien's coercive control, his misogyny, and his manipulation of agencies created an identifiable pattern of abuse that was missed.

9.3 Louise was not consistently recognised as a victim of abuse requiring help. Louise responded in ways recognisable as those of a victim of abuse: she minimised and normalised Damien's behaviour; she took responsibility for it; and she found it difficult to engage with support services. She managed Damien as best she could: by calming him down, ringing the police when she needed immediate help and then not supporting prosecutions in an effort to reduce any retaliation by Damien.

9.4 Missing the opportunities to identify Damien as an abusive person and Louise as his victim meant that a number of incidents were not flagged as domestic abuse and therefore missed a second level of scrutiny and the domestic abuse response. It also meant that incidents were not linked to help with the pattern identification.

9.5 *Silo-working and narrow focus.* To different agencies and at different times, Louise was 'a stable influence' (probation), a criminal justice researcher (responsible for tracking down any bail conditions, police), responsible for Damien's behaviour (loss of private tenancy because Damien broke in so many times, reported by Jade), an unreliable employee (her employer), an uncooperative witness (police and CPS when cases were dropped or not pursued without her evidence), and his alibi (probation again).

9.6 The agencies asked her to play a role in meeting their own agency-specific responsibilities. They did not have systems in place to keep her safe while she did so. Though they identified Damien as a violent offender, agencies missed the fact that Louise was his regular victim.

9.7 This incident-focus saw Louise's lack of engagement as obstructiveness. Professionals need a different approach to build the victim's trust and to find other ways to intervene in the situation. Professionals should be able to explain the benefits to the victim of disclosure and engagement and to describe the actions the professional can take.

9.8 In reviewing this case, it was not always possible to follow incidents through the whole of the criminal justice system – from charging, through disposal at court, through time in prison and then oversight on his release. The information trail was weak as Damien moved from oversight by one agency to

another. This was further complicated by Damien being a prolific offender and therefore criminal processes overlapped.

9.9 *Holding Damien accountable.* A key and constant failure in this case is the inability of the services to hold Damien accountable for his behaviour and abuse. Individual agencies showed poor practice with investigations not completed, research not being thorough, inadequate risk assessment and slow responses. Often the lapses of frontline workers were not caught in supervision.

9.10 The systems that were designed to assist agencies in identifying and responding to domestic abuse were applied with a very bureaucratic approach, missing the objective. For example, Damien's breaches of the restraining order, granted to keep Louise safe, were not pursued while an additional case was being developed. As we were unable to follow all the charges through the criminal justice system, it is not possible to examine decision-making regarding Damien through to the disposal of a case as CPS do not keep sufficient documents for this. There are unexplained outcomes as a result.

9.11 The risk assessing was poor. MPS noted 19 risk assessments following incidents between Damien and Louise. In 11, the risk was standard and in 8 the risk as medium. The 8 incidents in 2011 should have led to a high risk rating on escalation alone.

9.12 There are examples here of risk being downgraded because nothing has happened, the action plan is complete, or because Damien is temporarily detained. As different risk levels require different responses, the operational imperative for this downgrading is understood. But the downgrading often obscured the reality of the continuing risk to Louise.

9.13 The systems designed to help agencies work together in such cases – the MARAC, MAPPA and IOM – were not successful in managing Damien. There was a restraining order, Damien was on licence and being managed by probation, and the IOM group was overseeing him. But the breach of the restraining order was not prosecuted, nor was the breach of his licence conditions that would have taken him back to prison.

9.14 Though Damien showed little evidence that he was ready or willing to address his abusive behaviour, work aimed at improving his motivation might have helped. This case highlights an unintended consequence of using remand in domestic abuse cases. If a perpetrator is felt to be an on-going risk to the victim or likely to abscond, s/he is held on remand. But no interventions are possible on remand. Any resulting conviction may not then provide enough time in custody or on licence for the standard interventions that might reduce the risk. So remand and a conviction might actually lead eventually to higher risk for the victim.

9.15 These lost opportunities to hold Damien accountable, especially through returning him to prison, were significant.

10. Lessons learnt from the review

10.1 *Safety must be central.* Though all agencies have their own goals, statutory and legal responsibilities, keeping victims and their children safe must be at the centre of all interventions and systems to address domestic abuse.

10.2 *Non-engagement increases the risk for victims.* A victim who is not engaging with agencies or support will find it harder to find their way out of the abusive situation. Non-engagement of the perpetrator with agencies needs to be addressed directly with him or her. Non-engagement of a high-risk victim should trigger an enhanced response.

10.3 *Domestic abuse is everyone's business.* Every agency has a unique role to play in keeping victims safe and holding perpetrators accountable. The criminal justice agencies have a large part to play but this case shows that convictions are not the only goal for a coordinated community response (CCR) as convictions alone do not keep victims safe. Every agency needs a policy and process to ensure they fulfil their role in the CCR to keep victims and children safe.

10.4 *Risk can remain even after all action plans are complete.* Operational necessity should not obscure the risk that victims face. Risk is dynamic and can change rapidly. A victim that is assessed as not high risk (yet) still needs belief, support and safety advice.

11. Conclusions from the review

11.1 It is clear that Damien was dangerous and through his activities, we can see that he posed a particular threat to women. In the reports provided for this review, there was evidence of frustration on the part of services that Louise was not engaging with services. Louise rang services when she could not manage Damien. More active participation by her in agency responses might have made it easier for them to complete their activities, but would not necessarily have made Louise safer, as we have seen. Staying safe had to be Louise's primary concern.

11.2 The point of the CCR to domestic abuse is that it recognises the unique part each agency has to play in stopping domestic abuse and requires agencies to do their part and help other partners do their part so that victims are not alone in managing the risk to themselves and their friends and families.

11.3 The onus is now on the agencies involved to make the changes and embed the practices that make a coordinated community response to domestic abuse a reality and convince victims like Louise to trust that agencies can help them.

12. Recommendations from the review

12.1 There are many recommendations in this report. The many agencies involved provided their own suggestions for their agency and the Panel was committed to identifying further ways the CCR would be improved.

13. Haringey Council

13.1 **Recommendation 1**: Haringey Council to develop and implement a domestic abuse policy as a matter of urgency. This would provide information and guidance for staff working with the public. It would also include information and guidance for employees of Haringey Council as managers, colleagues and victims of domestic abuse and include information for how to escalate concerns

about one's own situation or that of others so that Haringey can be pro-active in tackling domestic abuse and supporting victims. Guidance accompanying the policy should include what support to provide for colleagues.

13.2 **Recommendation 2**: Haringey Council to encourage or require (as is appropriate to the relationship) organisations that work in partnership with the council, such as independent schools, and Arms-length Management Organisations (ALMOs) to have domestic abuse policies and practices for its employees and those who use their services.

13.3 **Recommendation 3:** Haringey Council require all local authority schools to:

- include responses to domestic abuse in their HR policies for staff and
- provide advice to staff about domestic abuse.

13.4 **Recommendation 4**: Haringey Council use this case in DA training to emphasise common weaknesses in a response to domestic abuse and how to address them, emphasising the role of every agency in delivering a coordinated community response for every victim of abuse.

13.5 **Recommendation 5**: Haringey Council's CSP ensures that action plans associated with responses to domestic abuse, including this DHR, are completed as quickly as possible to minimise the harm resulting from domestic abuse to its staff and citizens. The action plan from the original internal review should be updated and outstanding actions rolled into the action plan from this review.

13.6 **Recommendation 6:** Drawing on this report and the experience of panel members, create a strategy and guidance for addressing the situation of domestic abuse victims that find it difficult to engage with services. Consider high risk victims, victims of serial violent offenders and victims with complex needs.

13.7 **Recommendation 7**: When commissioning substance misuse agencies, Haringey Council require that such services:

- gather information about clients' relationships and families as part of their assessments,
- and that they identify risk and include this information in referrals and feed this to partner agencies through the multi-agency groups, including MARAC, and that they contribute to MARAC.

14. Hertfordshire County Council

14.1 **Recommendation 1**: That the Hertfordshire DA Partnership Board review the provision for DV victims presenting to GPs with local CCGs to ensure GPs understand their unique role in identifying domestic abuse and are trained to respond effectively.

14.2 **Recommendation 2**: As part of oversight of the local VAWG services, monitor Hertfordshire Constabulary's referrals to local support services, in particular the new IDVA service for high risk victims.

15. Her Majesty's Prison Service

15.1 This case has shown that the time domestic abusers are in prison either on remand or for short-term sentences is not used effectively to address behaviour or to engage with victims of their abuse. The prison system is not well linked to services in the community for victims of domestic abuse. There are tools and programmes that can deliver the following. This recommendation is aimed at the prison service demonstrating an overall commitment to its role in ending violence against women, thereby providing prison staff with grounds for intervention.

15.2 **National recommendation:** HMPS develop a national policy and practice for working with perpetrators of domestic abuse when they are in custody and for addressing its role in keeping victims and their children safe. This policy would:

- Ensure that perpetrators of domestic abuse are identified when in custody (even when offence leading to custody is not obviously domestic abuse), and that
- Make the new OM model explicitly address the abusive relationships of offenders. Work is undertaken with DV perpetrators in custody (whether for short or longer-terms) to address their abusive behaviours and views. Where prisoners are assessed as not suitable for this work yet, work is undertaken to prepare them for such work.
- Acknowledge the prison's role in protecting victims by:
  - (i) Creating opportunities for victims to access support
  - (ii) Signposting victims to support, and highlighting the freedom to make choices that the perpetrator's incarceration may be offering them
  - (iii) Improving communication and information-sharing with agencies in the community that work with victims and their children
  - (iv) Incorporating as part of the new initiative of monthly Offender Pre-Release Meetings, a requirement to explicitly address offenders' relationships, identifying abusive relationships and linking to external support for offenders and victims, and their families, so that safety measures can be put in place to protect victims and their children when the perpetrator is released
  - (v) Offering support services for women prisoners who are victims of domestic abuse

16. National Health Service

16.1 **National recommendation 1**: Implement the IRIS scheme nationwide to educate GPs and engage them in helping victims, perpetrators and their families.

16.2 **National recommendation 2**: That the NHS provide improved guidance to GPs on how to engage with DHRs including:

(a) The legal basis for sharing information in these circumstances

(b) The nature of the information needed by this process

(c) The selection of an appropriate IMR writer

(d) Support for staff in the surgery following a homicide of a patient of the surgery.

17. Home Office and the Ministry of Justice

17.1 **National recommendation 1**: That the Home Office conduct an audit of criminal justice processes to ensure that the system and its various agencies work together to create a coordinated response for the safety of victims of domestic abuse and to hold perpetrators accountable.

17.2 **National recommendation 2**: That the Ministry of Justice work with the Home Office to create a system enabling the police to be alerted when civil orders are granted that provide protection in domestic abuse cases. (This ties into MPS Recommendation 9 and Hertfordshire Constabulary Recommendation 3).

18. Metropolitan Police Service

18.1 **Recommendation 1** local level for Barnet

It is recommended that Barnet Senior Leadership Team (SLT) develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

- MAPPA (see Appendix 5)
- Information-sharing

18.2 **Recommendation 2** local level for Haringey

It is recommended that Haringey SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

- Sharing the lessons learned in this review
- Domestic Abuse Policies and Toolkits
- DASH First responders/ Specialist Staff/ Supervisors
- RARA, (risk management model: remove risk, avoid the risk, reduce the risk or accept the risk)
- MAPPA
- MARAC
- IDVA – referral to and working with to engage the victim
- IOM
- Research – local/ cross border

- Counter allegations
- Information sharing
- Safety planning

18.3 **Recommendation 3** local level for Enfield

It is recommended that Enfield SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete regular 'dip' sampling should be conducted to ensure compliance. This training should include:

- Sharing the lessons learned in this review
- Domestic Abuse Policies and Toolkits
- DASH First responders/ Specialist Staff/ Supervisors
- RARA
- MAPPA
- MARAC
- IDVA – referral to and working with to engage the victim
- IOM
- Research – local/cross border

18.4 **Recommendation 4** local level for Waltham Forest

It is recommended that Barnet SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

- Sharing lessons learned in this review
- Domestic Abuse Policies and Toolkits
- DASH First responders/ Specialist Staff/ Supervisors
- MARAC
- Information sharing
- Safety planning

18.5 **Recommendation 5** local level – Islington

It is recommended that Islington SLT develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with

Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

- Sharing lessons learned in this review
- Domestic Abuse Policies and Toolkits
- DASH First responders/ Specialist Staff/ Supervisors
- Research – local/cross border

18.6 **Recommendation 6** service level – TP Capability and Support – Public Protection

It is recommended that the MPS review how 'high risk' domestic abusers are profiled and flagged to ensure that investigators have the fullest available picture when assessing and managing risk.

18.7 **Recommendation 7** service level – the Judicial Order Working Group

It is recommended that this review be forwarded to Simon Tee, Head of the Criminal Justice Offender Managers Services (CJOMS), for the lessons learned to be considered by the Judicial Order Working Group.

18.8 **Recommendation 8** service level – Offender Management Working Group

It is recommended that this review be forwarded to Detective Superintendent Sean Oxley, for the lessons learned to be considered by the 'Offender Management Working Group'.

18.9 **Recommendation 9** service level – TP Capability and Support – Public Protection

It is recommended that upon receipt of a court order and/or restraining order that 'specified' crime report be opened, the victim contacted and the following actions completed:

- Contact the victim to gather and share information.
- DASH
- RARA
- IDVA – referral to and working with to engage the victim
- Emergency planning
- Special schemes
- Panic Alarms
- Special personal alarms
- Research
- Crimint
- MARAC
- MAPPA
- IOM

- ASBO
- Supervision
- Enhanced supervision
- DVPO/injunction/restraining order

18.10 **Recommendation 10**: service level

It is recommended that MPS circulate to their CSUs and PVPs information about their policy that allows the waiver of recovery costs for vehicles that have been reported as lost or stolen in situations of domestic abuse.

19. Hertfordshire Constabulary

19.1 **Recommendation 1**: That Hertfordshire Constabulary develop and deliver a training package for primary and secondary frontline investigators and supervisors to ensure understanding and compliance with Domestic Abuse policies and procedures. Once complete, regular 'dip' sampling should be conducted to ensure compliance. This training should include:

- Basic domestic abuse awareness, including coercive control
- Sharing the lessons learned in this review
- Domestic Abuse Policies and Toolkits
- DASH First responders/ Specialist Staff/ Supervisors
- RARA
- MAPPA
- MARAC
- IDVA
- IOM
- Research – local/ cross border
- Counter allegations
- Information sharing
- Safety planning and liaising with the victims

19.2 **Recommendation 2**: Risk assessments of frontline officers are monitored and a feedback is provided to ensure consistent and accurate risk assessments are provided by the staff.

19.3 **Recommendation 3**: It is recommended that upon receipt of a court order and/or restraining order that 'specified' crime report be opened, the victim contacted and the following actions completed:

- Contact the victim to gather and share information.

- DASH
- RARA
- IDVA – referral to and working with to engage the victim
- Emergency planning
- Special schemes
- Panic Alarms
- Special personal alarms
- Research
- Crime Information System (CIS)
- MARAC
- MAPPA
- IOM
- ASBO
- Supervision
- Enhanced supervision
- DVPO/injunction/restraining order

20. Crown Prosecution Service

20.1 It is important to understand how the whole of the criminal justice process works together to hold perpetrators of domestic abuse accountable for the harm they cause and to protect victims. The domestic homicide review process provides a way to do this. But, to be able to review and analyse the workings of this system, there must be information on each step in the process. Currently, the CPS record-keeping policies do not allow the CPS to contribute to this process. It is suggested that the CPS record-keeping policy should mirror other criminal justice agencies in the length of time it holds records of cases.

20.2 **National recommendation**: That the CPS review and revise its record-keeping policy so that it can contribute meaningfully to domestic homicide reviews by providing details of its decision-making in cases of domestic abuse and where protective orders are in place.

21. Homes for Haringey

21.1 Since the death of Louise and in the course of this review, Homes for Haringey has improved its response to domestic abuse in its premises and provided clear guidance for staff.

21.2 **Recommendation 1**: That Homes for Haringey create a policy and procedure that comprehensively deals with their role in situations where tenants are perpetrators or victims, or where domestic abuse has occurred in their premises. It should include:

- A response that prioritises the safety of victims and clear roles for staff
- Training for frontline workers, especially concierges and repair staff, to identify abuse and engage victims in help-seeking
- The sharing of information with other agencies so that the risks are known
- An understanding of risk assessment in domestic abuse
- Links to DV support structures in Haringey and neighbouring boroughs
- A process for sharing information on threats to staff safety internally
- Considerations of the alleged perpetrator's known relationships, where staff feel threatened
- Ensure all staff know the process for this and the expectations of Homes for Haringey about their role.
- Ensure all staff know about the counselling helpline.

21.3 **Recommendation 2**: Improve information sharing with other agencies through referrals to Hearthstone, MARAC and engagement with MAPPA and other multi-agency meetings. Monitor these to track the impact of improved training and procedures.

22. Haringey Anti-Social Behaviour Team

22.1 **Recommendation 1**: Refresh and formalise the procedure for requesting information from the MPS to ensure that requests are targeting all the information relevant to the concerns that the ASB is investigating.

22.2 **Recommendation 2**: ASB develop a VAWG policy that identifies their role in addressing VAWG, the training that staff need, the policies and procedures that link to this (safeguarding policies, for instance) and the link to the safeguarding procedures and relevant procedures and referral procedures. The ASB team's role in multi-agency work around VAWG, e.g. MARAC, MASH.

22.3 **Recommendation 3**: ASB team source VAWG and DA training for staff, including general awareness training, an understanding of risk assessment in domestic abuse and the MARAC process, safeguarding procedures and application of the relevant procedures and referral procedures.

23. V**ictim Support – London**

23.1 **Recommendation 1**: Strengthen systems with referring agencies, including:

- Request that referring agency supplies several safe contact numbers, if possible, and asks the victim for safe times to call.
- Staff training includes notifying referrer when contact cannot be established with referred victim.

- Staff to be reminded in case review sessions to notify referrer in such situations and ensure this action is recorded on the VS case management systems.
- As part of case management, random sampling of closed cases to be undertaken to ensure that case notes show whether referrer was notified of non-contact.

23.2 **Recommendation 2**: Staff to review case management system for victims' details where contact with victim has not been established to identify repeat DV incidents and possible referrals to MARAC.

23.3 **Recommendation 3**: At four-weekly case reviews with managers, cases where the RIC was borderline high risk, that is 12 or 13, are reviewed against previous and new incidents to inform professional judgement in the case.

24. Solace Women's Aid and Nia

24.1 **Recommendation:** That any victims of domestic abuse that are referred to the IDVA and MARAC that do not engage should be discussed in case reviews as a standing agenda item and other ways of getting support to the victim discussed.

25. Refuge – Hertfordshire IDVA service

25.1 **Recommendation:** That Hertfordshire IDVA service liaise with the local NPS Victim Contact Scheme to provide support and safety planning for victims and their families when perpetrators are released.

26. MAPPA

26.1 **Recommendation 1:** London MAPPA Strategic Management Board should maintain its focus on the assessment and effective management of the risks posed by domestic abuse offenders. Key areas include the following:

- Training for MAPPA Chairs to include domestic abuse awareness, particularly an understanding of coercive control
- Use of the MAPPA Category 3 (other dangerous offenders) where appropriate so that domestic abuse perpetrators who do not qualify for MAPPA Category 1[3] or for Category 2[4] may be managed under MAPPA.

[3] Registered sex offenders

[4] Violent offenders sentenced to more than 12 months in custody/detention in hospital under S. 37 or S 42 Mental Health Act

- The relationship between MAPPA and MARAC so that this is understood and implemented locally, in accordance with the Ministry of Justice MAPPA Guidance[5], as local guidance produced by the London MAPPA Executive Office and incorporated in NPS London MARAC Guidance.

27. Integrated Offender Management Unit

27.1 **Recommendation 1**: That the IOM Unit refresh and formalise the procedures and guidance for

- Actions to proactively manage non-compliance with IOM requirements and/or licence conditions. This would include clear guidance and standards for investigation, recording and enforcement
- Standards of non-compliance that should trigger a partnership assessment
- Appropriate actions where offenders commit acts of violence against women and girls, including coercive control

27.2 **Recommendation 2**: That the IOM Team receive training on violence against women and girls, including general awareness, safeguarding procedures and referral and other procedures to address the safety of victims

27.3 **Recommendation 3**: That the IOM Unit work with domestic abuse services to review their processes around prison release to identify opportunities to protect victims of VAWG.

28. London Community Rehabilitation Company

28.1 As the probation services have been re-structured, the LCRC narrative related above relates to the actions of the London Probation Trust at the time of the incidents described. Consequently, the recommendations that flow from this review for London LCRC only relate to the services that they now provide.

28.2 **Recommendation 1**: Create clear guidance on the robust management of absences by those on licence so that the opportunity to address offending and reduce risk to others is not missed and so that offenders are held accountable.

28.3 **Recommendation 2**: In light of the restructure, that LCRC ensure it is part of the local coordinated community response to domestic abuse by:

- Training LCRC staff on
  - (i) their part in addressing domestic abuse

[5] Ministry of Justice MAPPA Guidance 2012, pp 108FF, para 22.19 – 22.25

(ii) the local referral pathways to services for perpetrators and victims

- Preparing and attending the multi-agency groups that address domestic abuse, that is, MARACs, MAPPAs, and IOM.
- Creating protocols and policies to embed this involvement.
- Monitoring participation in MA groups and referrals to specialist agencies. This information is compiled and sent to the local VAWG strategic group.

28.4 **Recommendation 3**: That LCRC develop a domestic abuse policy that addresses offenders as victims and perpetrators of domestic abuse, including

(a) specific work with women on Community Payback scheme who are victims of domestic abuse

(b) ways to identify and support victims of domestic abuse, for instance, by adding relevant questions to assessment processes and by creating opportunities for women to disclose, discuss and address the abuse they have and are suffering

(c) clearly outlines the response to violent offenders' reports of their relationships that addresses the risk to offenders' partners, especially when there is a history of violence against women.

28.5 **Recommendation** 4: That LCRC explore the option of female-only projects as a way to create opportunities for victims of domestic abuse to discuss and address domestic abuse.

29. National Probation Service

29.1 **Recommendation 1**: Develop training for women-only cohorts so that issues of domestic abuse can be explored and strategies put in place during the probationary period.

29.2 **Recommendation 2**: That oversight of cases includes improvements in:

- Timing and quality of risk assessments
- The recording of risk management plans and progress against them,
- The recording of MA discussions (MARAC, MAPPA, IOM) and resulting action plans in client files
- Regular investigation of information and research to corroborate information from offenders and hold them accountable

29.3 **Recommendation 3:** Ensure that domestic abuse victims and their families are informed about the Victim Contact Scheme and the information it can provide when the perpetrator is sentenced to 12 months or more in prison or when the offender is detained as a mental health patient.

29.4 **Recommendation 4:** That the Victim Contact Scheme provide details of the local domestic abuse service(s) to victims and their families, and particularly when the service informs victims and their families of perpetrators' imminent release.

30. Substance misuse agencies

30.1 The information gathered from other agencies was incomplete and there was a reliance on the IOM to manage the risk posed to Damien's ex-partner, though her name was not known. The recommendation for substance misuse agencies focuses on using their engagement with clients to gather information, to understand the risk clients pose to their intimate partners and families and to understand their unique position to engage with perpetrators and victims of domestic abuse, while working within a coordinated response.

30.2 For a violent and unreliable offender with a drug problem, a partner may appear as a stabilising influence, but he or she could be at risk as well, as identified in the SafeLives-DASH risk assessment. If staff are at risk, then family members and partners are probably as well.

30.3 **Recommendation***:* Substance misuse services should

- Include in their domestic abuse policy a response to non-engagement with services by those on licence. This case shows the link between non-engagement and increasing risk.
- Engage with multi-agency approaches to addressing victim safety and perpetrator behaviour

31. North Middlesex University Hospital NHS Trust

31.1 **Recommendation 1**: Domestic violence training to become mandatory for all clinical staff, with priority given to staff in ED, maternity and sexual health clinics. Training to include:

- Routine enquiry (as stated in the Managing DV Policy, s. 62)
- Identifying behaviour, symptoms and injuries that are likely to be indicators of domestic abuse and enquiring further about them
- Creating a safe space to ask questions of the possible victim
- Responses to disclosures, including risk assessments, MARAC and referral pathways. Access to further information and advice
- Encouraging engagement of victims
- The unique role of health services in supporting and protecting victims of domestic abuse

31.2 **Recommendation 2**: That the Trust provide an IDVA service in ED.

31.3 **Recommendation 3**: The Trust's DV guidelines to be expanded to be used by staff across the Trust.

31.4 **Recommendation 4**: The Trust develop DV Champions throughout the hospital, again prioritising ED, maternity and sexual health clinics.

31.5 **Recommendation 5**: The Trust's DV policy is updated to reflect these changes.

Appendix 1: Glossary

Abbreviations	
124D	A booklet used by MPS to collect information on domestic abuse incidents
ABH	Actual Bodily Harm
ABT	Abstinence-Based Treatment
ALMO	Arms-Length Management Organisation
ASB	Haringey Anti-Social Behaviour Service
ASBAT	Anti-social Behaviour Team
BCST	Basic Custody Screening Tool
BEHMHT	Barnet, Enfield and Haringey Mental Health Trust
BME	Black and Minority Ethnic
BOCUs	Borough Operational Command Units
CCA	Community Care Assessments
CJOMS	Criminal Justice Offender Managers Services
CPN	Community Psychiatric Nurse
CPS	Crown Prosecution Service
CRI	Community Recovery Initiative
CRIS	Crime Reporting Information System
CSP	Community Safety Partnership
CSU	Community Safety Unit
DAAT	Drug and Alcohol Action Team
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Checklist
DASH	Drug Advisory Service Haringey
DHR	Domestic Homicide Review
DRR	Drug Rehabilitation Requirement
DV	Domestic Violence
DVIP	Domestic Violence Intervention Programme
DVLO	Domestic Violence Liaison Officer
DVO	Domestic Violence Officer
ED	Emergency Department

ETE	Employment, Training and Education
HAGA	Haringey Advisory Group on Alcohol
HDC	Home Detention Curfew
HMPS	Her Majesty's Prison Service
HO	Home Office
HRU	Harm Reduction Unit in Hertfordshire Police. The HRU is the second line for assessment of domestic abuse
IDAP	Integrated Domestic Abuse Programme
IDAPA	Integrated Domestic Abuse Programme Accelerated
IDVA	Independent Domestic Violence Advisor
ILLY	Database used by The Grove – Specialist Drug Service Haringey
IMR	Individual Management Review
IO	Investigating Officer
IOM	Integrated Offender Management -- is a nationally recognised approach as a key to reducing crime and reoffending. This approach brings together a number of stakeholders to supervise, manage and positively impact on the criminal activity of offenders within the community.
IRIS	Identification and Referral to Improve Safety domestic abuse training and support programme based in GP practices
LAS	London Ambulance Service
LCRC	London Community Rehabilitation Company
LCRC	London Community Rehabilitation Company – the probation company that manages all offenders in the community who are not deemed to be at high risk of harming others. Those at high risk of harming others are managed by the National Probation Service.
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MASE	Multi-Agency Sexual Exploitation Meeting
MPS	Metropolitan Police Service
NMUH	North Middlesex University Hospital Trust
NOMS	National Offender Management Service
NPS	National Probation Service
OASys	Offender Assessment System risk assessment

OGR	Offender Group Reconviction
OIC	Officer in Charge, refers to a specific case
OM	Offender Manager
PAVA spray	Incapacitant Spray
PNC	Police National Computer
PRU	Pupil Referral Unit – a collection of schools for children who cannot access mainstream schooling for health, safety or social reasons. Louise worked across 4 sites.
RARA	Acronym for police response to risk: Remove the risk, Avoid the risk, Reduce the risk, Accept the risk
RIO	Electronic recording system for drugs and alcohol services
SARA	Spousal Assault Risk Assessment
SERCO	Service Corporation
SLT	Senior Leadership Team
SPECSS	Separation, Pregnancy, Escalation, Community Isolation, Stalking and Sexual Violence
TWOC	Taking-Without-Consent
VAWG	Violence against Women and Girls
VL	Victim Liaison
VS	Victim Support
VS Herts	Victim Support Hertfordshire
WDP	Westminster Drugs Project