Final Version

DOMESTIC HOMICIDE OVERVIEW REPORT

London Borough of Haringey

Case of RB March 2014

Report Author and Chair of Review: Anthony Wills

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1. Executive Summary

1.1 Introduction

1.1.1 This is the Executive Summary of the Domestic Homicide Review (DHR) into the death of RB. The full Overview Report contains considerable detail about her death and the circumstances surrounding her murder. The intention of this summary is to outline, in a briefer format, how RB came to die in circumstances where her assailant was known to her and the role a variety of agencies played in supporting her and the man convicted of her murder. The lessons to be learnt from this murder are a key element of the Overview Report as well as this summary, albeit described in less detail in the latter.

1.1.2 RB was 42 at the time of her death, a black woman of Jamaican heritage and FL, the perpetrator, was 46 at that time, is Polish and had limited command of English.

1.1.3 The period of the review is considerable (agencies have reviewed their actions back to 2008) and this makes it necessary to deal with some of the information obtained with sensitivity and an acceptance that responses from that earlier period are different to those that have become accepted good practice.

1.1.4 The report has been anonymised and initials are used to identify the victim and the perpetrator. These have no bearing on their real names. Consideration was given to using fictitious names but the panel felt this was not viable due to the family of the victim not wishing to participate in the review process. Additionally, there are two GP practices anonymised as they played key roles in the lives of the victim (RB) and perpetrator (FL) and their true titles would undoubtedly lead to the identification of those individuals.

1.2 The death of RB

1.2.1 In March 2014, RB was stabbed by FL in the street near where she worked as a healthcare assistant (HCA) at the Avenues Primary Care Centre (called such for

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the purposes of this review) in Haringey. She died en route to hospital. FL was subsequently charged with her murder and on the 19th December 2014 he was found guilty and sentenced to life imprisonment with a minimum term of 20 years. FL was known to have had an intimate relationship with RB but the exact nature and length of this relationship has proven difficult to define with complete certainty.

1.3 The review process

1.3.1 This DHR is a statutory process which was instigated by the Haringey Community Safety Partnership (CSP). The Terms of Reference are shown at Appendix 1 but its intention is to identify the circumstances in which the perpetrator and victim were known to each other, to agencies involved in their lives and the lessons to be learnt from those interactions.

1.3.2 To ensure those lessons deliver change and improvements in the response to domestic violence an action plan, overseen by the Haringey CSP, also forms part of this process.

1.3.3 The time taken for this review to be completed has been excessive. It was necessary to replace the original independent chair and the approach taken to dealing with a complex case was subsequently revised. The delay cannot be ascribed to the panel members who were consistently supportive.

1.3.4 The panel consisted of every agency that had significant contact with RB or FL and additional information was sought, where necessary, from other agencies. The full details of those agencies is contained within the full report

1.3.5 It was also agreed to recruit a diversity and equality expert to the panel to ensure that we considered those issues and appropriately addressed them within the process.

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1.4 The findings of this DHR

1.4.1 There are four main areas for consideration within this review:

i. FL was responsible for RB's death and has been convicted of her murder. For this reason the care, treatment and contact he had with agencies and RB is considered first within this review.

ii. FL was a patient at the Avenues Surgery where RB worked and she treated him over many months. The context of his treatment and the wider role of the surgery are important to learning lessons for the future.

iii. RB was a patient at a surgery in another borough and she disclosed to them that she was a victim of domestic violence and their response is therefore an aspect of the review.

iv. Finally, RB came into contact with a number of other agencies between 2008 and 2011 whose role was either directly or indirectly, to consider her safety and needs in difficult circumstances. This section of the review has been able to identify what could have been done differently but due to the lapse of time this is dealt with more briefly and the panel have agreed to confirm the necessary changes have taken place and this is noted within the report.

1.5 FL and his contact with health agencies[1]

1.5.1 From April 2010 FL was known to health agencies for two principle conditions. He had a chronic physical health problem which required a considerable series of consultations at Avenues Surgery. It was here, where he was largely treated by RB (who was still treating him until 2014) that significant issues surrounding his relationship with RB, the surgery and its practices became evident and are discussed below.

1.5.2 The other medical condition was one of depression which was related to his threats to commit suicide in 2012 when these interventions took place. The

[1] FL was not known to the police in a significant way.

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Metropolitan Police Service was the first to become involved with FL and his threats to commit suicide. Their appropriate response was to ensure FL was treated within the NHS. The Whittington Hospital was the initial health agency involved and after in-patient care he came under the treatment of the Haringey Home Treatment Team (HHTT), a service supporting those with mental health issues within the community. Whilst under their care (as an out-patient) he again threatened suicide and was taken to the North Middlesex University Hospital and after a short admission was discharged and the HHTT were informed of this latest episode.

1.5.3 A number of issues arise from these interventions which are addressed in the report and outlined below.

1.5.4 FL was known to be in a relationship with a woman (probably RB) and the safeguarding response to her was inadequate. On one occasion (whilst at North Middlesex University Hospital) it was known that FL had threatened he would kill his girlfriend as well as himself. This did not elicit an appropriate response which should have at the very least involved HHTT being informed of this as they were caring for FL. They were provided with minimal information that FL had been admitted to North Middlesex University Hospital and subsequently discharged.

1.5.5 Clinicians at The Whittington and in the HHTT had assessed the threat FL posed to those with whom he was having a relationship and believed that no real threat existed. This was concluded without the full information which later became available, i.e. the knowledge of FL's threat to his girlfriend possessed by the North Middlesex University Hospital.

1.5.6 Safeguarding policies were found to include a reference to the threat to others known to a mentally unwell individual but it was considered that this was insufficiently prominent and was given insufficient weight. This is especially bearing in mind the heightened risk to others when an individual threatens suicide. It is also possible that agencies focused on the primary, presenting issue and this may have led to secondary concerns being less fully considered.

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1.5.7 FL had made it clear that he was in some form of relationship with a member of staff at his GP surgery. This was not considered by those treating FL as an ethical issue and did not lead to further action.

1.6 FL and Avenues Surgery

1.6.1 FL was being treated at Avenues Surgery in the main for a chronic physical condition. Additionally, the surgery knew from letters from the Whittington and North Middlesex University Hospital that he had threatened suicide and was being supported by the HHTT. One letter (Whittington) mentioned problems with a girlfriend and the other (North Middlesex University Hospital) was simply a referral with no mention of any threat to others. The surgery did not respond in any way to these letters apart from noting one “FAO RB”.

1.6.2 Information obtained during the homicide investigation, particularly from the contents of RB’s phone and testimony from the practice manager, demonstrates that FL was stalking RB in 2014, and probably earlier in 2013. The practice manager knew there was, or had been, a relationship with RB of some description, beyond that of a normal patient.

1.6.3 As has been described above FL was treated mainly by RB at the surgery. At FL’s trial and during the preceding homicide investigation it became clear that the practice manager at Avenues was also in an intimate relationship with RB and that he had had contact with FL.

1.6.4 At one point (May and July 2012) FL had been removed from the Avenues practice list with immediate effect because of the fear that FL could threaten RB in some way. He was re-registered within weeks without any form of safeguarding process or review.

1.6.5 The practice manager played a key role in the recruitment and supervision of RB and the processes within the surgery.

1.6.6 The review considered that there were a number of significant areas of concern in relation to the Avenues surgery. These are described below:

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- The response to FL and his mental health concerns was inadequate.

- The role of the practice manager is very broad, and in this case there seemed to be a lack of oversight from his employers. His actions were not policy driven and confused by his relationship with RB. His behaviour, as described to the police, was not in keeping with his role as practice manager and with supervisory responsibilities for RB (for example it was known to the practice manager from as early as 2012 that RB's actions went beyond medical treatment for FL and she was involved in non-medical aspects of his life).

- It became clear during the review that the role of the practice manager is defined by those contracted to deliver the service, i.e. the GPs. The role is clearly ill-defined meaning that this review was faced with the problem of holding post-holders to account and allocating responsibility for practice.

- Record keeping was poor and there was no domestic violence policy or effective response to safeguarding needs. For example, the police should have been informed of the concerns about FL when he was removed from the list but they were not contacted. Other concerns were expressed about general systems within the surgery.

1.7 RB and the surgery where she was registered as a patient

1.7.1 In 2008 RB was living with difficulties in her life. She had suffered a bereavement and was diagnosed with depression. She also began to discuss problems she was experiencing with her (then) partner and later disclosed violence within her (then) relationship. In 2013 she appeared to feel she had resolved her issues and no further mention of problems was evident in her notes.

1.7.2 Her GP practice (called Pembrey Medical Centre for the purposes of this review) had evidently supported her well around issues of depression and she was given what was, for the time, relatively standard advice about her domestic concerns, e.g. contact with the police and specialist services. This rather

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reactive approach may have been typical then but domestic violence policies and a more proactive approach, as advocated by the NICE guidance[2] would be more appropriate in 2016.

1.8 The response to RB around 2008 and 2011

1.8.1 It was during this period that the police were called by RB to "domestic related incidents". Largely as a result of this, various agencies took a role in supporting RB directly or being involved in her family and domiciliary issues. Much change has taken place since these events and the organisations involved have also changed. For the sake of transparency, the issues of concern are noted below with brevity:

- Police failing to swiftly remove firearms in possession of RB's partner at the time.
- Children's and Young People's Services (CYPS) losing sight of the issue of domestic violence and focussing on other issues (e.g. safeguarding children, not considering the role of alleged perpetrators involved with the family) as well as not communicating effectively with other agencies.
- Specialist support services having poor systems and processes which led to delays and case management issues.
- Housing options not being well-attuned to the needs of victims of domestic violence.
- Family Mosaic (an organisation commissioned at the time to provide floating support services) not providing a female worker, not supervising a poorly performing member of staff well and other communication and system issues.

1.8.2 Despite the distant nature of the contact RB had with these agencies it was reassuring to note that those agencies participated fully in this review and have

[2] https://www.nice.org.uk/guidance/ph50

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addressed all the issues referred to above in a satisfactory way.[3] These issues are more fully referenced within the Overview Report.

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1.9 Diversity and help-seeking

1.9.1 It is difficult to establish why RB was not in contact with specialist services when FL was present in her life. Her lack of contact may have been because of her previous experience or her perceptions of the value of the help she would receive. It may also have been because of the fact that she was involved in a relationship with a patient at the surgery where she worked. There may be other complex reasons for not seeking help, but the panel were concerned that her ethnicity, gender or quality of service may have been factors in not approaching supportive agencies and wish that all policies that address the issue of domestic violence consider the issue of help-seeking, especially those from minority ethnic groups.

1.9.2 Specialist services know this to be a concern but are often unable, due to the narrowness of their funding and remit, to provide the breadth of support that would help a woman who is living in similar circumstances to RB.

1.9.3 FL spoke poor English and he should have been offered better support in this regard on a number of occasions to facilitate an understanding of his health conditions and social history, possibly leading to a better understanding of any risk to others.

1.10 Good practice

1.10.1 Despite other problems the Independent Domestic Violence Adviser (IDVA) service at ADVANCE was consistent in its support for RB.

1.10.2 Haringey are also developing, within the parameters of a coordinated community response, a progressive and effective strategy based on a broader

[3] This is with the possible exception of the availability of alternative accommodation for victims seeking safety – a wider national concern which this report does not feel able to address.

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violence against women and girls approach.

1.11 Contact with family and friends

1.11.1 It is much to the regret of the new Chair of this Review and the panel that it has not been possible to speak to family or friends of RB. The close family of RB were very clear in their wishes that they not be contacted about this case. It was also not possible to trace friends who could have helped with the process. The practice manger was also unwilling to aid this review. This has led to the challenge of hearing the voice of RB within this review.

1.11.2 Efforts have been underway for many months to contact FL in prison but these, whilst still ongoing, have been unsuccessful and it appears this situation is likely to remain the same.

1.12 Conclusions

1.12.1 The outcome of many DHRs demonstrates that the killing of victims could be prevented. An improved understanding of domestic violence, more effective action (situated with an effective coordinated community response) and the ability to grasp the often limited opportunities that become available to intervene and support are examples of how things must continue to change.

1.12.2 It was not possible to predict RB's death because FL could not have been recognised as being a potential murderer given all previous known information about him. There was also a large gap between his last contact with relevant agencies and RB's death.

1.12.3 Opportunities in this case are noted which could have led to different practical responses which could, in turn, have led to different outcomes, and that may have meant RB not being killed. What it is not possible to establish is a direct link from those practical responses to the murder of RB. Broader approaches to safeguarding, particularly where an individual threatens suicide, alongside

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better policies around domestic violence are key issues which require addressing.[4] It is expected that the recommendations within this report will lead to a more effective response to domestic violence. The work in progress within the Violence Against Women and Girls Strategic Group will be a key catalyst in achieving this.

1.12.4 The GP practice needs to develop and improve its management of staff and processes as they relate to the issues discovered during this review.

1.13 Recommendations

Local – for the London Borough of Haringey and related agencies

1.13.1 The following recommendations are based on the findings of this review and are intended to deliver the changes that would have made a difference in this case. All recommendations will be part of an agreed action plan overseen by the Haringey CSP and the Violence Against Women and Girls (VAWG) Strategic Group.

1.13.2 **Recommendation 1.** That the Care Quality Commission (CQC), (supported by NHSE) undertake a further inspection of the Avenues Surgery to consider the issues raised in this review along with their earlier inspection, especially around issues of management, supervision, domestic violence policies, Health and Safety and the role and oversight of non-clinical managers.

1.13.3 **Recommendation 2.** Utilising the NICE Guidelines and the findings around mental health in this review, all NHS services covering Haringey should develop (preferably jointly) an improved safeguarding policy that addresses not just the safety of the patient concerned, but any intimate partners or family members (especially given the dynamics of domestic abuse). This policy should include clear use of interpreters, where necessary.

[4] Stalking and harassment, whilst not known to the statutory sector in RB's case clearly played a part in her victimisation and this should be further addressed within the Violence Against Women and Girls Strategic Group.

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1.13.4 **Recommendation 3.** That Pembrey Medical Centre institutes a domestic abuse policy based on good practice and the NICE guidance.

1.13.5 **Recommendation 4.** That the Haringey Violence Against Women and Girls Strategic Group seeks to enhance its broader response to the issue of domestic abuse and wider VAWG issues – leading to a Violence Against Women and Girls Strategy and partnership VAWG policies.

1.13.6 **Recommendation 5.** Family Mosaic to introduce a policy which includes a system of enquiry of all their clients to assess whether they are experiencing domestic abuse and to take appropriate action following any disclosure of abuse

1.13.7 **Recommendation 6.** That this review is disseminated to the Safeguarding Boards in Haringey for consideration within their local strategies and consideration be given to further dissemination within London or nationally, especially in light of the additional responsibilities for adult safeguarding contained within the Care Act, 2014

1.13.8 **Recommendation 7.** That all agencies involved in this review brief the employees who interacted with RB or FL about the findings of this review (and NHSE to be specifically responsible for informing the Avenues Surgery of the outcome of this review before publication).

National Recommendations

1.13.9 The following are recommendations which the panel wish to be instituted on a national basis. The Haringey CSP wishes to kept informed of the outcome of these recommendations.

1.13.10 **National Recommendation 1.** That any individual reporting suicidal thoughts within an NHS environment be routinely questioned about partners or those close to them to assess the risk to those individuals, in the light of the findings of this review and record and respond to that risk appropriately, if necessary informing the police or Multi Agency Risk Assessment Conference (MARAC).

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1.13.11 **National Recommendation 2.** That proper recording of all such events within a NHS setting and the risk assessment leads to appropriate information sharing to other agencies that are in contact with either the potential victim or the client. The records must show a decision making process which has considered information sharing and shows the action taken.

1.13.12 **National Recommendation 3.** That all NHS practices institute a domestic violence policy based on good practice and the NICE guidance.

1.13.13 **National Recommendation 4.** That the Department of Health considers defining the specific role of practice manager (with appropriate job descriptions and person specifications) and provide appropriate guidance and support to GP practices that utilise this function to ensure that such guidance is embedded in any contractual arrangements.

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2. Overview Report

2.1 Outline of the incident

2.1.1 In March 2014, RB, who was employed as a healthcare assistant (HCA) at the Avenues Primary Care Centre in Haringey (called such for the purposes of this review), left her workplace at 1pm, and was followed by FL who repeatedly stabbed her a short time later. Members of the public intervened and detained FL until uniformed officers arrived. RB was treated at the scene and subsequently transported to hospital but succumbed to her injuries en route. She was pronounced dead at 2.20pm that same day.

2.1.2 FL was arrested and a search of his home address was conducted where clothing and personal affects believed to belong to RB were found. A homicide investigation commenced the day after the homicide and FL was charged with RB's murder. FL was subsequently convicted of murder on the 10th December 2014 and sentenced on that date to life imprisonment with a minimum prison term of 20 years.

2.1.3 The panel would like to offer their sympathies to the family, friends, colleagues and acquaintances of RB for their loss and to thank those who have contributed to this DHR process.

2.2 The review process

2.2.1 These circumstances led to the commencement of the present Domestic Homicide Review (DHR) at the instigation of the Haringey Community Safety Partnership (CSP). The initial meeting was held on the 27th June 2014 to consider the circumstances leading up to RB's death. All agencies who had contact with RB or FL were required to complete Individual Management Reviews (IMRs) detailing the context of that contact and reviewing their response. These IMRs constitute a crucial element of the review process.

2.2.2 The DHR process was established under Section 9 (3) of the Domestic

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Violence, Crime and Victims Act 2004 and was conducted in accordance with the Home Office revised guidance 2013.

2.2.3 The purpose of these reviews 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 timescales they will be acted on, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process within individual agencies.

2.3 Terms of Reference

2.3.1 The full Terms of Reference are included in Annex 1. The purpose of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

2.3.2 This DHR was conducted in the London Borough of Haringey as this is where FL's residence and RB's workplace were located at the time of her death. RB was mainly a resident in the London Borough of Hammersmith and Fulham (LBHF) and agencies from that area have also been involved in this review.

2.3.3 Throughout this report, the term domestic violence is used to identify incidents or a pattern of threatening behaviour, violence or abuse (psychological,

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physical, sexual, financial or emotional), between adults who are or have been intimate partners or family members.

2.3.4 The cross-government definition of domestic violence and abuse at the time of this murder was:

2.3.5 Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

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

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

2.3.8 Coercive behaviour was made a specific offence on the 29th December 2015.

2.4 Parallel and related processes

2.4.1 A separate review considering employment issues in relation to RB has been commissioned by NHS England and has been completed by the same reviewer

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who completed the IMR for Avenues Primary Care Centre and the Pembrey Medical Centre.

2.5 Panel membership

2.5.1 Panel members included:

- Haringey Clinical Commissioning Group (CCG)
- Haringey CSP
- Haringey Strategic Lead, Violence Against Women and Girls
- Nina Murphy Associates – IMR author for General Practitioner for the victim and perpetrator
- The Nia project (Haringey IDVA Service)
- ADVANCE Advocacy service
- Solace Women's Aid
- Standing Together Against Domestic Violence
- NHS London
- LBHF Children's Services
- LBHF Housing Service
- Family Mosaic
- Barnet Enfield Haringey Mental Health NHS Trust
- North Middlesex University Hospital Trust
- Challenge Consultancy (to advise on diversity and equality issues)
- Metropolitan Police Service

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- London Ambulance Service (LAS)

2.6 Independence and delay

2.6.1 The independent chair of this DHR is now Anthony Wills who replaced the previous chair who was unable to complete the process. (The previous chair was involved between June 2014 and November 2015). Anthony is an associate of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic violence through multi-agency partnerships. He has served as a police officer for 30 years, concluding his career as a Chief Superintendent where he supported the development of the coordinated response to domestic violence. Since leaving the police in 2003 his main roles have been chief executive of Standing Together, DHR reader for the Home Office, DHR reviewer and as a consultant delivering improved responses to domestic violence. He has now been involved in over 20 DHRs.

2.6.2 He has no connection with the London Borough of Haringey or any of the agencies involved in this case.

2.6.3 The independence of the chair was considered by STADV and Haringey. However, the chair Anthony Wills concluded his term as an employee with STADV in 2013 and currently works as an associate with no line management responsibilities.

2.6.4 It is very evident that the process of completing this review has been significantly delayed. In part this is due to the apparent complexity of the case and problems with assessing the quantity of information available. This does not justify the late submission of this report to the Haringey CSP which must be explained by the challenges of producing a report that encapsulated the issues but did not then become over-detailed. The new chair has taken a different approach to these issues which had the support of the panel and is described below. The agencies involved in the panel have been consistently patient and supportive of the process and any delay cannot be ascribed to them.

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2.6.5 One of the unexpected and welcome benefits of this delay (although the delay remains regrettable) is that many agencies have already changed their practice in relation to the findings within their own IMRs.

2.7 Methodology

2.7.1 This DHR covers the period from 2008 onwards. During this lengthy period RB and FL had a series of contacts with agencies. These fall into four main areas (or contexts) and each is addressed separately but not necessarily chronologically. The reviewer has attempted to consider what actions should have been taken to safeguard RB, where the major responsibility for RB's death lies, related agency action and the potential for learning. It is necessary to be sensitive to those who knew RB and whilst this report attempts to be victim-centred, RB's relationships are also a factor in the complexity of this review and where possible these are dealt with in a sympathetic and confidential manner. IMRs have been sought from all agencies involved and further information provided where necessary.

2.7.2 During the 6-year period examined within this review RB was known to have had significant relationships with three men. Firstly, her partner with whom she had two children and who she continued to live with for some time after the relationship had foundered. The others were FL, who it is thought she met around 2011 and the practice manager at Avenues who has stated he began some form of relationship with RB around 2010.

2.7.3 The precise nature of these relationships has been impossible to define due to non-participation of the relevant parties in this process and limited personal information relating to RB.

2.7.4 The four contexts are:

i. **The perpetrator and his contact with agencies**

FL has been convicted of the murder of RB and bears the responsibility for killing her. For this reason this will be the issue addressed first. Prior to the death of RB he was in contact with various agencies where consideration must

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be given to their role in treating him and safeguarding those with whom he was in contact.

ii. **Avenues Primary Care Centre**

This is the practice where FL was a patient and where RB was working, initially as a practice nurse and then as a HCA. Without pre-empting the consideration of the role of this practice below it should be noted that FL had been removed from the list of the practice for his behaviour towards RB but was then allowed to re-engage with the practice. The practice manager at the surgery was also in a relationship with RB.

iii. **The care for RB at Pembrey Medical Centre, her own GP surgery**

RB was a patient at this practice throughout the period of this review. She disclosed to her GPs that she was suffering from domestic violence which makes their response to her of importance in this case.

iv. **The response to RB around 2008 to 2011**

During this period the police were called by RB on four occasions to the same address in what the police describe as “domestic related incidents”. At the time RB was undergoing problems in her then current relationship. These incidents led to agency involvement which is referred to in this report. The reviewer has taken the decision to treat this section with more brevity as the elapse of time is considerable but reference is made to the changes which have taken place as a result of the learning from this case

This period is also relevant as it may have impacted upon RB’s willingness to seek help when in the relationship and subsequently with FL. This is considered below.

2.7.5 Individual Management Reviews (IMRs) or similar were sought from all agencies who were in contact with RB or FL from 2008. IMRs were received from:

- Pembrey Medical Centre

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- Avenues Primary Care Centre
- North Middlesex University Hospital NHS Trust
- Barnet, Enfield & Haringey Mental Health NHS Trust
- ADVANCE – a voluntary sector specialised domestic abuse support service
- Family Mosaic – provider of housing floating support services in LBHF
- LBHF Housing Options Service
- LBHF Family Services
- Standing Together Against Domestic Violence – coordinating the multi-agency risk assessment conference to which RB was referred
- Metropolitan Police – who provided a letter outlining police contact with RB as the limited involvement did not require an IMR

2.7.6 Additional information was sought from and contributed by the following agencies as information came to light during the DHR process:

- Central London Community Health Trust
- Whittington Health Trust
- Camden & Islington Health Trust
- LAS

2.7.7 It was recognised that the panel was not entirely representative of the Haringey community and expertise around issues affecting black women was sought to ensure a balanced report. A briefing on relevant diversity issues was obtained from an expert on this subject: Femi Otitoju of the Challenge Consultancy. Femi became a member of the panel providing expert advice throughout the process.

2.7.8 The witness statements and other information gathered as part of the criminal justice process were also helpful in shedding light on the circumstances leading

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to RB's death.

2.8 Contact with family, friends and those who knew RB

2.8.1 This has been a difficult and largely unsuccessful part of the process. Contact was made by letter with RB's family including her adult children and a previous partner outlining the process and the benefits of their involvement. They were adamant that they did not wish to be involved in the process and felt that this was not in fact a "domestic homicide". They advised they would pursue legal action if further attempts were made to contact them.

2.8.2 Additionally, the practice manager at the Avenues surgery was spoken to as both a colleague of RB and an intimate partner but declined to add to the information already in the public domain as a result of the criminal trial.

2.8.3 No reply was received at that time from RB's other close relative who was also contacted in an attempt to expand on the very limited information available in relation to the background and context of RB's life.

2.8.4 Attempts have also been made to establish if RB was involved in any faith groups but no evidence has emerged whether she was religious or had any such affiliations.

2.8.5 With the change of reviewer, renewed consideration was given to try and seek further information from friends and relatives. The judgement of the new chair and the panel was that this would not be successful and it was right to respect their views as expressed to the previous chair. It was also not possible to identify friends of RB who could have assisted in the process.

2.9 Contact with the perpetrator

2.9.1 Efforts are still underway to interview the perpetrator in prison but these have yet to meet with any response.

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2.10 Diversity and equality

2.10.1 The Panel considered the protected characteristics under the Equality Act 2010 when analysing the facts of this case.

2.10.2 RB was 42 at the time of her death and a black woman of Jamaican heritage. FL was 46 at the time and is a white Polish national with a limited command of the English language. Race and sex (gender) are issues which bear consideration as themes within this report and are discussed below.

2.10.3 RB was treated with anti-depressant therapy at a time of difficulty in her life. FL was formally diagnosed with depression. Neither party was considered disabled by these problems. These do in any event receive mention within the review.

2.10.4 The panel felt that RB's previous marital status may have had an impact on how her later relationships were viewed by herself and others. This review was unable to draw any conclusions in this regard.

2.10.5 The other protected characteristics: age, disability, gender reassignment, and civil partnership, pregnancy and maternity, religion or belief and sexual orientation were not considered by the panel to be relevant to this review.

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3. The Facts

3.1 The death of RB

3.1.1 In March 2014, RB, who was employed as a HCA at Avenues Primary Care Centre in Haringey arrived for work at approximately 9am. FL was outside the surgery. It is recorded that he greeted her verbally and that she did not respond. When RB left her workplace at 1pm, witnesses saw FL follow behind her. She shouted at him to leave her alone. In Avenues, he grabbed her arm, pushed her against a fence and then repeatedly stabbed her. When she fell to the ground he continued to stab her. FL was arrested at the scene. RB was treated at the scene by LAS and emergency medical teams but she died en route to the Royal London Hospital by ambulance. She was pronounced dead at 2.20pm that same day.

3.1.2 FL was arrested and taken to Wood Green Police Station. He was examined by a Forensic Medical Examiner and a Psychiatric Nurse. He was deemed to be fit for detention and did not present with immediate mental health illness. A search was conducted of FL's home address where clothing and personal affects believed to belong to RB were found.

3.1.3 A post mortem gave the cause of death as multiple incised wounds.

3.1.4 A homicide investigation was instigated and FL was charged with RB's murder.

3.1.5 FL was convicted of murder on the 10th December 2014 and sentenced to life imprisonment with a minimum term of 20 years.

3.1.6 In his summing up the Judge said that: "You stabbed RB to death…It is my clear perception she had decided at last to end her relationship with you in favour of being with another man and made her wish entirely clear to you. In my judgement this was a simple act of revenge which you had planned would occur in the event of your rejection."

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3.2 The perpetrator and his contact with agencies

3.2.1 FL was not known to the police in connection with his relationship with RB. There were police reports of his aggressive behaviour at work (he worked in a bakery) in 2011 but these did not result in any criminal action. He has no previous records for domestic violence in either Poland or the UK.

3.2.2 He is known to have had a wife and four children in Poland. He arrived in England in approximately 2010.

3.2.3 FL was first registered at Avenues Surgery in April 2010. He was known to have had a variety of health concerns but the health problem which led to the majority of contact with Avenues and RB was a chronic limb problem which required lengthy treatment from September 2011.

3.2.4 Without going into vast detail about these attendances it should be noted that RB was principally involved in providing him with nursing care in relation to ongoing physical health conditions. Some consultations took place where no entries in the medical records were made. In 2011 FL attended a total of 13 consultations with RB. In 2012 there were a total of 47 recorded consultations with RB. RB was still treating FL in March 2014 for a variety of continuing physical health conditions.

3.2.5 During this period (on the 15th May 2012) RB reported to Avenues management that FL's behaviour had caused her to feel concerned for her safety. This is the first and only entry from all the documents consulted during the IMR process in which it is clearly recorded by professionals that RB was potentially at risk of being harmed by FL. The role of Avenues in dealing with this risk and associated issues is discussed below.

3.2.6 Whilst receiving treatment from Avenues, FL had significant contact with other health agencies mainly in relation to mental health and his threat to commit suicide.

3.2.7 On the 11th August 2012 FL called the police saying he wanted to commit suicide. After convoluted enquiries, the police traced the call to FL's workplace.

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He told the police that he had problems with his girlfriend in the UK (almost certainly RB) and his wife in Poland. The police took him to Whittington Hospital where he was seen by the Psychiatric Liaison Team.

3.2.8 It was established that whilst suffering severe depressive symptoms and emotional instability brought on by the ending of his relationship with his girlfriend he had no intent or plan to kill himself. Whilst under the care of Whittington Hospital, FL stated that his relationship with his girlfriend was "tempestuous" and that he considered "she was playing with his emotions". He also admitted attempting two previous suicides.

3.2.9 FL agreed to engage with Haringey Home Treatment Team (HHTT – a service to support such individuals with home treatment where this is considered to be the least restrictive option for the individual) and was then supported by them until the 4th October 2012. At this time, he was discharged with his agreement as his mood had improved. (HHTT had no further contact with him after this date.)

3.2.10 During this period there was limited contact by HHTT with other agencies caring for FL (e.g. District Nursing Services dealing with his leg ulcer). The key issue was contact with Avenues. FL had made it clear that he did not want his involvement with the HHTT to be passed to the practice as his girlfriend worked there, although her role was recorded as an administrator. The records show that a discharge letter was sent to Avenues and earlier discussions had taken place with a practice nurse there about medication. It is not known if this practice nurse was RB.

3.2.11 There was no contact with the surgery about the ethics of an employee at Avenues being in a relationship with FL, as this may have been considered as inappropriate within the NHS.

3.2.12 The IMR considering HHTT's actions in relation to FL (completed by Barnet, Enfield & Haringey Mental Health Trust - BEHMHT) mentions that "there is a sense that the team were discussing the relationship (with RB) but were not of the clinical opinion that he was a risk of harm to others".

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3.2.13 On the 4th September 2012 and during the period FL was being supported by HHTT, FL was taken by ambulance to North Middlesex University Hospital Emergency Department after reporting to police that he wanted to kill himself and to the LAS that he might kill his girlfriend. The identification of this girlfriend was not revealed through any recorded questioning of FL.

3.2.14 The records show that he said "that he did not want to live because his girlfriend had disappointed him and is avoiding him. He wanted to end his life as he thinks there is nothing to live for."

3.2.15 FL was discharged later that day with notice that the psychiatric liaison nurse had been asked to contact him. This nurse noted the next day (the 5th) that HHTT were caring for him and were aware of his attendance at North Middlesex University Hospital.

3.2.16 There is no record at either North Middlesex University Hospital or HHTT that the information about the threat to his girlfriend was passed to HHTT. A letter was sent by North Middlesex University Hospital to Avenues repeating the fact that FL had discussed killing himself or his girlfriend.

3.2.17 During this period of care for FL there is no record of professional interpreting being delivered. There is commentary about his request for an interpreter (9th September 2012) and a subsequent entry saying an appointment had been made later (18th September 2012) to allow for an interpreter. FL did not attend for this appointment but it is not known if an interpreter had been arranged.

3.2.18 Clearly friends and relatives were utilised (as mentioned in IMRs) to help with translation but there is no doubt that FL struggled with English and this may have made obtaining a social history, particularly in relation to his girlfriend and her safety, and collecting detailed information about his symptoms challenging.

3.2.19 After October 2012 The HHTT and North Middlesex University Hospital had no further contact with FL following the interventions described above.

3.2.20 The relevant section of the safeguarding policy of North Middlesex University Hospital (and which is similar in other health settings) is copied below, with a

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small section highlighted and underlined by the reviewer:

RISK ASSESSMENT

Risk assessment that includes the assessment of risks of abuse, neglect and exploitation of people using services should be integral in all assessment and planning processes including assessments for self-directed support and the setting up of personal budget arrangements. Assessment of risk is dynamic and ongoing during the Safeguarding Adults process. It should be reviewed throughout the process so that adjustments can be made in response to changes in levels and nature of risk. The primary aim of a Safeguarding Adults risk assessment is to assess:

- Current risks that people face
- Potential risks that they ***and other adults*** may face.

3.2.21 It may also be helpful to quote at this point (from a witness statement taken after RB's death) made by a relative of FL.: "[FL] was totally in love with RB and would follow her all the time; they have lived together on and off at his most recent address from March or April 2013 and had also lived together prior to that in a rented room; they were planning a future together and talking about getting married; RB had talked about taking a mortgage for a flat but wanted FL to divorce his wife in Poland first; in the past he had sent money from the UK to his wife and children in Poland but he stopped doing so after RB told him that he had to choose between her and his family in Poland; FL chose RB and they were happy together; on one occasion in the second part of 2012 when RB left him he was on his way to kill himself by jumping under a train but a friend of his stopped him; in September 2012, he again threatened he would kill himself after RB left him, he was admitted to St Ann's Hospital where he was in a terrible state and was looked after by a psychiatrist, he was prescribed medication; around Christmas 2012, FL followed RB to her address and said [to his sister] that he had seen her there; he said that RB had cheated on him because he had seen her in another room in the house with a manager from her surgery; FL

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accompanied by RB visited them at least twice at their home address; FL said he loved RB very much and never in the past had he mentioned harming her."

3.3 Avenues Primary Care Centre

FL and Avenues

3.3.1 As has been described above, FL was treated at Avenues on very many occasions. On most of these occasions he was treated by RB.

3.3.2 Many of these occasions resulted in poor or non-existent record keeping over a number of years.

3.3.3 FL's mental health issues were known to Avenues through a letter from the Whittington Hospital (received 13th August, 2012) describing secondary care service support and a letter from North Middlesex University Hospital (received 10th September 2012) outlining a suicide attempt and a depressive episode. This letter included the information that FL had threatened his girlfriend which appears to have been RB (although not named).

3.3.4 On the 26th October the practice received a discharge letter from FL from HHTT.

3.3.5 These issues are described at some length in the IMR produced on behalf of Avenues. The issues are summarised below.

3.3.6 The letter from the Whittington Hospital mentioned problems FL was having with a girlfriend. The letter was annotated "FAO RB just for info", scanned into the system and available to RB.

3.3.7 There is no record of any contact with mental health services relating to RB's relationship with FL.

3.3.8 FL disclosed (on the 12th August 2012) that he was seeing specialist GPs at St Ann's but these were in fact HHTT.

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3.3.9 The letter from North Middlesex University Hospital did not suggest any particular action for the practice and shows simply a referral to the GP but, as stated above, FL at the time had said he needed help or would kill himself or his girlfriend.

3.3.10 No summary of FL's mental health problems was made resulting in a lack of a "problem code" being applied to his records, preventing the highlighting of his mental health position and easy access to those issues.

3.3.11 The discharge from HHTT letter does not show a diagnosis but describes a prescription for an anti-depressant (Mirtazapine) for 14 days and suggests a continuation of this drug. FL was added to the repeat prescribing list, with no apparent consultation, and with no need for a GP review. The processes followed in the practice (by a GP) resulted in FL being able to obtain repeat prescriptions until January 2014.

3.3.12 As FL was not diagnosed as suffering from a serious mental illness he was not subject to a Care Programme Approach. As he was prescribed anti-depressants he should have been added to the depression register at Avenues resulting in automatic reviews.

3.3.13 In fact, FL was seen by a GP on the 5th December 2012 and the same GP carried out a medication review on the 8th March 2013. No detail is recorded and no change in medication occurred. FL was seen again by another GP on the 19th March and 7th June 2013 and depression was noted on both occasions. After this time there is no further consideration of his depression or use of structured tools to assist with assessment of his current position. Much of the consideration is based on managing what is described as hypertension (abnormally high blood pressure).

3.3.14 The issue of his threats to commit suicide and be a threat to another do not seem to have been mentioned in these consultations.

3.3.15 There is also evidence in his records that he was not compliant with the directions for his medication, although this is not shown in the records as being

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followed up.

3.3.16 It is also notable that the IMR comments that the decision not to use a structured tool was not recorded as being a result of FL's limited English.

RB and Avenues

3.3.17 It is necessary to set RB's employment at Avenues in some context. She commenced working as a practice nurse at the surgery in April 2011 having worked in a similar role at another surgery for a few months in West London. The practice manager for both surgeries is the same individual.

3.3.18 In July 2013 RB was suspended from the Nursing and Midwifery Council Register following an investigation and hearing. The practice kept her in employment but changed her role to that of HCA. This new role did not, according to the relevant IMR, "make any difference to the care which RB offered to FL".

3.3.19 In May 2012 RB requested that FL be removed from the Avenues practice list with immediate effect. The IMR states that "RB had reported to the practice manager that FL was behaving inappropriately towards her and she feared he might attack her". There appears to be no other record of what the threat actually was and the police were not called despite this being the Primary Care Trust (PCT) policy in such a case. It was also not recorded as a significant event in the practice records, again contrary to policy.

3.3.20 Despite this removal FL continued to be seen by RB for health care reasons and on the 9th July was re-registered with the practice. No record of any discussion about how this process happened has been found. Again it is worth quoting the IMR: "It is already unusual to remove a patient from a GP list with immediate effect, it is extremely unusual to re-register such a patient."

3.3.21 RB supported FL in other ways. She phoned his employer to say he was too ill to work and became the guarantor for his flat, the latter being also known to the practice manager. This is described by the IMR author as being "way beyond

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the boundary of a professional relationship".

3.3.22 It is also notable that the letters relating to FL's mental state were received by Avenues after his removal and return to the list but this did not prompt any action around the safeguarding of RB. One such was annotated "FAO RB just for info" and scanned onto the system which would have made it available for RB if she accessed and read the entry.

The role of the practice manager

3.3.23 It is a matter of public record from the criminal trial of FL that the practice manager played a decision-making role in managing FL's conduct towards RB at and around the surgery on a number of occasions. He was also engaged in an undisclosed extra-marital affair with RB, from approximately December 2010 until her murder. He stated that beyond his two formal statements to the police which have been examined for this review he was not prepared to contribute any additional information to this process.

3.3.24 Information provided during the homicide investigation by the practice manager demonstrated that he had acted in a manner that involved observation of RB's contact with FL at FL's home, without RB's knowledge. The records of calls and text messages obtained by the police also show that at times, including late evenings and at week-ends, he was in communication with her at times that overlapped with FL's repeated phone calls and numerous text messages. The content of these conversations is not known from the records available.

3.3.25 From the police investigation it is very clear that the practice manager was heavily involved in the difficulties RB was having with FL for the six to eight weeks prior to RB's death. He saw FL enter RB's flat on one occasion and witnessed FL leaving the following morning. On the 18th March, the day before her murder, he arranged a meeting with FL where FL accused him of spoiling everything. This also led to him discussing FL with RB's previous partner. He is quoted as saying to RB that he believed FL was a fantasist and dangerous.

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3.3.26 The review referred to above, relating to practice within Avenues, where the practice manager has clear responsibility, demonstrates problems with the management of the practice. In discussions with the IMR author for the surgery and others it is apparent that human resource process, e.g. appraisals and performance management were lacking despite the findings in the next paragraphs.

3.3.27 In November 2014 the Care Quality Commission (CQC) inspected Avenues and found it was a “good” practice. Some reservations were expressed about its safety which required improvement. Apparently “staff understood their responsibilities to raise concerns and to report incidents”. This review does not appear to support that finding. The safety referred to by the CQC appears to be in relation to processes around emergency medicines. Domestic violence is not mentioned.

3.3.28 Whilst it was described as “good for being well led” the practice had a number of policies and procedures which governed activity which required review. No such reviews had taken place for five years and it is unclear if these included any policies relating to domestic violence.

Help-seeking by RB late 2013 -14

3.3.29 It is known that RB did not seek help in her issues with FL towards the end of her life from the agencies previously involved with her. At this time, she was receiving a massive number of texts, up to 40 in a day, and some calls from FL. (This is known as a result of the criminal investigation.)

3.3.30 RB rarely replied to these messages but when she did it was noticeable that she said things like “get away from the surgery”, “get away from where I was working” and “stop disturbing me at work”. The content of FL’s messages is largely in the form of pleading, accusing and questioning. In them he threatens that he will kill himself and once says “I do not want to kill you, I love you”.

3.3.31 To anyone with a minimal knowledge of domestic violence it is absolutely

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apparent that FL was stalking and harassing RB and it is likely a specialist or trained worker would have regarded RB as being at high risk of harm. It is not known to what extent any personnel at Avenues knew the extent of FL's behaviour towards RB at this time.

3.4 The care for RB at Pembrey Medical Centre, her own GP surgery

3.4.1 RB was registered at this practice before 2008. It was in this year that she was feeling "low" after the death of her stepmother and difficulties in the relationship with her partner at the time. In 2008 depression was diagnosed and further difficulties with her partner noted. She was well supported in relation to her depression.

3.4.2 RB received support from the West London Mental Health Team at this time and the records show that bereavement and the relationship with her partner were significant issues for RB. There was no mention of domestic violence in what was a relatively comprehensive description of RB's concerns.

3.4.3 In April, May and June of 2009 it was recorded in the GP notes that violence was now present in her relationship (and this was supported by her testimony to other agencies, e.g. ADVANCE and LBHF Family Services). RB was encouraged to contact the police and was advised about specialist services, including refuges.

3.4.4 From this point on whilst the fact that she had reported domestic violence continued to be noted in records there were no further reports apart from minor comments about the divorce not proceeding well.

3.4.5 In 2013 RB reported that there was no further domestic violence and that she was enjoying her role as a practice nurse.

3.4.6 In 2013 this practice had taken part in a trial for implementing a specific referral pathway for domestic violence which had not been in use when RB was reporting the domestic violence to her GP. Whilst the outcome of this is unknown neither this nor a policy were readily in evidence to the IMR author.

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3.5 The response to RB around 2008 - 2011

3.5.1 A significant number of agencies had been involved with RB after the police had become involved in "domestic related incidents" in early (January) 2009. It was clear from her medical records that she was undergoing difficulties in the relationship with her partner in 2008 but it was when the police were called that this escalated to a more active, but not necessarily collaborative statutory and voluntary sector partnership response. As the period from 2008 – 2011 is some distance from her relationship with FL and subsequent death, the actions, concerns and remedies are included within this section rather than the later analysis which concerns other issues. Each agency has submitted an IMR and this is dealt with separately below.

3.5.2 **Metropolitan Police.** Risk assessments were correctly recorded as a result of the four domestic related incidents reported by RB in 2009. Referrals were made to ADVANCE and Family Services. There was no report of violence to the police by either partner.

3.5.3 The issue of significance was that RB's partner was in possession of firearms (shotguns) and there was a delay in removing these despite fears expressed by other agencies. The existence of the firearms was known about in January 2009 but they were not removed until September 2010. The police recognise this was an unnecessary delay but have now improved their practice in this area in light of Home Office guidance.[5]

3.5.4 **LBHF Family Services.** This agency was involved with RB and her family between January 2009 (the first police call) and September 2009 in relation to reports of domestic violence. It was on this basis that the Initial Assessment (IA) was correctly commenced. This focus was lost when safeguarding issues about one of RB's sons were raised and this then became the primary objective of the

[5] "Guidance on Firearms Licencing Law" December 2015. This has also led to a policy of searching the police national computer for firearms flags in these cases and taking appropriate action to remove firearms when present. Domestic assault being recognised as an example of when such action should be taken.

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assessment. In the IMR author's words the IA became "one dimensional in nature" leading to a less complete approach to the case subsequently.

3.5.5 The subsequent referrals and action within Family Services were affected by this IA and gaps in communication with other agencies and responses began to appear (including those in relation to the children in the home). Additionally, the role of the alleged perpetrator was not an obvious element of the process.

3.5.6 This was felt by the IMR author to reflect the poor practice of the time and that the response now to any situation where domestic violence is an issue is vastly improved. Notwithstanding this improvement the recommendations for Family Services were:

- Ongoing training around domestic violence, particularly risk assessment and analysis.
- Improve chronology recoding to ensure comprehensive history of families is readily available.
- Assessments must include the contribution of the alleged perpetrator and this added to the risk assessment if he/she does not engage.

3.5.7 The panel is satisfied that these changes to their approach are now embedded in their response.

3.5.8 **ADVANCE.** This is a specialist support service for victims of domestic violence based largely in inner West London. Their first referral in relation to RB was on the 12th January 2009 after the initial call to police. This case was based around a different partner at this time (not FL). Following multiple attempts to contact RB the case was closed when there was no response.

3.5.9 The second referral was on the 31st March 2009 following the second police report.

3.5.10 Contact was established with RB and she was then provided with very regular and full support from an Independent Domestic Violence Adviser (IDVA). RB's

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issues were largely about her safety and housing and she was very explicit in describing her fears (and this is when the firearms issue also took prominence). What is very noticeable is that the IDVA maintained a fully supportive role when circumstances changed, when RB changed her mind about options due to fluctuating circumstances and when the risk had apparently reduced. The chronology is very clear that there were a very large number of contacts between the IDVA and RB which maintained the safety of RB as the focus of the work. Whilst other problems have been identified the work of the IDVA in this case is to be commended.

3.5.11 Problems identified in this case by ADVANCE centre around:

- Delays in referral from the police to ADVANCE.
- Delays in contacting victims, leading to poor communication.
- Delay in referral to Multi Agency Risk Assessment Conference (MARAC).
- Case note recording and management, including case closure.
- Associated processes both internally and externally.

3.5.12 ADVANCE has implemented all ten internal recommendations as a result of this case which addresses the issues discussed. Since the commencement of this review ADVANCE have also attained SafeLives Leading Lights[6] accreditation (in 2011 and re-accredited in 2015).

3.5.13 **LBHF Housing Options Service.** This organisation has undergone substantial re-organisation since 2009 (RB was in contact with them between March and September 2009). Housing was clearly an issue for RB and the position was exacerbated by her then partner working for an organisation closely connected to LBHF Housing. This was dealt with sensitively and confidentially. It was also noted in the case notes that RB had a "genuine uncertainty…how best to proceed" which is also evident in the case notes of other organisations.

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[6] http://safelives.org.uk/practice-support/resources-domestic-abuse-and-idva-service-managers/leading-lights

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3.5.14 The developments since 2010 include devolving decisions about temporary accommodation to frontline staff, better use of a "housing" IDVA and allocated case workers and better communication between Housing Options and Family Services.

3.5.15 Problems which linger on are the availability of alternative accommodation, dealing with staff whose partner works for the housing agency (although this was dealt with well on this occasion) and all agencies developing domestic violence policies that look at staff involvement and effective responses. Such policies are the subject of a recommendation below.

3.5.16 **Family Mosaic.** This is an organisation commissioned by LBHF to provide floating support services to people in need of housing support. RB used their services between July 2010 and May 2011 and support was provided by a male worker. The database in use at the time was de-commissioned in 2013 and the IMR author had to rely on case notes, other notes and personal recollection. Mirroring Family Services issues, a plan was agreed for RB but it largely focused on the son's needs rather than the broader issues RB was facing.

3.5.17 The case was closed in 2011 but the IMR states that contact with RB was intermittent and despite her non-engagement and frequently cancelling appointments and missing home visits, fell short of the level of contact expected. It goes on to say that "she could have received more holistic and effective support".

3.5.18 The specific learning from this case which remains applicable is:

- Female workers conducting assessments where domestic violence may be an issue.
- Joint working with other agencies involved in the case.
- Better supervision of poorly performing staff.
- Engagement and completion of home visits to be considered in supervision.

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3.5.19 Family Mosaic has satisfied the panel that all these recommendations have been implemented.

3.5.20 During panel discussions, Family Mosaic felt that they could introduce a system of enquiry of all their clients to assess whether they were experiencing domestic violence. They asked that this be included as a recommendation for their service.

3.5.21 **Standing Together Against Domestic Violence.** This organisation coordinates the MARAC at which RB's case was first discussed. It appeared on the agenda twice and on both occasions all relevant information was shared and actions completed. When RB was transferred to temporary accommodation in Wandsworth her case was also transferred to the Wandsworth MARAC where her case was discussed three times. The case was not brought back to the MARAC as RB had been offered a permanent address (although she chose not to take this) and there was no known repeat victimisation.

3.5.22 The IMR from Standing Together makes the point that this case was based around a different perpetrator at this time (not FL) but also recognises that continuous training on referrals and the MARAC process is necessary to safeguard high risk clients known to all the caring agencies. This is a continuing process within the MARAC system.

3.5.23 What is hard to establish is whether RB's experience of the support she received from these agencies on the first occasion she reported domestic violence was of a good enough standard to ensure she reported such issues in the future. The fact is that she did not seek help again when experiencing various forms of threat and abuse from FL. This is further discussed below in Diversity and in later stages of the report.

3.6 Diversity and equality

3.6.1 This issue has benefited from the experience and expertise of a diversity expert commissioned by Haringey Council to support the panel.

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3.6.2 RB was a black woman of Jamaican heritage. The only evidence of a pro-active stance about her race or ethnic origin is in relation to the crime report to the police on the 5th September 2009 where it is recorded that she did not appear to have felt isolated from support or have any cultural issues that made it harder for her to seek help.

3.6.3 Within HHTT the records (RIO) shows a reference to FL's "Jamaican girlfriend" with no mention of the relevance of her ethnicity.

3.6.4 As discussed above, RB was provided with a male support worker from Family Mosaic. She was not encouraged by Family Services to seek help early on in their response to her problems. Communication problems (delays) by ADVANCE (a fact established by that organisation in their IMR) and the support offered by Avenues surgery are issues that bear further consideration below.

3.6.5 What is noteworthy is how rarely RB’s race and ethnic origin is considered by any of the agencies with whom she came into contact.

3.6.6 In relation to FL, his first language was not English and this is evident from many of the IMRs. On three occasions the police were able to offer support in relation to FL’s lack of English (a leaflet and two contacts with a “language line” interpreter). Such support is not evident within other agency activity and this would have allowed a deeper and more accurate understanding of his mental state, general health and social history, including that of his relationships.

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4. Analysis

4.1 Introduction

4.1.1 This review has been hampered by an inability to hear the voice of RB in the sense that her contact with agencies was limited and none of those closely involved in her life participated in this review. She did not report any concerns about FL formally to any agency, with the exception of the surgery where she worked when he was de-listed and shortly after re-instated. Those who were in contact with her, her previous partner and the practice manager at Avenues, have declined to share with this review what they knew of the context of her relationship with FL.

4.1.2 It has therefore been necessary to rely on the information from IMRs and the criminal investigation and trial. This shows that men in RB's private relationships knew that FL was a threat and, whilst they may have advised her, this knowledge did not reach any caring agencies at the time she was killed.

4.1.3 There were two periods when the threat to RB was potentially known to agencies that had a duty to safeguard her. These are during the period from 2008 to 2011 when her relationship with her then partner was the subject of reports to various agencies. The second is when FL was treated by various NHS agencies that knew, or should have known, about his girlfriend and the threat to her. This period concluded in 2014 when her death occurred

4.1.4 It is also evident from all the above that NHS funded organisations play a key role in the care, treatment and support of victims and perpetrators. It was obvious that the NICE guidance on domestic violence: Domestic violence and abuse: multi-agency working[7] bears strongly on the issues raised in this report but it does not appear to have been utilised as a means of ensuring sound performance.

[7] https://www.nice.org.uk/guidance/ph50

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4.2 The period of 2008 - 2011

4.2.1 As can be seen above, it was clear that RB received significant support throughout this period, particularly from ADVANCE. Every agency was able to identify some form of problem within their processes that could have improved their response. For the purpose of this review it is not necessary to apportion significant responsibility to any agency, partly because the other partner involved was not FL and also because of the passage of time.

4.2.2 The structural changes, continuing recommendations and new policies will have had a positive impact on the response to domestic violence in a general sense. It would be unreasonable to attribute any of the agency failings from this period to the subsequent death of RB.

4.2.3 The issue of help-seeking has been the subject of much discussion within the panel. It is right to ask the question whether, for example, the focus on the safeguarding of children instead of a broader view including the domestic violence had the effect of deterring RB from disclosing later fears for her safety. Also one can consider whether the failure to offer female support workers or her race or ethnicity were factors in her finding help.

4.2.4 The truth is that this cannot be convincingly ascertained either positively or negatively. It is reasonable to analyse the support provided by ADVANCE and surmise that this was of a good standard, showing empathy and determination to support RB despite varying circumstances and decisions. There is no evidence that the service she received during this period by any of the agencies substantially affected her decision not to seek help in 2013 and 2014. It remains possible that further specialist support, post crisis, may have made a difference to both her attitude to seeking help and the options that she chose in her life.

4.3 The period around 2012 and the response to FL

4.3.1 What is indisputable is that FL murdered RB in 2014 and that he had discussed his relationship with a number of agencies in 2012. At the Whittington, with the

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HHTT and at North Middlesex University Hospital there was an awareness of a relationship with a woman. In some cases, this relationship was known to be difficult (i.e. RB was seeking to end it) and in others he was known to have threatened her (or at least a girlfriend which in all likelihood was RB) and that the relationship was "tempestuous".

4.3.2 The response to this knowledge was inadequate. It is clear that some consideration was given during the period under support from HHTT to his relationships and that clinicians involved assessed that no real threat existed. This, however, was not with the full knowledge available within the NHS and that known specifically by North Middlesex University Hospital.

4.3.3 It is clear that the "threat to the girlfriend" information possessed by North Middlesex University Hospital should have been passed to HHTT which would then have allowed them to further examine this issue.

4.3.4 The safeguarding policies of NHS agencies refer to the potential risk to others but this is often a vague reference and does not always discuss the dynamics of domestic violence within the relationship of the patient.

4.3.5 Additionally, it is known in domestic violence cases that the threat of suicide by a potential perpetrator can raise the threat to the victim/partner and in many cases can result in the murder of that partner.[8]

4.3.6 There is no reliable prevalence data on domestic violence and abuse, but the Crime Survey of England and Wales (CSEW) offers the best data available. The 2013/14 CSEW found that, overall, 28.3% of women (an estimated 4.6 million women) have experienced domestic violence since the age of sixteen. However, official reporting of the Crime Survey of England and Wales underestimates the extent of domestic violence and underestimates its impact on women and men.[9]

[8] See Femicide in New York City 1990-1999, Victoria Frye, downloadable from hsx.sagepub.com at Durham University

[9] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/how-common-is-domestic-abuse/

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4.3.7 These statistics alone demand an effective response but what can also be seen in this case is that a focus on a single issue (e.g. an individual's mental health) does not lead to sufficient consideration of wider issues and the possible threat to others. This therefore leads to the recommendations below about safeguarding policies, understanding of the dynamics of domestic violence and information sharing.

4.3.8 Additionally, the HHTT at FL's request did not share full information with his GP surgery about his mental health and the fact that his girlfriend worked there. This is a professional boundary issue which should have resulted in further consideration with HHTT and an ensuing discussion with Avenues.

4.3.9 It must be noted that these events, where FL was discussing suicide, were many months before he took RB's life. It is difficult to assertively ascribe the action/inaction in 2012 directly to the act of murder in 2014.

4.3.10 However, it is not difficult to describe them as missed opportunities, for this is what they are.

4.4 Avenues' response and the period leading up to RB's death in 2014

4.4.1 The Avenues surgery is key to this review. The victim was a member of their staff and the perpetrator was a patient. The policies, processes and management are all areas that are problematic.

4.4.2 The surgery has been examined by the CQC and found to be operating to a good level but this review throws doubt on those findings. Areas such as record keeping, managing risk, health and safety and reporting concerns need further consideration. Specific policies around domestic violence are lacking and this gap is very relevant to this case.

4.4.3 The highly unusual and problematic circumstances surrounding the removal of FL from the practice list in May 2012 and his subsequent re-instatement show a disregard for policy (not contacting the police) and the safety of a member of staff.

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4.4.4 Also the practice relating to the treatment of FL's depression and the repeat prescribing of drugs, without effective reviews, is both poor practice and a missed opportunity to explore the context of his life – which significantly included a member of staff at the surgery. This being apparently known as evidenced by the letter from North Middlesex University Hospital.

4.4.5 Additionally, the separate review by the IMR author shows that employment practice needs improvement.

4.4.6 The role of the practice manager in this case is confused by his relationship with RB. There is no bar to social relationships with colleagues but he was in a position of authority, knew of the threat by FL (although possibly not the gravity of that threat) and had a duty of care to a member of staff. His actions seem inappropriate and require further examination, alongside the performance of the practice generally. This could possibly be conducted though CQC processes, NHS England's examination of the contractual position or under Health and Safety legislation.

4.4.7 The point has been made throughout this review by those working within the NHS that the generic role of practice manager is ill-defined and is the responsibility of those contracted to deliver the service, i.e. the GPs. This case demonstrates that this autonomy may require further consideration.

4.4.8 It was towards the end of 2013 and into 2014 before her death that RB was being possibly stalked and harassed by FL. As has been said above the nature of the calls made RB a high risk victim, albeit unknown to those agencies previously engaged with RB. There remains the possibility that the practice manager knew more about the context of this situation and had he adopted some form of professional safeguarding approach RB could have received more expert support. The relationship with the practice manager may have been the reason she did not seek different help at this point.

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4.5 Pembrey Medical Centre and their response to RB

4.5.1 Largely the practice was supportive of RB and gave her reasonable advice about seeking help for the domestic violence she was reporting. It also appears that her treatment for depression was thorough and helpful to the extent that in 2013 she was reporting that those problems were behind her. Of course we know that this was relative in the sense that other problems had arisen. A continuing approach to specific enquiry of people possibly experiencing domestic violence can be a useful way of assessing levels of risk and need.

4.5.2 The apparent lack of a domestic violence policy and clear referral/care pathway is an area where improvements could be made within this practice.

4.6 Diversity and help-seeking

4.6.1 As has been mentioned in this review there is no conclusive evidence of race or ethnic issues playing a negative part in the death of RB. Apart from a rare comment, it does not seem to have been a great consideration for any of the agencies. Bearing in mind the prevalence of those from black or afro-Caribbean communities suffering domestic violence (along with all women) this is disappointing, particularly when noting that they are less likely to access services. "There is little variation in the prevalence of domestic violence by ethnicity (Walby and Allen, 2004). However, survivors from black and minority ethnic communities are less likely to access statutory services, (Batsleer, *et al* 2002; Rai and Thiara, 1997)".[10]

4.6.2 Within any policy or practice relating to a response to domestic violence it would seem essential to address the issue of reduced help-seeking by those from minority ethnic groups.

4.6.3 This also leads to recognition of the need to adopt a Violence Against Women and Girls approach. Haringey are developing a 10-year strategy in this regard

[10] http://www.equation.org.uk/wp-content/uploads/2012/12/Working-with-Black-Women-Experiencing-Domestic-Abuse1.pdf

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and have adopted the Government definition of Violence Against Women and Girls. Policies relating to Violence Against Women and Girls must be developed across the partnership agencies with the inequality of violence towards women and its gendered nature being well-documented and requiring addressing.

4.6.4 Having said this, it is difficult to establish whether RB did not seek help because of her treatment, either as a female victim or a black woman (or possibly because of her relationship with a patient). The former possibilities exist however and this makes it necessary to address within new policies promulgated as a result of this review.

4.6.5 Specialist services know this to be a concern but are often unable, due to the narrowness of their funding and remit, to provide the breadth of support that would help a woman who is living in similar circumstances to RB.

4.6.6 FL spoke poor English and the lack of any offer (apart from the police described above) to facilitate discussions, reviews of his health and enquiries about his social history, and specifically his danger to others is highly regrettable. Unfortunately, it seems in this case that those more intrusive questions may not have been asked in depth in any event so, once again, offers to provide interpreting is a factor that must exist within a broader response to domestic violence.

4.7 Partnership

4.7.1 This case involves agencies across two London boroughs separated by some distance. This does make responses more complicated but the majority of the development that is now required seems to be centred around health organisations serving Haringey. As yet Haringey does not have a fully-formed coordinated community response to domestic violence and this may be of benefit as the recommendations from this report are implemented. Plans are in place to achieve this (including the Violence Against Women and Girls 10-year strategy) over the next year.

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4.8 Good practice

4.8.1 Despite other problems, the IDVA service at ADVANCE was consistent in its support for RB.

4.8.2 The London Borough of Haringey are developing approaches based on sound practice which will also recognise the lessons from this review.

4.8.3 In September 2014 the partnership in Haringey agreed to adopt the definition of Violence Against Women and Girls as used by the Mayor's Office for Policing and Crime and the Government. Work commenced on developing an integrated response to all strands of Violence Against Women and Girls (including domestic violence and abuse). Haringey's governance structure and arrangements for Violence Against Women and Girls have been significantly improved and the partnership is committed to implementing a coordinated community response to all forms of Violence Against Women and Girls.

4.8.4 As part of the work undertaken over the last 12 months the partnership has reviewed the existing domestic violence service arrangements and the care/referral pathway. A new pathway has been designed to reflect best practice. A new IDVA service contract has been commissioned by the council (in conjunction with the CCG) which will combine IDVA and IRIS provision.[11] IRIS will cover 25 GP practices in the borough initially for 3 years. This is due to be launched in May 2016.

4.8.5 Developments planned for 2016 also include:

- Launch of a Violence Against Women and Girls publicity campaign.
- Development of a 10-year Violence Against Women and Girls strategy.
- Commissioning of a domestic violence perpetrator service.

[11] http://www.irisdomesticviolence.org.uk/iris/about-iris/about/

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5. Conclusions

5.1 Preventability and predictability

5.1.1 It is possible to view many concluded DHRs and observe that a failure to understand domestic violence creates a gap between that limited understanding and effective practice. The consequent poor response can therefore be described as an aberration that fails to prevent domestic homicides when that outcome, prevention of death, is entirely attainable. In a strictly theoretical sense it is therefore possible to make the argument that every, or almost every such murder is preventable.

5.1.2 This case brings that argument into sharper focus. There are many reasons for believing that it was impossible to predict RB's death. Some of these factors are:

- The lack of knowledge of FL's potential to become a murderer.
- His previous lack of records about any history of violence.
- RB's lack of contact with support services.
- The distance between FL's threat to commit suicide (and towards his "girlfriend") and RB's eventual death.

5.1.3 These factors do, in fact, make it impossible to follow a trail of behaviour which could have predicted RB's death – as far as the gathered information allows.

5.1.4 This does not however deny the possibility that if opportunities had been grasped RB's death could have been prevented. Some of those opportunities in this case are:

- A broader approach to safeguarding, particularly when mental health is an issue, towards those connected to a patient, especially the intimate partner.
- Professional practice delivering an effective response to a duty of care for employees (e.g. the letter from North Middlesex University Hospital to FL's

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practice and RB's workplace).

- An understanding of the dynamics of domestic violence and the additional challenges faced by black women in seeking help.
- Domestic violence policies that are embedded in practice.
- Information sharing.

5.1.5 Therefore, whilst RB's death was not predictable it must be said that there were missed opportunities, albeit sometimes distant from the events of 2014, that could have protected her from FL, and her subsequent death. This would be true in many partnership areas where much development is still required but the various components of the NHS may have to travel a greater distance than other agencies. A coordinated response will help in achieving a successful journey.

5.1.6 This review does not seek to apportion blame by individuals but seeks explanations for actions and solutions to problems where they exist. Some of the support given to RB was kind and professional, and there is a suspicion that even advice she was given in her work setting was intended to help, if ultimately misguided.

5.1.7 It is also vital that the presence of suicidal thoughts or actions with any individual potentially means a heightened risk to others.[12] The safeguarding of others must form part of any response to such an individual.

5.1.8 The fact remains that the Avenues surgery did not protect RB's interests effectively in a number of ways and they must improve their practice and deal with the findings of this review.

5.1.9 All health services and particularly mental health services must address the wider safeguarding issue and apply a greater understanding of domestic violence in each case where there is a possibility it exists.

[12] The Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Model quotes Menzies, Webster and Sepejak 1985, and Regan, Kelly, Morris and Dibb, 2007 in relation to a perpetrator threatening suicide and the potential of heightened risk to others.

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6. Recommendations

Local – for the London Borough of Haringey and related agencies

6.1.1 The following recommendations are based on the findings of this review and are intended to deliver the changes that would have made a difference in this case. All recommendations will be part of an agreed action plan overseen by the Haringey CSP and the Violence Against Women and Girls Strategic Group.

6.1.2 The exception to this are those recommendations which are intended to have a national impact and which are identified below.

6.1.3 They do not include those changes implemented by the agencies who dealt with RB or FL during the period of 2008 – 2011. These have already been put into practice prior to the production of this report.

6.1.4 The first recommendation below elicited considerable debate amongst the Review Panel but there was agreement that the context of the Avenues surgery required some form of examination in the light of the findings of this review. It became clear that such a recommendation did not fit easily into the current structures and processes but it was essential that further expert and independent analysis of their practice be conducted.

6.1.5 **Recommendation 1.** That the CQC (supported by NHSE) undertakes a further inspection of the Avenues Surgery to consider the issues raised in this review along with their earlier inspection, especially around issues of management, supervision, domestic violence policies, Health and Safety and the role and oversight of non-clinical managers.

6.1.6 **Recommendation 2.** Utilising the NICE Guidelines and the findings around mental health in this review, all NHS services covering Haringey should develop (preferably jointly) an improved safeguarding policy that addresses not just the safety of the patient concerned, but any intimate partners or family members (especially given the dynamics of domestic abuse). This policy should include clear use of interpreters, where necessary.

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6.1.7 **Recommendation 3.** That Pembrey Medical Centre institutes a domestic abuse policy based on good practice and the NICE guidance.

6.1.8 **Recommendation 4.** That the Haringey Violence Against Women and Girls Strategic Group seeks to enhance its broader response to the issue of domestic abuse and wider VAWG issues –leading to a Violence Against Women and Girls Strategy and partnership VAWG policies.[13]

6.1.9 **Recommendation 5.** Family Mosaic to introduce a policy which includes a system of enquiry for all their clients to assess whether they are experiencing domestic abuse and to take appropriate action following any disclosure of abuse.

6.1.10 **Recommendation 6.** That this review is disseminated to the Safeguarding Boards in Haringey for consideration within their local strategies and consideration be given to further dissemination within London or nationally, especially in light of the additional responsibilities for adult safeguarding contained within the Care Act, 2014.

6.1.11 **Recommendation 7.** That all agencies involved in this review brief the employees who interacted with RB or FL about the findings of this review (and NHSE to be specifically responsible for informing the Avenues Surgery of the outcome of this review before publication).

National Recommendations

6.1.12 The following are recommendations which the panel wish to be instituted on a national basis. The Haringey CSP wishes to kept informed of the outcome of these recommendations.

6.1.13 **National Recommendation 1.** That any individual reporting suicidal thoughts within an NHS environment be routinely questioned about partners or those close to them to assess the risk to those individuals, in the light of the findings

[13] Ideally such policies will consider, with local partners, a broader Violence Against Women and Girls approach, as per the Government strategy

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of this review and record and respond to that risk appropriately, if necessary informing the police or MARAC.

6.1.14 **National Recommendation 2.** That proper recording of all such events within a NHS setting and the risk assessment leads to appropriate information sharing to other agencies that are in contact with either the potential victim or the client. The records must show a decision making process which has considered information sharing and shows the action taken.

6.1.15 **National Recommendation 10.** That all NHS practices institute a domestic violence policy based on good practice and the NICE guidance.

6.1.16 **National Recommendation 11.** That the Department of Health considers defining a specific role of practice manager (with appropriate job descriptions and person specifications) and provide appropriate guidance and support to GP Practices that utilise this function to ensure that such guidance is embedded in any contractual arrangement.

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Annex 1 – Domestic Homicide Review Terms of Reference for RB

This Domestic Homicide Review is being completed to consider agency involvement with RB and her partner, FL, following her death in March 2014. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

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

2. To review the involvement of each individual agency, statutory and non-statutory, with RB and FL during the relevant period of time: **01/01/2008 –date of the homicide**.

3. To summarise agency involvement prior to **01/01/2008**.

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

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

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

7. To commission a suitably experienced and independent person to:
   a) chair the Domestic Homicide Review Panel
   b) co-ordinate the review process

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c) quality assure the approach and challenge agencies where necessary
d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established Terms of Reference.

8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

9. On completion, present the full report to Haringey Community Safety Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be involved:
    a) Haringey Clinical Commissioning Group
    b) Nina Murphy Associates – IMR author for General Practitioner for the victim and perpetrator
    c) The nia project (Haringey IDVA Service)
    d) ADVANCE Advocacy service
    e) Solace Women's Aid
    f) NHS London
    g) London Borough Hammersmith and Fulham Children's Services
    h) London Borough Hammersmith and Fulham Housing Service
    i) Family Mosaic
    j) Barnet Enfield Haringey Mental Health NHS Trust
    k) North Middlesex University Hospital Trust
    l) Met Police Critical Incident Advisory Team – representing Borough Met police
    m) Homes for Haringey
    n) London Borough Haringey Community Safety
    o) London Borough Haringey Public Health
    p) LAS

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q) Change Consultancy (see below)

12. **Change Consultancy.** An independent equality, diversity and inclusion expert has been commissioned to inform the panel to help understand the victim's experience of domestic violence and identify any learning opportunities that may specifically relate or be relevant to her identity as a black woman and her experience of male violence.

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

Collating evidence

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

15. Each agency must provide a chronology of their involvement with the victim RB and the alleged perpetrator FL during the relevant time period.

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

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

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Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and wider family.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
    d) Analyse agency responses to any identification of domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the training available to the agencies involved on domestic abuse issues.

Liaison with the victim's and perpetrator's family

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

20. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

21. Coordinate with any other review process concerned with the children of the victim and/or alleged perpetrator.

Development of an action plan

22. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

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23. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

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

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

Confidentiality

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

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

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

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Annex 2 – Panel Members and Agencies Represented

Panel member	Agency
Anthony Wills, Chair	Associate, Standing Together Against Domestic Violence
Anna Carpenter, Tri Borough Service Manager	London Borough of Hammersmith and Fulham Children and Young People Services
Victoria Hill, Violence Against Women and Girls, Strategic Lead	London Borough of Haringey
Karen Ingala-Smith, Chief Executive Officer	nia
Kate Jones, Operations Manager	Family Mosaic
Femi Otitoju, Diversity Consultant	Challenge Consultancy Ltd
Mary Sexton, Executive Director of Nursing Quality and Governance	Barnet, Enfield and Haringey Mental Health Trust
LJ Winterburn, Operations Director	Solace Women's Aid
Melissa Altman, Operations Director	Advance Advocacy Project
Hazel Ashworth, Safeguarding Adults Lead	Haringey Clinical Commissioning Group
Pam Chisholm, Critical Incident Advisory Team	Metropolitan Police
Eve McGrath, Safeguarding Adults	North Middlesex University Hospital NHS Trust
Sheeylar Macey, IMR Reviewer	NHS England

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Vanessa Lodge, Director of Nursing	NHS England
Toby Graves, Head of Housing	London Borough of Hammersmith and Fulham
Eubert Malcolm, Head of Community Safety and Regulatory Services	London Borough of Haringey
Angie Middleton, Patient Safety Lead Mental Health	NHSE London

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Annex 3 – Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic, time bound) and for the completion and implementation of the Action Plan. The CSP will monitor the implementation and delivery of the Action Plan.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
What is the over-arching recommendation?	*Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)*	*How exactly is the relevant agency going to make this recommendation happen?* *What actions need to occur?*	*Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?*	*Have there been key steps that have allowed the recommendation to be enacted?*	*When should this recommendation be completed by?*	*When is the recommendation and actually completed?* *What does the outcome look like?*

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Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
That the CQC (supported by NHSE) undertake a further inspection of the Avenues Surgery to consider the issues raised in this review along with their earlier inspection, especially around issues of management, supervision, domestic violence policies, Health and Safety and the role and oversight of non-clinical managers.	Local	CSP to write to CQC to ask for an additional inspection, highlighting the failings of the practice CQC to undertake an additional inspection	Community Safety Partnership CQC	Letter from co-chairs of the CSP to the CQC CQC undertakes a further inspection	December 2016	Completed: Letter sent to CQC in January 2017. Completed: Following initial concerns raised during the DHR process, the Practice was re-inspected in December 2016. As the service is rated as requires improvement it will be re-inspected within six months to allow further scrutiny into the areas identified within the review.

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Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Utilising the NICE Guidelines and the findings around mental health in this review, all NHS services covering Haringey should develop (preferably jointly) an improved safeguarding policy that addresses not just the safety of the patient concerned, but any intimate partners or family members (especially given the dynamics of domestic abuse). This policy should include clear use of interpreters, where necessary.	Local	NHS services (including North Middlesex University Hospital and BEH) to review their safeguarding policies with a focus on mental health and domestic abuse)	North Middlesex University Hospital NHS Trust Barnet Enfield Haringey Mental Health Trust Haringey Clinical Commissioning Group	Review of existing safeguarding policies across each service/trust with development of new safeguarding policy across each service	December 2016	Completed: Whittington Hospital updated their policy in 2016. Completed: The NMUH safeguarding adult policy was updated and ratified at the NMUH internal safeguarding committee on the 1st March 2016 the DA policy was updated and ratified at the safeguarding internal committee on the 7th February 2017. Mostly completed:

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Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
						BEH have added an addendum to both their Domestic Abuse and safeguarding policies. They are waiting internal sign off but have provided evidence of amendments. Note – The trust did not develop a joint policy as per the recommendation as each trust has different requirements. However, all 3 work together on the Safeguarding Adults' Board Training and Development sub-

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						group to develop joint training on safeguarding and on domestic abuse.
That Pembrey Medical Centre institutes a domestic abuse policy based on good practice and the NICE guidance.	Local	Development of a robust domestic violence policy that ensures all staff have training in line with their responsibilities Pembrey to consider becoming an IRIS practice	Pembrey Medical Centre NHSE	Development of a DV policy based on NICE guidance Development of training for all staff on DV and the dynamics of abuse Scoping meetings with IRIS provider around support being provided by the commissioned provider to the practice	December 2016	Awaiting response from NHSE

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Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
That the Haringey Violence Against Women and Girls Strategic Group seeks to enhance its broader response to the issue of domestic abuse and wider VAWG issues – leading to a Violence Against Women and Girls Strategy and partnership VAWG policies.	Local	Development of a partnership VAWG Strategy with associated policies and procedures including HR and training standards for all agencies	VAWG Strategic Group	VAWG Strategy undergoing development	November 2016	Completed: VAWG Strategy developed and launched in November 2016
				VAWG HR policy agreed with HR and steps to development and disseminate	February 2017	Completed: VAWG HR Policy and Guidance sent to HR and Legal in March 2017
				VAWG minimum training standards for all agencies to be developed	February 2017	Completed: VAWG Training sub-group created and minimum standards to be developed by June 2017

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Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Family Mosaic to introduce a policy which includes a system of enquiry of all their clients to assess whether they are experiencing domestic abuse and to take appropriate action following any disclosure of abuse	Local	Development of appropriate domestic violence referral pathways and training for staff to understand risk and safety planning	Family Mosaic	Development of a DV policy for the whole organisation, not just floating support services Development of an appropriate referral pathway for all victim/survivors	December 2016	Completed: Routine enquiry question on assessment form and is included in the assessment and support planning policy. Domestic abuse is discussed as part of core training academy, plus additional stand alone training offered.
That this review is disseminated to the Safeguarding Boards in Haringey for consideration within their local strategies	Local	Briefing sessions and learning developed and disseminated to SAB and LSCB	VAWG Strategic Group LSCB and SAB business manager	Paper briefing developed for safeguarding boards DHR Panel members from	December 2016 (depends on the acceptance of the DHR findings by the Home Office)	Completed. Paper sent to LSCB and ASB based on all Haringey DHRs since 2011 and on research

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and consideration be given to further dissemination within London or nationally, especially in light of the additional responsibilities for adult safeguarding contained within the Care Act, 2014.				LSCB and SAB to attend the briefing session facilitated by the DHR Chair		conducted by the Home Office and Standing Together The DHR Chair has retired so the session content has been included in the safeguarding paper.
That all agencies involved in this review brief the employees who interacted with RB or FL about the findings of this review (and NHSE to be specifically responsible for informing the Avenues Surgery of the outcome of this review before publication).	Local	Develop a briefing session for agencies facilitated by DHR chair	Community Safety Partnership and DHR Chair	DHR Chair to facilitate a briefing for DHR panel members Panel members to brief any employees who interacted with RB or FL	Before publication (TBC depending on Home Office acceptance dates)	Completed

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That any individual reporting suicidal thoughts within an NHS environment be routinely questioned about partners or those close to them to assess the risk to those individuals, in the light of the findings of this review and record and respond to that risk appropriately, if necessary informing the police or MARAC.	National		Home Office			
That proper recording of all such events within a NHS setting and the risk assessment leads to appropriate information sharing to other agencies that are in contact with either the potential victim or the	National		Home Office			

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Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
client. The records must show a decision making process which has considered information sharing and shows the action taken.						
That all NHS practices institute a domestic violence policy based on good practice and the NICE guidance.	National		Home Office			
That the Department of Health considers defining a specific role of practice manager (with appropriate job descriptions and person specifications) and provide appropriate guidance and support to GP Practices that utilise this function to ensure that such guidance is	National		Home Office			

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embedded in any contractual arrangements						

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