Domestic Homicide Review

- Overview Report -

Commissioned by

Hammersmith and Fulham
Community Safety Partnership

Victim: "Jane"

Died: June 2016

Independent Chair and Report Author: Stephen Roberts QPM, MPA (Cantab)

Date Completed: March 2019

h&f
hammersmith & fulham

Contents

Jane was "a loving person who held the family together. It was always family first and she always looked after her kids."

Tribute to Jane from one of her children

Preface

The Independent Chair and Review Panel would like to begin this report by expressing their sympathy to the family of Jane and thanking them, together with others who have taken part in this Domestic Homicide Review (DHR), for their involvement, contributions and patience.

The Independent Chair would also like to thank the Review Panel for their participation in this DHR.

This is a report of a Domestic Homicide Review (DHR) conducted under the terms of Section 9 of the Domestic Violence, Crime and Victims Act 2004. The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- A person to whom [they were] related or with whom [they were] or had been in an intimate personal relationship, or
- A member of the same household as [themselves],

with a view to identifying the lessons to be learnt from the death.

The report uses the cross-government definition of domestic violence and abuse (DA) as issued in March 2013. The definition states that domestic violence and abuse is:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

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

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Jane, a resident of Hammersmith & Fulham (H&F), prior to the point of her death at the hands of her partner, John, in June 2016. John died by suicide immediately after killing Jane.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was offered or accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 A decision was made by H&F's Community Safety Partnership (CSP) to commission this review, following notification by the Metropolitan Police Service, because the circumstances of the homicide fell within the terms of the above legislation.

1.4 The review considers what has been learned of both Jane and John. Prior to the homicide, neither Jane nor John had come to the notice of any agency in the context of domestic abuse.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.6 A DHR does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

Timescales

1.7 The DHR was formally commissioned by the Hammersmith and Fulham Community Safety Partnership on 17th August 2016. All agencies were asked to secure whatever material they might have to contribute to the review and, where appropriate, commence their own Individual Management Reviews (IMR).

1.8 Completion of the review was considerably delayed beyond the six-month limit specified in the guidelines. These delays were the result of particular factors:

- The time taken to negotiate and arrange discussions with family members and friends, some of whom lived abroad. Seeking family views on the draft report entailed considerable additional delay;
- Delays in access to medical records, eventually resolved by NHS England. It should be noted that the delays were the result of the relevant Practice Manager (who was unaware of current guidance) exercising proper caution in disclosing medical records;
- Identifying appropriate specialist Black and Minority Ethnic (BME) VAWG community-based groups with which to discuss the needs of BME women relevant to this review;
- Additional IMRs were required at a late stage of the review;
- The need for additional panel review meetings;
- Achieving the agreement of the Review Panel on the content and language of the report; and
- Immediately prior to the presentation of the review reports to the CSP, senior Children's Social Care staff re-examined case records and discovered additional information which had not been provided to the review at an earlier stage. The discovery necessitated amendments to the report to ensure its accuracy and completeness.

1.9 The Independent Review Panel gave final approval of the Overview Report and Executive Summary via email in March 2019. The Overview and Executive Summary reports were taken to the Community Safety Partnership on 7th June 2019 and formally agreed in September 2019 following a request for amendments by the CSP. The Home Office was updated as to this fact on 11th August 2019. Following the completion of agreed changes, the DHR was submitted on 27th September 2019 to the Home Office Quality Assurance Panel for review and approval.

1.10 The Home Office provided notification and approval for publication on 30 November 2020. The Home Office letter is included in Appendix D.

Confidentiality

1.11 The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published.

1.12 As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved.

1.13 The pseudonyms were chosen by the Independent Chair in consultation with the family member who engaged with the review.

1.14 The Home Office DHR Report Guidance recommends using pseudonyms rather than initials in reports. However, in relation to Jane's children, the Independent Chair and Review Panel felt, by way of exception, the anonymity of the children would be best served by the use of initials in this instance. This was deemed necessary given the allegation and disclosure of sexual abuse. The protection of the child and their identity and the wider family context was viewed as paramount.

2. Methodology

Terms of Reference

2.1 The review was guided by the following terms of reference:

- To establish what lessons may be learned from the case regarding ways in which local professionals and agencies worked individually and collectively to safeguard victims.
- To determine how those lessons may be acted upon.
- To examine and where possible make recommendations to improve risk management mechanisms within and between all relevant agencies.
- To identify what may be expected to change and within what timescales.
- To assess whether the relevant agencies have appropriate and sufficiently robust procedures and protocols in place and the extent to which they are understood and adhered to by their staff, including an examination of the metrics and

management information mechanisms in relation to risk assessment and management.

- To improve service responses including, where necessary, changes to policies, procedures and protocols.
- To enhance the overall effectiveness of efforts to reduce domestic abuse and its impact on victims through improved inter and intra agency working.
- To maximise opportunities for fast time learning and overall partnership improvements as well as medium and longer-term enhancements.

2.2 The Review panel agreed that the focus period for the review should be between September 2006 and Jane's homicide in June 2016. The start date enabled the allegation of sexual assault of one of Jane's children by John to be considered within the review, since this is regarded as a significant event in the course of the tragedy. Events outside this timeframe have been included in the review to provide an appropriate context.

Contributors to the Review

2.3 On notification of the homicide, local agencies were contacted and asked to check for their involvement with Jane and / or John and to secure their records.

2.4 Those agencies that reported having no contact with either Jane or John prior to the homicide included:

- The borough Public Health - Substance Misuse Unit
- West London Mental Health Trust
- National Probation Service
- Community Rehabilitation Service
- Victim Support Service
- The borough Safer Neighbourhoods Unit
- Angelou Partners
- The borough MARAC
- The borough Anti-Social Behaviour Unit

- The Metropolitan Police

2.5 IMRs were requested from:

- the Family GP Practice (which had provided care for both parties)
- H&F Children's Services
- H&F Housing Department

The IMRs were of a suitable quality and content. IMRs were not conducted by anyone directly involved with the victim, the perpetrator or either of their families or by an immediate line manager of any staff involved. In addition to the above, formal submissions were also provided by:

- Standing Together (second-tier DA charity)
- The Clinical Commissioning Group
- Pinnacle Group (borough housing provider; part of H&F)

All three organisations provided helpful additional material and context which is reflected in the review and ultimately in the recommendations.

2.6 In addition to the above, the following material was made available:

- The MPS provided a copy of the report prepared for HM Coroner, detailing the immediate context of the incident and what could be discovered of the events within the home leading up to the deaths.
- The MPS also provided information on allegations of crime made by one of Jane's children. A short report was provided in lieu of an IMR.
- Access was granted to the records of H&F Children's Social Care.
- With the assistance of NHS England, access was given to the GP and hospital records of both John and Jane.
- Housing records for the address occupied by Jane and John covering only routine management matters were made available by Pinnacle Trust.

2.7 The borough Violence Against Women and Girls Strategy 2015 to 2018 was examined together with the 2015/16 and 2017/18 VAWG Annual Reports. The 2018/19 VAWG Action Plan was also assessed.

2.8 In order to assess the accessibility of advice to members of the public, the relevant H&F websites were examined. Additionally, a dip sampling exercise was conducted by the Independent Chair. The exercise was undertaken on a weekday evening between 5.00pm and 7.30pm. Each medical centre/GP practice, pharmacy and local supermarket in the vicinity of Jane's flat was visited to search for any publicly available written material offering advice and/or contact details for DA services. At each medical centre, notice boards were examined for such advice and the reception staff on duty spoken to.

Family, Friends, Work Colleagues and Wider Community

2.9 Jane was the mother of three children all of whom were adults at the time of the tragedy, one of whom lived at the address where the tragedy took place. Throughout this report the three siblings are referred to as Child A, Child B and Child C. The Independent Chair met two of the three children and members of the extended family at Jane's inquest. He explained the nature of a Domestic Homicide Review and his role.

2.10 At the time of the inquest, family members were understandably too distressed to engage further with the review. In the weeks following the inquest, the Independent Chair wrote to the family members (enclosing the explanatory DHR Home Office leaflet) via their MPS Family Liaison Officer (FLO), explaining the nature of the review and seeking agreement to make contact. The request was unsuccessful. The FLO also explained the support available from Advocacy After Fatal Domestic Abuse (AAFDA).

2.11 In a further attempt to engage the family, the Independent Chair contacted one of the adult children by telephone. At the time when the contact was made, this family member agreed to a further telephone conversation the following day, but when the Independent Chair attempted to re-contact, three separate calls spread over a few hours were all rejected. Three text messages failed to elicit contact. A year later, another of the adult children (Child A) unexpectedly contacted the Independent Chair by text message and agreed to meet to discuss the relationship between Jane and John and explain something of the history of the family. Two planned meetings were cancelled by Child A at very short notice (due to Child A's childcare issues) but a meeting took place several weeks later, in May 2017. At this meeting, the possibility of engagement with other family members was also discussed. Initial indications that one of Jane's siblings would be prepared to meet the Independent Chair. On the advice of Child A, the Independent Chair tried to make contact by telephone, but three calls were all rejected. Despite the best efforts of Child A, no further family involvement was achieved. Child A had indicated that further contact

with the Independent Chair should be via e-mail. Despite several attempts, e-mails to the address which had been supplied went unanswered. Finally, in March 2018 the Independent Chair sent a copy of the draft Overview Report to Child A by e-mail, asking for comments. No response was received. It must be emphasised, however, that without the assistance of Child A, a meaningful review would have been almost impossible.

2.12 A further attempt to re-establish contact with Child A was made by the Victims' Programme Coordinator on 1st March 2019 by letter (sent via email) upon completion of the final overview report, inviting them to provide any further comment. No response was received to this contact. After amendments were made to the report in September 2019, the updated version was sent via email to Child A for comment.

2.13 The CSP will write to the family again prior to the publication of the Overview Report and Executive Summary. This is to ensure there is an opportunity to feedback and debrief with family members. A copy of the embargoed Overview Report will be provided to the family at this time.

2.14 The review also benefits from information from a colleague of Jane and a colleague/friend of John. Contact details of these colleagues were provided by the MPS Homicide Investigation Team. These individuals made it clear they did not wish to engage with the review in any way or to meet the Independent Chair. The offer of advocacy support was considered inappropriate. Since both individuals had given evidential statements giving background information about Jane and John, this material was used to inform the portrayal of Jane, John and their relationship.

Review Panel Members

2.15 An independent Review Panel was established. Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

2.16 In addition to the Independent Chair, the Review Panel members were:

Name	Job Title	Agency
Sally Jackson	Partnership Manager	Standing Together Against Domestic Violence
Felicity Charles[1]	Victims' Programme Coordinator	H&F, Community Safety

[1] Came into post in 2017, previously the H&F CSU was represented by Kate Delaney.

Name	Job Title	Agency
Caroline Birkett	Head of London Services	Victim Support
Guy Sanderson	Head of Service	H&F, Pinnacle Trust
Lorren Stainton	Safeguarding Programme Officer	NHS England
Janice Cawley	Detective Inspector	Metropolitan Police, Specialist Crime Review Group
Anna Carpenter	Head of Safeguarding, Review and Quality Assurance	H&F, Children's Social Care
Pragna Patel	Director	Southall Black Sisters

2.17 Representatives from Hammersmith and Fulham Council's Anti-Social Behaviour Unit and Adult Safeguarding teams attended the first panel meeting but were not required as part of the substantive panel.

2.18 The Violence Against Women and Girls (VAWG) Strategic Lead, also attended one panel meeting and provided comment on the report.

2.19 The Review Panel met on 6th October 2016, 7th November 2017, 4th September 2018, 6th December 2018 and gave final approval via email in March 2019. Between October and 2016 and November 2017, the Independent Chair met with agencies independently and correspondence occurred by phone, in-person and via email with agencies. This occurred individually and collectively with partners. Based on the information ascertained during this period, the Independent Chair drafted the overview report. Following a change in Council staff overseeing the delivery of the review in October 2017, a request was made to the Chair for additional panel meetings to be convened to discuss the review collectively as a panel. As a consequence, there were three further panel meetings.

2.20 Southall Black Sisters (SBS) was identified as an appropriate specialist BME VAWG organisation to assist in the review. SBS is a voluntary sector organisation which campaigns on (inter alia) domestic abuse issues and especially in relation to women from Black and Minority Ethnic communities. The draft Overview Report formed the basis of detailed discussions with SBS. These discussions have informed the review and provided a wider perspective on the particular needs and barriers facing BME women experiencing domestic abuse. A representative of SBS was invited to join the Review Panel.

2.21 Both the Clinical Commissioning Group (CCG) and the GP Practice with which Jane and John were registered, were contacted at the start of this review. The CCG had no record of contact with either Jane or John and declined membership of the Review Panel – it should be noted that throughout the process, the CCG were consulted and in fact made significant contributions to the review and its recommendations. The GP Practice was unable to provide representation on the Review Panel due to a shortage of doctors and the imminent retirement of one of its senior practitioners.

Independent Chair and Author of the Overview Report

2.22 Stephen Roberts, QPM, MA (Cantab), was appointed by the Hammersmith and Fulham Community Safety Partnership as Independent Chair of the Review Panel and Report Author. He is a former Deputy Assistant Commissioner of the Metropolitan Police (retired 2009), now working as a private consultant. He has extensive experience of partnership working at borough and pan-London level. He is a former Director of Professional Standards and Director of Training and Development for the Metropolitan Police. He is entirely independent of the Community Safety Partnership and all other agencies involved in this review. He has completed training for the role (including an update for the 2016 Guidance) and has successfully chaired and authored domestic homicide reviews for other Community Safety Partnerships.

Dissemination

2.23 Once approved by Home Office, the Executive Summary and Overview Report will be published online on the Council's website: https://www.lbhf.gov.uk/crime/domestic-violence/fatal-domestic-violence .

2.24 The Executive Summary and Overview Report will be shared with key local statutory and partnership boards including:

- Community Safety Partnership Board
- Safeguarding Adults Board and the board's Serious Case Review Subgroup
- London Safeguarding Children's Partnership
- Health & Wellbeing Board
- VAWG Strategic Board and the Risk and Review and DHR subgroups

2.25 They will also be shared with the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

2.26 The recommendations will be owned by the CSP. The Community Safety Unit at H&F will be responsible for developing an action plan in response to the

recommendations and monitoring progress, as well as hosting a learning event to bring together local partners to consider the DHR.

2.27 Actions and learning events will be taken forward in the context of the wider partnership. This process will be coordinated through the Risk and Review Group and the DHR Subgroup. In December 2019 an event was held for professionals in relation to DHR learning, which incorporated themes and learning from this review.

2.28 One-page learning summaries will be created for professionals and used to aid learning across the partnership.

Parallel Proceedings

2.29 An inquest was held in respect of the death of Jane on 20th October 2016. HM Coroner concluded that Jane had been unlawfully killed. It was his conclusion that there had been no evidence of any "red flags" which agencies should have noticed and thus that there had been no reasonable opportunity for any intervention. HM Coroner concluded that John had taken his own life.

3. Case History and Chronology (The Facts)

3.1 The principal subjects of this report are the victim and perpetrator referred to as "Jane" and "John" whose identifying particulars are:

Jane	Born: 1966 Caribbean Island	Resident of Hammersmith & Fulham	Black, Afro Caribbean	No known religious affiliations
John	Born: 1966 Caribbean Island	Resident of Hammersmith & Fulham	Black, Afro Caribbean	No known religious affiliations

Precise dates are given unless either unavailable or liable to compromise anonymity.

3.2 Jane arrived in the UK in 1996 and was well established with her three children by the time John came to settle here.

3.3 Both Jane and John were born on an island in the Caribbean group and spent their early lives there. Jane knew John initially as a family friend, while they both lived on the island. While still on the island, they formed a relationship, although it is not known exactly when. John worked for some years in the United States of America (USA). He came to live in the UK from the USA, entering in 1998.

3.4 It is reported that John was known to have perpetrated domestic abuse against a previous partner while still in the Caribbean. Nothing has been discovered to suggest that any abuse perpetrated by John prior to his arrival in the UK was known to the authorities in the Caribbean.

3.5 Jane is described by one of her children as, “A loving person who held the family together. It was always family first and she always looked after her kids.” The culture of the extended family is described as “very private.” Several members of that extended family, some of whom had also settled in the UK, were aware that John had perpetrated physical violence against Jane over a number of years. One member recalls, in about 2000, witnessing shouting between the couple and the fact that John had hit Jane in the face. According to this account, it was only Jane’s intervention that prevented this witness from stabbing John.

3.6 Jane and John were married in 2007, at which time, John moved into the flat occupied by Jane. Jane had three children (Child A, Child B and Child C) by a previous relationship. Child C lived with Jane and John.

3.7 Jane received a number of financially attractive job offers in the UK and US. She was prevented from accepting them by John on the grounds that they would have entailed more travel than was required for her local employment. Whilst it is not possible to assess the extent of the pressure exerted by John, the fact that he sought to limit Jane’s employment opportunities may be regarded as evidence of some degree of coercive and economic control.

3.8 On 23.09.2010 an allegation was made that John had assaulted Jane’s Child C some years previously, when Jane herself was out of the UK. Child C told their sibling (Child A) what had happened. The following day, with Child C’s agreement, and in John’s presence, Child A told their mother about the allegation. John refused to leave but denied the allegation. Child C temporarily moved out of the family home and stayed with their elder sibling (Child A) and their partner. Child C said the assault had taken place some four years earlier. H&F Children’s Social Care (CSC) was informed and held an immediate joint strategy discussion with the local police Child Abuse Investigation Team (CAIT), at which it was agreed that CSC would lead on the investigation. The sexual assault was recorded as an allegation of crime by the MPS.

3.9 On 28.09.2010, a CSC Social Worker visited Child A’s home and interviewed Child C, who disclosed that they had been sexually assaulted up to ten times by John when aged 12.

3.10 The incidents of sexual abuse were described as touching over the victim's clothes. This, and the historic nature of the allegations, rendered a forensic examination inappropriate and unjustified. The police sought to interview the victim but they declined.

3.11 CSC further considered the allegations as part of an investigation under Section 47 of the Children Act 1989 and conducted a Core Assessment. Jane was seen and spoken to by the social worker several times as part of the assessment. John was invited to attend the CSC offices for interview but declined. Ultimately, the social worker concluded that the family had acted protectively by reporting the allegations and agreeing that the young victim should stay with another family member – the case was accordingly closed (on 15.11.2010). Counselling support via West London Action for Children was offered to the family, on a voluntary basis, in order that Child C might receive emotional support for the abuse they had experienced. The offer was accepted but because the case was closed there would have been no CSC follow-up. Information gathered from one of Jane's adult children during this DHR suggests that John had been violent toward them in the past. During the 6 – 8 week period of the investigation and assessment, Jane did not disclose any allegations of domestic abuse by John. There is no evidence on the file to determine if Jane was asked directly about the nature and dynamics of her relationship with John, nor is there any indication about how this might have been approached and explored with her. Research shows that victims are less likely to make disclosures of domestic abuse unless directly asked.[2]

3.12 John was granted indefinite leave to remain in the UK in 2012, despite having been the subject of the allegations by Child C. It should be noted, however, that the allegations were unsubstantiated and unsupported by forensic or other evidence: indeed, the CSC records indicate that Child C was upset because Jane chose to believe John's account rather than that of Child C. In such circumstances, even had Home Office been informed/aware of the allegations, they could not have constituted grounds for refusal of leave to remain.

3.13 On 14.09.2012 Child C presented to H&F as homeless. However, the child chose to leave the office before a social worker could undertake any assessment. Jane was contacted by the Duty Social Worker. This is an example of good practice, whereby the Duty Social Worker contacted Jane, having made the link with the previous incident. Records indicate that Jane's perspective was that the child did

[2] Westmarland, N., Hester, M. and Reid, P. 2004. Routine Enquiry about Domestic Violence in General Practices: a Pilot Project http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/rk6280finalreport.pdf

not like the strict boundaries that had been imposed and thus decided they would prefer not to live at home. There was no discussion at this point about whether John was in the home or about the child's relationship with John.

3.14 By 2015 the relationship between Jane and John had deteriorated. He was spending weeks at a time away from the family home and Jane had decided that the couple should separate. By April 2016 Jane had become more certain that she would seek a divorce and by early June (at the latest) she had told her children and confided in a colleague about her plans. John was aware that Jane was seeking separation/divorce. Separation is a risk factor linked to homicide, with 2017 Femicide Data[3] finding that 55% of women killed by their ex-spouse were killed within the first month of separation.

3.15 In his evidential statement to police, a colleague of John described him as "a ladies' man" who frequently "chatted up" women and who had a long-term relationship with another woman. John confided in his colleagues that his wife would "kill him," if she discovered he was seeing other women. The police homicide investigation did not include the identification or tracing of this woman. Tracing of this woman by the review would have constituted an invasion of her privacy. Additionally, the necessary investigative resources were not available to the Chair. John was known by his colleagues as very even-tempered and someone who would simply smile at people if they got angry with him. Colleagues never saw or heard any evidence that John had been abusive to Jane. Women's Aid note that, "perpetrators are often well respected or liked in their communities because they are charming and manipulative[4]" and this can prevent people from recognising the abuse or victims from seeking help for fear of not being believed.

3.16 In discussions with his colleague, John confided that his wife asked him to sign divorce papers when she had returned from a holiday in America. These requests were repeated over a period of weeks. In the weeks before the homicide, John had suffered an injury at work. His colleague, knowing that Jane would not welcome John back at their flat, offered John accommodation at his own home. John declined the offer, telling his colleague that, "If she thinks I'm going after all that work (i.e. decorating the flat) in there, she's crazy."

[3] Femicide Census (developed by Karen Ingala-Smith and Women's Aid Federation of England working in partnership, with support from Freshfields Bruckhaus Deringer LLP and Deloitte LLP). (2018) *The Femicide Census: 2017 findings. Annual Report on cases of Femicide in 2017*. Published online: Karen Ingala Smith and Women's Aid

[4] Women's Aid (2015) https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

3.17 Jane sometimes confided in a friend at her work. Apparently, Jane was aware that John had a relationship with another woman but was "not unduly worried." The friend was not aware of any indicators (physical or otherwise) of domestic abuse and Jane did not make any disclosures.

3.18 By mid-June 2016, Jane had told John that she wished him to leave their flat permanently. On the same day Jane engaged a locksmith to attend the following morning to change the door locks. Jane's colleague recalls hearing Jane make the arrangements but did not get the impression that Jane thought her separation from John would be in any way difficult.

3.19 That night, Jane's resident child heard shouting and screaming from their mother's bedroom. John had repeatedly stabbed Jane and then turned the knife on himself. Police were called and arrived at about 0430 to find Jane and John both dead.

3.20 At the time of the homicide both Jane and John were aged 50. Jane worked as an Office Manager at a local firm. John was a painter and decorator.

3.21 Toxicological evidence indicates that though neither Jane nor John had recently consumed alcohol; John had used cannabis prior to his death. John's use of illegal drugs was substantiated by a witness in the police enquiry who indicates that John used both cannabis and cocaine. There is no evidence from medical records or elsewhere that John considered his drug use as problematic or that he was offered or had sought help.

3.22 As part of this review, Jane's and John's medical records were examined. There is no indication in Jane's record of any domestic abuse enquiry or disclosure. Jane's medical record does, however, contain an unusually high number of clinical entries (1,450) and a large volume of correspondence. It is evident from the record that Jane presented to her GP Practice often and with multiple symptoms. Her medical history included multiple panic attacks, counselling referrals, possible non-accidental injuries (e.g. falling down the stairs) and unplanned pregnancies. These are all factors which have been highlighted in research as potential indicators of domestic abuse and which have been found as present in a review of DHR cases[5]. Jane's medical record does not contain any note about whether she was asked specifically if she was experiencing domestic abuse or that she may benefit from additional support regarding reproductive health. In a consultation in October 2013, a GP questioned Jane about possible causes for her multiple attendances

[5] Standing Together Against Domestic Violence (2016) 'Domestic Homicide Review Case Analysis' https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5efb6ce1d305a44006cb5ab9/1593535715616/STADV_DHR_Report_Final.pdf

and variety of symptoms. She apparently responded that she was "happily married with a full-time office job". As part of the IMR process undertaken by Jane's GP Practice, records of local Psychology Services, and two local counselling agencies, were checked but there is no trace of Jane accessing these services.

3.23 The GP Practice IMR mentions that its doctors have received a great deal of training since 2010 in matters of domestic abuse as well as a briefing in the IRIS[6] system in 2013/14 – however IRIS is not implemented locally. It is noteworthy that of all the GP services visited in the sampling exercise aspect of this review, only Jane's practice displayed an informative poster about where victims of abuse could seek help.

3.24 John's medical records contain no suggestion that he might have been considered as a risk to his partner.

Emerging Themes

3.25 The case history indicates the emergence of a number of identifiable domestic abuse risk factors:

- evidence of some degree of coercive control and economic abuse in the relationship between Jane and John;
- allegations of John's physical violence towards Jane and her children;
- allegations of sexual abuse by John towards one of Jane's children;
- Jane's multiple attendances at her GP Practice with unplanned pregnancies and a variety of injuries from falls etc.;
- imminent separation pending Jane's formal application for divorce.

Diversity and Equality

3.26 *Race*: As indicated at para. 3.1 both Jane and John were black afro-caribbeans. Criminological research[7] on a sample of 207 domestic homicides in London indicates that when compared with London's general ethnic makeup, there is an over-representation of people of Black African/Caribbean origin as both victims and perpetrators. Similar disproportionality is found in equivalent studies in the

[6] http://www.irisdomesticviolence.org.uk/iris/
[7] Love & Lethal Violence – Sebire 2013 (http://library.college.police.uk/docs/theses/SEBIRE-Love-and-lethal-violence-Oct-2013.pdf)

US[8]. It must be acknowledged that the term "Black African/Caribbean" encompasses a variety of cultures and thus varied relational dynamics. More research would be helpful in clarifying the relationship(s) between ethnicities, cultures and economic circumstances.

3.27 Although, tragically, it is not possible to know from Jane's perspective the way in which race affected her particular situation, it has been critical for the Review Panel to consider the way her experience as a Black woman may have impacted on her experience of abuse, in particular her ability and confidence to access help and support but also the way in which help and support was perceived and/or provided to her. It has also been important to consider the intersection of race and gender together. Likewise, while we cannot know John's perspective, consideration must also be given to the context that race provides in terms of his own help seeking patterns and perceptions or the response of services.

3.28 BAME women's experience of violence and abuse is often intersecting and overlapping. It is evident that victims of domestic abuse from BAME communities experience greater barriers to disclosing their situations and accessing support[9] due to such factors as institutional racism, inequalities (e.g. in health provision), mistrust of social support agencies (especially the Police) which results in services being – or being perceived as – inaccessible. Imkaan also note barriers including fear; not connecting their own experiences as VAWG prior to being linked in with specialist support; and not knowing about the types of support that exist, including a lack of publicity on BAME VAWG services[10].

3.29 While it has not been possible to know the extent in which such factors impacted on decision making for Jane or John, the Review Panel considered the lessons that could be learnt from this case relating to local provision for BAME communities more generally – specifically, awareness raising, accessibility and provision of specialist services. Specific efforts are required to increase identification of BAME victims and families and to ensure access to specialist 'by and for' support.

3.30 *Marriage and civil partnership*: Jane and John were married. Marriage as an institution has been associated with specific gendered norms and roles in relationships. Separation was also highlighted as an issue as Jane was intending to divorce John.

[8] "Female Intimate Partner Homicide – a population-based study" - Moracco et al, 2003

[9] Imkaan (2013) Beyond the Labels: Women and girls' views on the 2013 mayoral strategy on violence against women and girls https://drive.google.com/file/d/0B_MKSoEcCvQweFdIaWd0QTd5Nk0/view

[10] ibid

3.31 *Pregnancy and maternity:* The GP report references a number of unplanned pregnancies with associations of separation and low mood. Unfortunately, no information was available as regards what support was offered to her thereafter. There are well documented links between domestic abuse and pregnancy. Pregnancy, particularly unplanned pregnancy, is a risk factor for domestic abuse[11] and NICE Guidance[12] highlights multiple unplanned pregnancies as an indicator of domestic abuse.

3.32 *Sex:* Jane, female, was murdered by John, who is male. The majority of victims of domestic homicides (homicides by an ex/partner or family member) are female (70%)[13]. Domestic abuse is gendered, with women being at greater risk in terms of frequency, severity and impact, experiencing higher rates of repeated victimisation and being at great risk of serious harm.[14]

3.33 There is no information available to the panel to indicate age; religion or belief; sexual orientation; gender reassignment or disability were issues in this review.

4. Overview

4.1 As previously noted, whilst there is evidence that John was violent towards Jane and her children over a period of several years, neither Jane nor John had come to the notice of any agency in the context of domestic abuse. Other than in respect of entirely routine housing matters, the only significant engagements of any member of the household with official agencies were:

- Jane's extensive presentations at her GP Practice (and subsequent referrals for hospital consultations), including four presentations, between 1999 and 2006, for unplanned pregnancies.
- The allegation, made in 2010, that at some time in 2006, John had sexually assaulted one of Jane's children (Child C). The allegation was followed up,

[11] Gottlieb, A. 2012. 'Domestic violence: a clinical guide for women's healthcare providers.' The Obstetrician & Gynaecologist. 14:197–202

[12] NICE (2014) Domestic Violence Abuse and Multi Agency Working https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621

[13] Office for National Statistics (ONS). (2017) Domestic abuse in England and Wales: year ending March 2017. Published online: ONS

[14] Walby, S. and Towers, J. (May 2017) 'Measuring violence to end violence: mainstreaming gender', *Journal of Gender-Based Violence*, vol. 1, no.

producing further allegations that John had in fact multiple sexual assaults on the same child.

- The presentation of Child C at the offices of H&F as homeless in 2012.

5. Analysis

5.1 The Coroner at Jane's inquest determined that she was unlawfully killed by John and that he subsequently died by suicide. The psychological phenomenon known as "outcome (or hindsight) bias" is a common feature of the way in which those analysing a sequence of events allow their knowledge of the outcome to influence their beliefs about the correctness of decisions prior to that crisis point. The phenomenon might be expected to apply with particular force in a case such as this, where deaths have occurred. In this case, however, HM Coroner concluded, there were no "red flags" that were, or should have been, identified by the agencies in relation to the risks within the relationship between Jane and John.

5.2 This review has noted the presence of a number of possible indicators of abuse, including high risk indicators, as well as missed opportunities for professionals to have enquired about domestic abuse. The fact that opportunities were overlooked cannot, however, be taken as proof that more diligent efforts would have averted the tragedy. It is known that victims of abuse (and especially victims from ethnic minority communities) face a variety of factors which inhibit disclosure of abuse even when asked directly. What this review does offer to practitioners is a tragic illustration of the possible consequences of failing to seize every opportunity to identify and support victims.

5.3 There is evidence that Jane's immediate family had some knowledge of John's past domestic abuse against a former partner when he, Jane and many of her family lived in the Caribbean. According to a family member, Jane experienced abuse from John both before leaving the Caribbean and once they were living in the UK. This links to research which highlights that members of 'informal networks', which may include family, friends and/or colleagues, can often hold vital information about the context that may not be known to formal agencies[15]. During this period, Jane engaged with H&F Children's Social Care in connection with the allegation that John had abused one of her children. This period of engagement

[15] Standing Together Against Domestic Violence (2016) Domestic Homicide Review (DHR) Case Analysis. http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf

with CSC was an opportunity for the social worker to explore the family dynamics. There is no information on the file to indicate that Jane disclosed or was asked directly about domestic abuse. A possible explanation is provided by Standing Together, from that organisation's wide experience of abuse cases, is that survivors often report fear that their children may be removed from their care if they disclose domestic abuse. It is incumbent on professionals to be aware of indicators and risk factors and to enquire safely.

5.4 The London Child Protection Procedures[16] acknowledge research linking child abuse with domestic abuse between partners – i.e. a significant proportion of families in which there is abuse of children, domestic abuse is also a feature. Given this body of evidence there was an opportunity for the social workers dealing with Jane's child's case to be professionally curious about the relationship between Jane and John and to consider domestic abuse enquiry. Disclosures are more likely when women are directly asked about their experiences of domestic abuse[17].

5.5 The IMR provided by CSC identifies the fact that the Section 47 enquiry into the allegation of assault was closed without checks being made on either adult. The case file shows that attempts were in fact made by the Social Worker to obtain dates of birth for both Jane and John, but these attempts were unsuccessful. The family could not be engaged with the investigation and the information could, therefore, not be obtained. None of the reports received by CSC from other agencies included the dates of birth for Jane or John. Checks were requested and run by the police but without dates of birth, completing checks was not possible. There appears to have been no exploration of the possibility that John had been violent toward the family. Recommendations 8 (a-d) address these issues.

5.6 A discrepancy in information recorded by CSC and the police Child Abuse Investigation Team (CAIT) was identified in relation to the allegations of sexual assault on Child C. At the point of the joint strategy discussion between CSC and CAIT, agencies were aware of a single allegation of sexual assault. The home visit conducted by CSC five days later, however, revealed a disclosure of multiple allegations of sexual assault. While it is evident that there was ongoing information sharing between CSC and the lead Police Officer in CAIT, it was noted that this could have been explicit with regards to the multiple allegations of sexual abuse. There is no evidence, however, of this being a systemic issue. Furthermore, the re-examination of the CSC case record has evidenced the fact that several

[16] London Child Protection Procedures 2017, section 28.18.2 & 3

[17] Price, S. & Baird, Kathleen & Salmon, Debra. (2007). Does routine antenatal enquiry lead to an increased rate of disclosure of domestic abuse? Findings from the Bristol Pregnancy and Domestic Violence Programme. Evidence Based Midwifery. 5. 100-106. 10.7208/chicago/9780226680576.003.0020.

attempts were made to obtain a formal statement from Child C, using the established relationship between with the Social Worker. Child C declined to meet the officer or to make a formal statement but was encouraged to contact the officer at any time should they change their mind.

5.7 The review and evidence recognise there are often a number of barriers faced by women which may prevent them disclosing abuse and this may be compounded for BME women who face additional and intersecting barriers. Therefore, agencies must be more accessible to victims; intersectional in their approach; alert to the many barriers which may inhibit disclosure of abusive behaviour; and proactive in safely enquiring about DA.

5.8 Southall Black Sisters is a community-based campaigning organisation offering specialist support to women experiencing abuse from BAME communities and where appropriate, signposting victims to mainstream services. The organisation is well-established and has accumulated many years of experience and expertise helping and supporting BAME women who are victims of abuse. Advice from SBS suggests that BAME women experiencing abuse are best supported by specialist organisations/agencies that have a specific focus and expertise on the additional needs of such women. This is reflected in research that highlights the importance of BAME VAWG organisations that are "independent, specialist and dedicated, run by and for the communities they seek to serve".[18] SBS note barriers for BAME women reporting domestic abuse including distrust of statutory bodies and fear of children being taken into care.

5.9 John was aware of Jane's desire for a separation and divorce for some time before the tragedy and may even have known that she had arranged to have the locks changed at her flat. Separation/divorce, violence and coercive control have been identified as high-risk factors in escalating abuse and linked to homicide.

5.10 The research on London domestic homicides (see para 3.26) indicates that 47% of such deaths occur despite an absence of recorded warning signs. The issue therefore arises whether it may be possible for the agencies to promote a greater awareness of significant factors and/or events which may escalate risk, with the aim of ensuring that victims feel safe and able to seek advice and support from agencies which are accessible and non-judgmental, where they will be listened to and believed. Standing Together describes this aspect as "an environment of responsive services providing a coordinated community response." Such an

[18] Imkaan, 2015. State of the Sector: Contextualising the current experiences of BME women ending violence against women and girls organisations https://drive.google.com/file/d/0B_MKSoEcCvQweWY4cDJMeG1QTkk/view

environment must address the factors identified from research. The aim should be to link women with specialist services, tailored to the needs of individuals, considering any relevant cultural or community needs and addressing barriers to disclosure and access to services.

5.11 The borough's Violence Against Women and Girls strategy and the annual performance reports were examined as part of this review. The strategy identifies access to its domestic abuse services as the first priority. A range of useful performance indicators are specified and the annual report measures progress. The 2017/18 Annual Report[19] and 2018/19 Action Plan represent a highly sophisticated and detailed approach to suppressing domestic abuse, which may be of value to other partnerships.

5.12 Considerable effort is expended seeking feedback from survivors of abuse as a means of improving the effectiveness of services. Whilst such an effort is useful and commendable, it measures the views only of those who had been identified as experiencing domestic abuse and linked in with support. This particular case concerns a victim who had not disclosed, and was not asked about, domestic abuse which perhaps points to the need for additional measures to raise awareness and improve access within the wider community.

5.13 As part of the annual assessment of progress against the VAWG strategy, a survey of survivors was undertaken asking them about barriers to access. Approximately 50% of survivors identified barriers/challenges they had experienced in seeking support. Amongst the identified impediments were:

- Not knowing where to go for help or what that help would consist of;
- Fear, including fear of repercussions, fear of not being believed and fear of the services;
- Not identifying their situation as domestic abuse;
- Not knowing the UK law; and
- Difficulties with being passed between various agencies due to fluctuating risk levels.

Given that these problems were reported by those who had *overcome barriers* to seeking support, it is very likely that there is a wider group of victims of abuse who

[19] www.lbhf.gov.uk/sites/default/files/section_attachments/vawg_addendum_2018-19_for_website.pdf

have been unable to surmount the challenges of accessing services. Supportive professionals asking appropriate, direct, questions may assist such "hidden" victims. The role of the Coordinated Community Response is therefore critical in ensuring that support is available *where women are.*

5.14 Jane sought the services of her GP Practice on multiple occasions and her presentations were varied. It is noted in the IMR prepared by the practice that she did not benefit from much continuity of care, despite the frequency of her attendance and referrals to specialist consultations. She was referred to counselling services on several occasions and the IMR suggests that various doctors clearly considered underlying non-medical causes for her problems. There is no record, however, despite this and the frequency and nature of her attendance, of Jane being asked about whether she was experiencing abuse – although on one occasion in 2013, she claimed to her GP that she was a, "happily married woman with a full-time office job." The IMR noted that because Jane also had a lot of genuine pathology it may have made the possibility of DA less obvious to the GPs seeing her, particularly where there was a lack of continuity of care. The need for additional support for GPs who are constantly struggling under the constraints of short consultation times with patients was highlighted. In this context, it is noteworthy that had IRIS been made available to the practice, GP's would have been automatically alerted to the possibility of abuse as a result of the nature and multiplicity of Janes presentations and subsequently prompted to enquire about DA. Through IRIS, GPs would have also had access to an enhanced referral pathway to specialist domestic abuse services through the Advocate/Educator role.

5.15 It is evident from the volume of GP interactions and the nature of complaints that there is a need for further professional curiosity as a way to understand and identify potential indicators as abuse. Standing Together note in the analysis of DHRs that in over half of interpersonal homicides, there were missed opportunities to ask about domestic abuse. Most frequently observed was a lack of professional curiosity. They go on to state that there is a need for "more professional curiosity in thinking beyond basic policy and procedure." [20]

5.16 The GP report references a number of unplanned pregnancies with associations of separation and low mood. There are well documented links between domestic

[20] [20] Standing Together Against Domestic Violence (2016) Domestic Homicide Review (DHR) Case Analysis. http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf

abuse and pregnancy. Pregnancy, particularly unplanned pregnancy, is a risk factor for domestic abuse[21] and NICE Guidance[22] highlights multiple unplanned pregnancies as an indicator of domestic abuse. The Royal College of Nursing highlight that some termination providers use an approach of routine enquiry into domestic abuse in all women's health settings, including women requesting termination of pregnancy.[23] NICE identifies sexual health clinics as a setting in which routine enquiry about DA should be considered best practice due to the high frequency of presentations and outcomes associated with DA in sexual and reproductive health care. In this case, routine enquiry as part of termination services may have elicited a disclosure.

5.17 Research was undertaken via the internet to see what advice and/or relevant contact details could be found referring to local agencies. The various websites and pages provided useful information and helpfully signposted relevant services Notably, the Angelou Partnership – see below). No information was available to the review concerning Jane's access to either mobile information technology or such facilities in her home and there is no indication she experienced digital disadvantage. She was, however employed as an Office Manager in a local firm. It is thus probable that she had access to internet search facilities at work. More generally, other victims in need of support would be able to find help *provided* they had the ability and access to a smart phone or computer. So called Digital Disadvantage, is most likely to bear down hardest on ethnic minorities and especially those who are economically deprived.

5.18 The Angelou Partnership is an independent service commissioned by H&F to deliver the borough's Violence Against Women and Girls services. The partnership consists of nine specialist organisations which offer support ranging from increasing safety and understanding the criminal justice system, to enhancing emotional wellbeing. The partnership can support over the phone, face to face, or in a group format depending on the needs and preferences of those affected. Anyone seeking support may self-refer direct to the organisation of their choice, may do so via the Angelou Partnership itself, may be referred by any professional (either directly or via MARAC) from any relevant agency.
The partnership consists of:

[21] Gottlieb, A. 2012. 'Domestic violence: a clinical guide for women's healthcare providers.' The Obstetrician & Gynaecologist. 14:197–202

[22] NICE (2014) Domestic Violence Abuse and Multi Agency Working
https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621

[23] RCN (2020). Termination of Pregnancy: A RCN Framework

- **Domestic Violence Intervention Project (DVIP)** - Services for men who have been violent to their partner, and for women who have suffered domestic violence. It supports parents and children affected by domestic violence.
  Al-Aman is DVIP's Arabic Speaking Project that offers support to Arabic speaking clients across London.

- **Advance -** For women and girls (aged 15+) living in London Borough of Hammersmith & Fulham experiencing domestic violence from current or former partner/family member, including forced marriage/honour-based violence.

- **Women & Girls Network** - Women and Girls Network (WGN) is a women-only organisation providing free and confidential advice, advocacy, counselling and support group services for women and girls who have experienced gendered violence, including sexual and domestic violence. Its overall aim is to promote, preserve and restore the mental health and well-being of women and girls, to empower them to make a total and sustainable recovery from their experiences of violence.

- **Woman's Trust** - Woman's Trust is a women-only organisation providing free and confidential therapeutic services including counselling and support group, self-development workshops and mother and children art therapy workshops for women who have experienced domestic services abuse. We support women's mental and emotional recovery from their experiences of domestic abuse.

- **Solace Women's Aid** - Solace Women's Aid is an independent charity working across London, providing life-saving support offering refuges, advice, counselling, advocacy, support groups and family & children's projects, enabling survivors to live free from abuse.

- **Al-Hasaniya** - Al-Hasaniya serves the needs of Moroccan and Arabic-speaking women and their families in London – primarily Kensington and Chelsea residents, but with some pan-London projects – providing support for health, welfare, education and cultural activities.

- **Hestia** – Is the largest provider of domestic abuse refuges in London and have the largest team of specialists working to combat Human Trafficking across the Capital and the South East. Hestia's Butterfly Project is a community-based

women's group. Run by survivors for survivors, it provides support for women who have experienced or are currently experiencing domestic abuse.

- **Galop** - LGBT anti-violence & abuse charity. We give advice and support to people who have experienced biphobia, homophobia, transphobia, sexual violence or domestic abuse.

- **African Women's Care** - Creating access to the use of available health and social care resources to African refugee women and children with preference to those from Ugandan origin.

5.19 Standing Together Against Domestic Violence (a second-tier organisation) is one of the constituent organisations of Angelou. It plays a major role in the coordination of domestic abuse services in Hammersmith and Fulham, coordinating the delivery of the borough's VAWG projects, including:

- Health-related projects – Standing Together work across primary, secondary and mental health care settings to improve identification and response to DA. The projects have also benefitted from specialist co-located health IDVAs provided by Advance and Victim Support. The Pathfinder Project is a national project coordinated by Standing Together alongside SafeLives, Against Violence and Abuse, Imkaan and IRIS which implements a 'whole-health' approach across all areas of health within a geographical region. Hammersmith and Fulham Council, the Royal Borough of Kensington and Chelsea and Westminster have recently become a Pathfinder site, which will include IRIS.

- Children's Social Care Project – the project involves the co-location of IDVAs (provided by Advance) and specialist perpetrator workers (DVIP) within CSC. Standing Together coordinate the project.

The charity already has initiatives aimed at reaching out to victims of abuse where there may be additional barriers to accessing services and support.

- The SAFE (Safety Across Faith and Ethnic Communities) Project – funded as a pilot by the Esme Fairbairn Trust – empowers communities to be a part of the coordinated community response to domestic abuse. The project employs a coordinator to support faith and minority ethnic communities to understand, recognise and address domestic abuse.

- The “Ask Me” Project provides two-day training courses in domestic abuse intended to increase the confidence of community members to be more professionally curious when dealing with suspected victims of abuse. The project is actively promoted and marketed to GP practices and health centres by the CCG.

5.20 Angelou Partner, Advance, employ a Housing IDVA (Independent Domestic Violence Advisor), funded through H&F, who is co-located within Housing Options. The IDVA provides support for women experiencing domestic abuse who present at Housing Options and is similarly a resource for staff. There is also a Housing Coordinator provided through STADV.

5.21 The CCG has taken a more prominent role in the promotion of measures to identify victims of domestic abuse since 2016 despite bids to government to fund IRIS training having repeatedly failed. The Home Office identifies IRIS as a model that the NHS can adopt to help respond effectively to DA:

> *“A range of effective interventions can make it easier for NHS services to play their part. For example, the Identification & Referral to Improve Safety (IRIS) model in health practices is a domestic violence and abuse training, support and referral programme to support GPs in asking about and responding to disclosures.” (Ending Violence Against Women & Girls Strategy 2016 – 2020, p21: HM Government 2016)*

Home Office and Department of Health agree and endorse the IRIS model; however, its implementation currently lacks central funding. Greater availability of central funding would address the issue (see Recommendations 6 and 12). The non-availability of IRIS renders it even more important that health practitioners are aware of their potential to discover domestic abuse and guide victims to the most appropriate referral pathways.

5.22 In this context, Standing Together’s health-related projects are of great importance and have gone some way to meeting the requirement at a local level. Additionally, the CCG has funded a part time post (3 days a week) for a named GP to work with colleagues to enhance awareness and identification of a range of safeguarding issues including domestic abuse with the aim of promoting an increasingly proactive approach to the issues. From April 2018 the CCG instituted a routine “dashboard” approach to monitor the performance of GPs identifying and referring suspected cases of abuse as well as the nature and extent of follow-up to each case.

5.23 Jane and John lived in accommodation provided by Pinnacle Group. Pinnacle provides, tenancy management, repairs & maintenance and is a contracted-out service for the Local Authority. The group describes itself as "Providing high quality housing management services on behalf of affordable housing landlords." If its staff have concerns about a child and/or domestic abuse taking place in premises where they have been working, there are mechanisms in place for them to report their concerns to Social Services via their own Area Managers. Jane was the registered tenant of the flat and two of her children were recorded by Pinnacle as being residents. There was nothing in Pinnacle housing records indicating John's occupation or that he was a joint tenant. Although Jane arranged for her locks to be changed by a private locksmith, the process for this work to be undertaken should be through the Housing Department. The Housing Department has a three-hour timeframe for lock changes where the requirement is urgent, as in cases involving domestic abuse. Lock changing requests, as well as the need for repairs to what might be non-accidental damage may be indicators of abuse. Maintenance staff should thus be reminded of their ability to provide early warning of domestic abuse and the ways in which such concerns should be highlighted to managers.

5.24 In addition to routine contacts between maintenance staff and tenants, other opportunities exist for the identification of households where there may be abuse:

- Those suffering domestic abuse are statistically more likely to be in arears for rent and as such Income Officers should be alert to signs of abuse within such households. Although there were no rent arrears in this case, it is useful to be aware in terms of wider learning and in considering the links between housing and economic abuse.
- Similarly, routine tenancy audit and fraud checks provide opportunities to identify those at risk of abuse.

5.25 Given the range of opportunities for housing staff and contractors to identify abuse at an early stage, training in these issues should be considered as part of the VAWG forward plan.

6. Lessons to be Learnt

6.1 The principal lessons to be learnt from this case may conveniently be grouped under three main headings:

- Barriers likely to be experienced by BAME victims of abuse which may make it more difficult to access support.

- The complex and intersecting nature of these barriers and the impact they have on how violence and abuse is experienced and understood, how and where support can be accessed, and the way in which support is received and perceived. This includes the intersection between gender and race, but also considering factors such as *digital disadvantage (i.e. lack of discreet access to the internet)*.

- Missed opportunities to enquire about domestic abuse and the necessity, in view of the above factors and in the presence of indicators of DA, to ensure that professionals from all agencies are trained, proactive and able to take advantage of all opportunities to ask about, identify, and respond effectively to, abuse.

6.2 **Barriers to support** – Improving access to support for BME women requires a variety of measures both to widen awareness amongst community members, businesses and agency professionals and to enhance facilities and specialist support. Recommendations 1, 2, 3, 5, 8(a to d) and 10 are aimed at increasing awareness amongst key groups. Recommendations 4, 6, 9 and 11 are aimed at enhancing facilities.

6.3 **Intersectionality** – An intersectional approach is critical to understanding the various ways in which race and gender "interact to shape the multiple dimensions of Black women's experience, [recognising] that the intersection of racism and sexism factors into Black women's lives in ways that cannot be captured wholly by looking at race or gender dimensions of those experiences separately"[24]. For this reason, recommendations 1, 3, and 4 have been developed to further support the particular measures required to increase the likelihood that BME victims will have available to them "an environment of responsive services providing a coordinated community response". Recommendation 4 has been developed in line with research[25] that highlights that organisations which work most efficiently and effectively in addressing the intersectional needs of marginalised women facing violence and abuse are 'led by and for' organisations. Recommendation 7 is intended to ensure that there is not an over-reliance on internet-based information which may not be easily available to BME victims, especially those for whom English is not their first language.

[24] Crenshaw, K. (1991) Mapping the Margins:Intersectionality, Identity Politics and violence Against Women of Colour

[25] Imkaan (2019) 'The Value of Intersectionality in Understanding Violence Against Women and Girls. https://www2.unwomen.org//media/field%20office%20eca/attachments/publications/2019/10/the%20value%20of%20intersectionality%20in%20understanding%20violence%20against%20women%20and%20girls.pdf?la=en&vs=3339

6.4 **Proactive Professionals** – Professionals must make identifying domestic abuse part of what they do day-to-day. Reducing the time that it takes to identify and support victims is critical to preventing "murder, serious injury and enduring harm"[26]. Each professional contact represents an opportunity to support a victim and their family to get help. Missed opportunities to identify and respond to abuse were identified in this case and, in general, SafeLives[27] data shows that 85% of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse. Recommendations 3, 8 and 10 are aimed at encouraging and supporting professionals and community members to improve their professional curiosity and thus, identification and response to domestic abuse, recognising the difficult and sensitive challenges of safely and empathetically asking potential victims about abuse and support.

7. Conclusions and Recommendations

7.1 Although there were no direct disclosures of domestic abuse by Jane or any family member, the review has highlighted a number of high-risk indicators of abuse and missed opportunities for agencies to enquire about the possibility of DA. Such missed opportunities are all the more critical considering the additional barriers faced by BAME victims in disclosing abuse and accessing support. This report acknowledges the additional barriers faced by BAME women and identifies a clear imperative to address these.

7.2 A principal finding from this review is that increasing identification and access to support for BAME victims of domestic abuse, requires services which proactively reach out to 'minority' communities. Engaging relevant community organisations may assist in mapping services to needs. On a cautionary note, care will be required to ensure that specialist organisations which work specifically with BME women facing violence and abuse should be targeted as potential partners.

7.3 **Recommendation 1**

In order to increase identification and access to support, material that is designed for communities where there are barriers to disclosing abuse and seeking help is required. Engagement with appropriate minority community groups could facilitate both production and dissemination of such material. The material produced should

[26] SafeLives (2015) 'Getting it Right the First Time' https://safelives.org.uk/policy-evidence/getting-it-right-first-time

[27] ibid

be made available to all GP practices, medical centres and other venues where it may be accessible to victims.

7.4 **Recommendation 2**

Workplaces offer an additional context in which disclosure of abuse can be promoted. To this end, H&F to consider a campaign to encourages workplaces and employers to raise the awareness, especially amongst managers, of domestic abuse and what may be done to support employees. – *A number of public sector examples of such an approach already exist, notably, that introduced by the London Borough of Hackney for the care of its own staff. See also "Employers Initiative on Domestic Abuse"*[28]

7.5 **Recommendation 3**

Improved, evidence-based training is required to enable social services, medical, nursing and community workers to understand the particular needs of BAME women in the context of domestic abuse/VAWG.

7.6 **Recommendation 4**

When recommissioning VAWG services, H&F should consider the specialist services which may be required to cater for the needs of BAME women.

Implementation may be assisted with the advice and expertise of a suitable second tier specialist organisation e.g. Imkaan

7.7 **Recommendation 5**

NHS(E) via Medical Directors, to remind GP practices of the importance of all staff being aware of DA issues and indicators as well as the appropriate referral routes for those seeking advice.

7.8 **Recommendation 6**

Pursue current bids for funding to enable the Identification & Referral System to Improve Safety (IRIS) training for GPs and staff.

In the absence of IRIS, training on the indicators of abuse, safe enquiry and how to respond to DA to be delivered to GP practices in the borough.

[28] https://eida.org.uk

7.9 **Recommendation 7**
Examine the currently available material to ensure that there is not undue reliance on internet-based advice to ensure adequate advice is available to those who lack access to internet services.

7.10 **Recommendation 8a**
H&F Children's Services manager and social workers to consider the research around links between sexual abuse, homelessness and domestic abuse during contacts with families.

7.11 **Recommendation 8b**
H&F social workers to explore parental relationships and make routine enquiries about domestic abuse when children make allegations of sexual abuse and/or physical abuse about parents.

7.12 **Recommendation 8c**
H&F Children's Services manager to ensure that dates of birth and full police checks are completed and recorded and considered as part of s47 core assessments.

7.13 **Recommendation 8d**
H&F provide updated training to front line social workers on linking sexual abuse to domestic abuse.

7.14 **Recommendation 9**
VAWG providers to consider opportunities to promote specific targeted services to identified ethnic minority groups to improve disclosures of abuse and thus access to DA services.

7.15 **Recommendation 10**
Raise the awareness of DA amongst Housing staff and contractors of the opportunities which may be presented to identify unreported abuse.

7.16 **Recommendation 11**
The Home Office to support NHS(England) in commissioning IRIS nationally, thereby promoting the aims of the national "Ending Violence Against Women & Girls Strategy 2016 – 2020 (HM Government 2016).

Appendix A: Action Plan

Recommendation	Scope	Action to Take	Lead Agency	Key milestones achieved in enacting recommendation
Recommendation 1 Production and dissemination appropriate publicity material on domestic abuse, targeted at minority communities where there are barriers to disclosing domestic abuse.	Local	• Undertake review current local domestic abuse resources to ensure they meet the needs of BAME victims. • Identify whether there are any gaps in materials for local communities based on borough profile and needs assessment. • Update resources with local VAWG services and design team to create accessible materials for BAME survivors. • Promote and share resources through operational and strategic groups within the council and across local agencies • The above to occur alongside re-commissioning of VAWG services	H&F Community Safety Unit with support from • VAWG Strategic Lead • STADV • Advance/Angelou	• H&F Key languages identified • Posters and awareness leaflets translated into key languages • Leaflets and posters for local specialist BAME organisation in multiple languages • Materials promoted through partnership and in community
Recommendation 2 H&F to consider a campaign to encourage workplaces and employers to raise the awareness, especially amongst managers, of domestic abuse and what may be done to support employees.	Local	• H&F website VAWG page to be updated to include domestic abuse information for employer via the Employers' Initiative on Domestic Abuse https://www.enei.org.uk/ • H&F VAWG and domestic abuse policy to be completed which details the response to vicitms and perpetrators within the workplace. • H&F VAWG Partnership will provide training on DA for local businesses through the Business Improvement District.	H&F Community Safety and Communications Team H&F Community Safety, H&F Human Resources and VAWG Strategic Coordinator	• Completed DA Policy • Targeted work and training completed with organisations about how to respond to DA; Standing Together's work in ICHT/CW includes support for staff experiencing DA. • Promote Employers' Initiative on DA on website and work with H&F Business Teams to do targeted work with local organisations. • Liaise with ENEI around H&F businesses signed up to the initiative
Recommendation 3 Improved, evidence-based training is required to enable social services, medical and community workers to understand the particular needs of ethnic minority women in the context of domestic abuse/VAWG.	Local	• Recommendation to be taken to the local VAWG Training Subgroup and incorporated into 19/20 VAWG training programme • Recommendation to be taken to the Pathfinder Steering Group and liaise with the project's Equality, Diversity & Intersectionality Coordinator to ensure needs of BME women embedded in training to health professionals • Recommendation taken to the Safeguarding Children's Board (SCB) to ensure needs of BME women incorporated into safeguarding training	H&F Community Safety Unit and VAWG Strategic Lead with support from SCB Chair	• Taken to training subgroup and incorporated into local training brochure • Taken to CHOG and SCB • Specialist training delivered by BME services – Asian Women's Resource Centre, Midaye, IKWRO • Pathfinder EDI Coordinator delivered sessions to health staff as part of Pathfinder

Recommendation	Scope	Action to Take	Lead Agency	Key milestones achieved in enacting recommendation
		• Recommendation taken to the Children and Health Operational Group to ensure learning cascaded to professionals at all levels. • DA training delivered via the LSCP to all professionals working in the borough. • Specialist training to GPs and health providers delivered through Standing Together and IRISi.		• Specialist training provided by CHOG Coordinator to health professionals. Staff report increased knowledge of indicators of DA and how to respond.
Recommendation 4 When recommissioning VAWG services, H&F should consider the specialist services which may be required to cater for the needs of ethnic minority victims. Implementation may be assisted with the advice and expertise of a suitable second tier specialist organisation e.g. Imkaan.	Local	• Specialist BME provision incorporated in VAWG recommissioning process; second-tier specialist BME VAWG organisation, Imkaan, to be included in consultation and recommissioning activities • Specialist local BME organisations to be included in consultation activities and events to ensure service is co-produced. • Service Specification for recommissioning VAWG provision to include specialist support for BME women affected by domestic abuse/VAWG	H&F Community Safety Unit and VAWG Strategic Lead with support from: • STADV • Imkaan/Women's Aid	• Consultation with specialist BME services undertaken • Women's Aid/Imkaan consultant for re- commissioning and delivered workshops • Service specification has clear requirement for provision to include specialist VAWG support to BME women
Recommendation 5 NHS(E) via Medical Directors, to remind GP practices of the importance of all staff being aware of DA issues and indicators as well as the appropriate referral routes for those seeking advice.	National with Local input	• NHSE to liaise with medical directors to ensure recommendation addressed at a national level. • DHR and recommendation to be highlighted to CCG, Pathfinder Steering Group and Children and Health Operational Group (CHOG) for local implementation. • DHR learning to be discussed at, and disseminated through, the CHOG • Standing Together Against Domestic Violence (STADV) to continue to offer free specialist DA training, including the development of a 'champions network', to GP surgeries in H&F. • Data and monitoring about training offered to GP practices in H&F to be provided quarterly to track take-up and performance. • Children & Health Coordinator to ensure GP practices have access to DA resources and materials to display in consulting and waiting rooms.	NHS England – London Investigations Team H&F Community Safety Unit / VAWG Strategic Lead Children and Health Coordinator, STADV H&F CCG, Designated Adult Safeguarding;	• Recommendation taken to medical directors • Local implementation through CCG • Ongoing learning through VAWG and health governance structures

Recommendation	Scope	Action to Take	Lead Agency	Key milestones achieved in enacting recommendation
		• CCG to promote and encourage attendance at GP training provided by STADV.	Designated Safeguarding Children	
Recommendation 6 Pursue current bids for funding to enable the Identification & Referral System to Improve Safety (IRIS) training for GPs and staff. In the absence of IRIS, training on the indicators of abuse, safe enquiry and how to respond to DA to be delivered to GP practices in the borough.	Local	• Recommendation to be raised through Pathfinder Project steering group. • Learnings from Pathfinder IRIS implementation to be adopted locally and to support business case/funding opportunities for IRIS in H&F practices. • Children & Health Coordinator to continue to deliver training to GP practices in the borough; training covers identification, risk and response. • IRIS implemented across 25 GP practices in H&F for 1 year.	H&F Community Safety Unit / VAWG Strategic Lead Standing Together	• VRU confirmed funding for IRIS in H&F in November 2019 • Pathfinder learning event • Pathfinder toolkit launched • GP practices identified, DA champions in practices. • Advocate Educator appointed.
Recommendation 7 Review the balance between digital and physical advice/publicity material	Local	• This recommendation to be undertaken alongside recommendation 1. • Publicity and materials to be reviewed as part of re-commissioning of VAWG provision.	H&F Community Safety Unit with support from • VAWG Strategic Lead • STADV • Advance / Angelou	• Material reviewed and translated • Materials in online and physical format • Material in physical locations including pharmacies, grocery stores etc.
Recommendation 8a H&F Children's Services manager and social workers to consider the research around links between sexual abuse, homelessness and domestic abuse during contacts with families.	Local	• Learning & Improvement – Research to be cascaded via the Learning & Improvement Newsletter • Bite-Size learning sessions to be scheduled 2-3 times a year • 'Strengthening the identification and response to sexual abuse across the professional network' is an ongoing priority. Multi-agency action plans are being developed. Bitesize learning sessions will continue to be delivered	H&F Children's Social Care	• Information cascaded • Training delivered to staff and ongoing sessions scheduled to ensure embedded learning • Multi-agency plans have been reviewed at the LSCP
Recommendation 8b H&F social workers to explore parental relationships and make routine enquiries about	Local	• Routine enquiry of domestic abuse to be introduced as standard practice • Systemic Clinicians will be asked to draft some question framing to support this conversation and implementation	H&F Children's Social Care	• Framework and plan established for routine enquiry • Training sessions for staff on how to enquire

Recommendation	Scope	Action to Take	Lead Agency	Key milestones achieved in enacting recommendation
domestic abuse when children make allegations of sexual abuse and/or physical abuse about parents.				• Roll out and embedded within policy
Recommendation 8c H&F Children's Services manager to ensure that dates of birth and full police checks are completed and recorded and considered as part of s 47 core assessments.	Local	• This is standard practice for SW and management oversight. • Thematic audit re; quality of s47 enquiries will be undertaken under the QA framework to ensure practice is being followed	H&F Children's Social Care	• Audits under the QA framework and data reports established to monitor practice standards. • Quality Audit of S47's established and carried out
Recommendation 8d H&F CSC provide updated training to front line social workers on linking sexual abuse to domestic abuse.	Local	• Bitesize sessions will be delivered – see actions for recommendation 8a • Recommendations will inform the Learning & Development strategy	H&F Children's Social Care	• As per 8a • Updated L&D strategy
Recommendation 9 VAWG providers to consider opportunities to offer specific targeted services to identified ethnic minority groups to improve disclosures of abuse and thus access to DA services.	Local	• Recommendation to be taken to local Specialist Services group. • Recommendation taken to training subgroup for opportunities for specialist BME training. • Referral pathways into the Angelou Partnership's specialist BME services to be promoted throughout H&F. • (As per recommendation 4) Service Specification for recommissioning VAWG provision to include specialist support for BME women affected by DA/VAWG.	VAWG Strategic Lead Community Safety Unit Community Safety Unit and VAWG Strategic Lead with support from Angelou Partners Community Safety Unit; VAWG Strategic Lead	• Recommendations taken to key VAWG governance groups • Increase in referrals to specialist BME services • As per recommendation 4
Recommendation 10 Raise the awareness of DA amongst Housing staff and contractors of the opportunities which may be presented to	Local	**<u>Governance</u>** • Housing services to participate in the Housing Operational Group (HOG) including attendance and meetings and reviewing data to track performance. • H&F to consider funding opportunities to seek Domestic Abuse Housing Alliance accreditation https://www.dahalliance.org.uk/	Housing	Increased participation of Housing in HOG

Recommendation	Scope	Action to Take	Lead Agency	Key milestones achieved in enacting recommendation
identify unreported abuse.		**Learning & Training** • DHR learning session to be arranged for all Housing services at team meetings to ensure relevant learning form DHR is disseminated to staff. • DHR learning to be discussed at, and disseminated through, the HOG. • Domestic abuse to be considered as part of training needs assessment for all Housing services to identify staff training needs. • Housing Officers and contractors to be alert to indicators of abuse (e.g. ASB, high volumes of repairs, lock changes etc.) through access to specialist training and development of resources for staff. **Publicity and Signposting** • Domestic Abuse posters and leaflets to be displayed in Housing Offices in the North and South of the borough. • Housing teams to be aware of co-located Housing IDVA to ensure survivors are linked in with support when attending H&F Advice.	Community Safety Unit and Housing Housing and Community Safety Unit. Housing Coordinator, STADV Housing Housing Advance Housing	Commencement of DAHA accreditation DHR learning event held DHR included as part of HOG Training Needs Assessment carried out Training and resources made available Leaflets and resources widely circulated and put out Increased access to Housing IDVA
Recommendation 11 NHS(E)to seek funds from Home Office to support the implementation of IRIS nationally.	National	• NHS to discuss IRIS with the Home Office as highlighted in the HO VAWG strategy • Recommendation to be highlighted to the Home Office upon submission of overview report.	NHS National Safeguarding Team	Discussion between Home Office & NHSE Inclusion of recommendation as part of DHR submission

Appendix B: Glossary of Terms

AAFDA	Advocacy After Fatal Domestic Abuse
BME	Black & Minority Ethnic
CSC	Children's Social Care (Hammersmith & Fulham)
DA	Domestic abuse
DHR	Domestic Homicide Review
FLO	Family Liaison (police) Officer
GP	General (medical) Practitioner
IMKAAN	UK black feminist organisation dedicated to addressing violence against black & minoritised women
IMR	Individual Management Review
IRIS	Identification, Referral to Improve Safety
H&F	Hammersmith and Fulham
MARAC	Multi Agency Risk Assessment Conference
NHS(E)	National Health Service (England)
SBS	Southall Black Sisters
VAWG	Violence Against Women and Girls

Appendix C: Home Office Letter

Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848
www.gov.uk/homeoffice

Felicity Charles
Community Safety Manager
Community Safety Unit
Hammersmith & Fulham Council

30 November 2020

Dear Felicity,

Thank you for submitting the Domestic Homicide Review (DHR) report (Jane) for Hammersmith & Fulham CSP to the Home Office. Due to the Covid 19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 23rd September 2020 therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agree the feedback.

The QA Panel commented that the tribute at the start was touching and the addition was most welcome. The delays were generally well explained and valid given the ongoing attempts to engage with family, friends and colleagues throughout the process. The Panel also thought it was interesting to see the chair did a dip sampling, which shows they went above and beyond. Consideration of Jane's ethnicity and the domestic abuse to which she was subject was well documented and set out the complexity and intersecting nature of barriers to reporting and the possible obstacles facing BME women and minority communities. There was good quality analysis around equality and diversity and issues around disclosure for BME women, including use of BME specialists, e.g. Southall Black Sisters who were on the panel and research from IMKAAN. It was also positive to see an explanation of the local specialist services available for victims.

A considerable number of pertinent and reasonable recommendations are made resulting in a wide range of agencies undertaking a change in their policies and

training put in place, including for the children's social services and the health sector. In addition, the inclusion of economic abuse within the emerging themes was welcomed.

The report is probing and reflective, it is positive to see meaningful and intersectional learnings despite DA not being known by agencies. This was overall, a very well written and in-depth report considering the obstacles facing the panel whilst attempting to gain information

The QA Panel believe that there are some aspects of the report that may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The chronology is unclear and should be in the main body. Dates, not just years are needed, though the date of death should be removed.
- It would be useful to know roughly when the relationship began, not just when Jane and John got married.
- The gender of Child C is on page 41.
- The review doesn't include any information about those checks that might have been done when John entered the country – given suggestion of prior abusive behaviour. Neither does it comment on why John was given indefinite leave to remain the UK in 2012, when allegations of child abuse had already been made against him - 3.5/3.9 It is unclear what the lessons are here and what should the Home Office do as a result.
- The analysis contradicts HM Coroner's findings – 5.1/5.2 – what is happening about that finding?
- The action plan is not outcome focussed. It is unclear, particularly in respect of those actions marked as completed, what difference members of the public should expect to see around making the future safer. The plan does cover a number of areas from local to national, but without clarity around outcomes and assurance.
- Although it was good to see the explanation of local specialist services available for victims, this section would have been strengthened with more description and analysis around referral pathways for victims into these services.
- There were several mentions of "digital disadvantage" or victims lacking

access to smart phones or computers to be able to research and access information about services. There is also a related recommendation around this. There are two issues around this. The first is a question as to whether there were questions about Jane, the victim, being at digital disadvantage. It wasn't entirely clear if this was discussed because it's an issue for victims (including BME women) or that Jane did face these particular issues. The second point is that in the context of domestic abuse, it would have been helpful to look beyond "digital disadvantage" to technology abuse, including how women can experience a lack of safe access to technology as a result of abuse. Related recommendations could have centred around how women experiencing technology abuse can safely access support as well as be supported to access technology safely.

- There were over 1400 GP appointments – there is not much evidence of health professionals picking up on any signals – this is a really important point, made in

  the context of IRIS but should also be stressed around professional curiosity and knowledge.

- The Panel were curious to know more about their housing status – the review states housing was provided by Pinnacle but they offer a range of services, so it was not necessarily clear. Given that John killed Jane after she asked him to leave their flat permanently (and had arranged for a locksmith, though it's unclear if he knew about this), and he had previously told a colleague "If she thinks I'm going after all that work [i.e. decorating the flat] in there, she's crazy" (paragraph 3.16), more information about the housing tenancy/status might be helpful, and would link into the economic abuse that has been identified.

- Terminations
  - Would have expected to see more specific analysis and recommendations around the pregnancy termination services provided to Jane. Did she receive any routine enquiry? What support did they offer? Are there specific recommendations around domestic abuse for health services that provide termination services?
  - 3.21 the details around the number of "unwanted" pregnancies (also the term "unwanted") as well as the use of "when she was separated from her husband" which feels like it has an inference. Perhaps the wording could be amended here to 'a number of'? Whilst the Panel understand why this is considered important information, perhaps there is a way that some of Jane's privacy could be preserved?

- 2.14 Were friends offered the support of an advocate? This layer of support may have helped them to engage directly with the process.
- 3.15 Refers to a long-term relationship that John had with another woman – was there any attempt to get further information on her experiences?
- Easy to identify this family because of the details given around heritage and the specifics of the perpetrators career. Perhaps the CSP could consider removing the reference to his country and make this more generic (for instance Caribbean) and also remove references to the perpetrators career? A little more anonymisation to protect Child C in particular (even if they are now an adult).
- Typos
    - Are the dates in 1.9 correct? Says HO QA approval Sep 2019?
    - Why did Police not do an IMR? (GP, CSS, Housing)
    - Child A, B, C names are inconsistent, for example called C in 3.9, sometimes Child C sometimes child C
    - Ages of children unclear as states adult children at start but then seems they were children? Useful to clarify
    - Would be good to confirm the correct age of the victim.
    - Typo in footnote 21

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published along the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

Linda Robinson
Chair of the Home Office DHR Quality Assurance Panel