



**HILLINGDON COMMUNITY SAFETY  
PARTNERSHIP  
DOMESTIC HOMICIDE REVIEW**

**Overview Report into the homicide of Lottie  
March 2015**

**Independent Chair and Author of Report: Della Fallon**  
**Associate Standing Together Against Domestic Violence**  
**Date of Completion: March 2017**



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**Executive Summary is a standalone document attached to this document**

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# 1. Introduction

## 1.1 Details of the incident

- 1.1.1 In March 2015, Lottie was stabbed by her partner Bert. She was pronounced dead the morning of the incident. Lottie's partner, Bert, was convicted of her murder in May 2016 and sentenced to a minimum of fifteen years imprisonment.

## 1.2 Domestic Homicide Reviews

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

- 1.2.2 The purpose of these reviews is to:

- (a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- (b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- (c) Apply those lessons to service responses including changes to policies and procedures as appropriate.
- (d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

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

## 1.3. Timescales

- 1.3.1 This review was commissioned by the Safer Hillingdon Partnership (SHP) in accordance with the Revised Statutory Guidance for Domestic Homicide Reviews (March 2013), before the 2016 Guidance was issued.

- 1.3.2 The initial meeting was held on 8<sup>th</sup> July 2015 to establish the scope of the review and there have been seven subsequent meetings of the Review Panel.

- 1.3.3 On the 11<sup>th</sup> March 2015, the Borough Commander wrote to SHP formally requesting a DHR. On the 18<sup>th</sup> March 2015, the SHP informed the Home Office of their intention to commission a DHR. On the 28<sup>th</sup> August 2015, in advance of the

six-month deadline, the SHP notified the Home Office of the delay to the DHR. The Home Office was notified again on the 11<sup>th</sup> February 2016 and on the 20<sup>th</sup> December 2016 of further delays to the process.

- 1.3.4 The report was shared with Lottie's family on the 9<sup>th</sup> March 2017 and presented to the SHP on 28<sup>th</sup> March 2017.
- 1.3.5 At the meeting on the 28<sup>th</sup> March 2017, the SHP asked for one of the recommendations to be reworded. The revised wording was agreed on 5<sup>th</sup> June 2017. The advocate shared the revised recommendation with the family who supported the revision but expressed a wish to see the full DHR, including the action plan, before it was finalised for submission. A meeting involving the family, their advocate, and representatives from the London Borough of Hillingdon took place on the 17<sup>th</sup> July 2017. At that meeting it was agreed that the family would be regularly updated on progress with the action plan.
- 1.3.6 The review was conducted in Hillingdon as this was where Lottie was murdered. Both Lottie and Bert lived in Hillingdon for many years and had attended schools in the borough as children. In 2014 Lottie lived briefly in Slough. For this reason, the agencies involved with the review were predominantly Hillingdon based, but Thames Valley Police was also represented. The Review Panel were asked to review events from 1<sup>st</sup> June 2009 up to the homicide. This date was chosen because there was a reference to a MARAC<sup>1</sup> referral for Lottie in late 2009. The panel was unable to retrieve the file, which had been archived, but it was confirmed by the Metropolitan Police that Lottie had been referred to MARAC having been the victim of domestic abuse by Reg, Bert's half-brother. Agencies were also asked to summarise any relevant contact with Lottie or Bert prior to 2009.
- 1.3.7 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. This review has taken longer than that for a number of reasons, namely; it took some time initially to commission and secure an Independent Chair for this review, as well as to ensure that the review had the necessary comprehensive and dedicated administrative cover. There was subsequently a significant delay in some Individual Management Reviews (IMRs) and chronologies being received and the panel had to wait to receive the final Central and North West London NHS Foundation Trust (CNWL) Internal Investigation report. The large number of IMRs (twenty-four) requested meant that the panel needed to meet on four occasions to consider them and the lengthy report required several meetings of the panel to allow for full consideration of the issues raised.
- 1.3.8 There was also significant family involvement in the DHR process, including both the victim and perpetrators families. A late request was received, on 21<sup>st</sup> October

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<sup>1</sup> Multi-Agency Risk Assessment Conference

2016, from a family member for an additional meeting with the DHR Chair and the final meeting with the family to consider the draft report was delayed until the 9<sup>th</sup> March 2017, at their request. Following the SHP meeting on the 28<sup>th</sup> March 2017, the family had a final meeting with representatives from the London Borough of Hillingdon to review the full DHR, including the action plan.

1.3.9 The panel met on the following dates:

- 8<sup>th</sup> July 2015: initial meeting
- 13<sup>th</sup> October 2015: IMR review
- 24<sup>th</sup> November 2015: IMR review
- 12<sup>th</sup> January 2016: IMR review
- 1<sup>st</sup> March 2016: IMR review
- 28<sup>th</sup> June 2016: draft report
- 17<sup>th</sup> October 2016: draft report
- 22<sup>nd</sup> November 2016: final report

1.3.10 In addition, CNWL undertook a serious incident investigation in parallel with this review, as both the victim and perpetrator were known to local mental health services. The DHR Panel considered an early draft report at its meeting on the 1<sup>st</sup> March 2016 but a final version was not available for inclusion in the DHR report until 13<sup>th</sup> January 2017.

1.3.11 The criminal case was delayed because the sentencing judge requested a three-month psychiatric assessment, to be completed by the end of January 2016, after the review had been established. The Independent Chair was asked by the Metropolitan Police not to make contact with the families until the trial had concluded as several family members were intended to be called as witnesses, which led to a further delay. The legal process did not conclude until May 2016 when Bert was found guilty of murder.

1.3.12 The victim's family were aware of the review having been sent the Terms of Reference in July 2015. The Family Liaison Officer from the Metropolitan Police maintained close contact with the family and ensured that they were aware of the DHR. The perpetrators family was also aware of and involved in the DHR.

## **1.4 Chair of the DHR and Author of the Overview Report**

1.4.1 The Chair of the Review and author of the Overview Report was Della Fallon, an Associate DHR Chair working with Standing Together Against Domestic Violence (STADV), an organisation dedicated to developing effective, coordinated community responses to domestic violence. Della has spent her entire career working in the field of mental health, in service development, commissioning and more recently as a senior independent director of an NHS Foundation Trust. She

is currently the chair of the Epsom Health and Care Board; a first tier tribunal member (mental health); and a lay representative with Health Education England, Kent, Surrey and Sussex. Della has no connection with Hillingdon or any of the agencies involved in this case.

1.4.2 STADV has been involved in the DHR process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 1<sup>st</sup> January 2013 to 17<sup>th</sup> May 2016.

1.4.3 *Independence:* Della Fallon has no connection with the London Borough of Hillingdon or any of the agencies involved in this case. Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.

## **1.5 Terms of Reference**

1.5.1 The full Terms of Reference are included in **Appendix 2**. This review aims to identify the learning in Lottie and Bert's cases, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

## **1.6 Parallel Reviews and Related Processes**

1.6.1 The CNWL undertook a serious incident investigation in parallel with this review, as both the victim and perpetrator were known to local mental health services. The investigation process was underway when the DHR began. The DHR Terms of Reference were later added to the investigation's Terms of Reference. A senior member of CNWL staff was a panel member and updated the panel on progress at each meeting. The Independent Chair of the DHR was shown an early draft of the report and this was then shared with the DHR panel. The final report was shared with the panel on 13<sup>th</sup> January 2017. The findings of this investigation are incorporated into the DHR report.

1.6.2 The Metropolitan Police IMR documented the findings from the post mortem.

1.6.3 No inquest was conducted.

1.6.4 After Lottie's murder, the Metropolitan Police Directorate of Professional Standards (DPS) undertook a review of the circumstances around the 26<sup>th</sup> December 2014 incident and the subsequent delay to Bert's arrest. The outcome from this review was presented to the panel and is incorporated into the DHR report.

## **1.7 Composition of Review Panel**

1.7.1 The Review Panel members and chair are shown in **Appendix 3**.

## 1.8 Methodology

- 1.8.1 The approach adopted was to seek IMRs for all organisations and agencies that had contact with Lottie and/or Bert. Twenty-seven agencies were identified in the initial scoping undertaken by the CSP and at the first panel meeting and twenty-three IMRs were received. It was also considered helpful to involve agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.
- 1.8.2 In recognition of the specific health needs of both Lottie and Bert, the panel membership included a psychiatrist with drug and alcohol expertise and a senior manager with general adult mental health expertise.
- 1.8.3 All IMRs included chronologies and analysis of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period of 1<sup>st</sup> June 2009 to the date of the homicide.
- 1.8.4 Both Lottie and Bert used several aliases. Agencies were asked to check their records for contact with any of these names.
- 1.8.5 On the whole, the IMRs provided were comprehensive and the analysis supported the findings. Following comments, questions and suggestions some IMRs were redrafted and once complete were comprehensive and high quality. IMRs were received from:
- (a) Central and North West London NHS Foundation Trust – Mental Health Services – submitted their Internal Investigation report.
  - (b) General Practice for Lottie – two practices
    - (i) GP 1 registered 1/5/12
    - (ii) GP 2 registered 5/11/12 (same as GP 3 below)
  - (c) General Practices for Bert – five practices
    - (i) GP 1 registered 1/6/09
    - (ii) GP 2 registered 21/3/13
    - (iii) GP 3 registered 8/4/14
    - (iv) GP 4 registered 24/6/14
    - (v) GP 5 registered 25/11/14
  - (d) Greenbrook (provider of Hillingdon Urgent Care Centre)
  - (e) Hillingdon Hospital
  - (f) London Borough of Hillingdon Children's Social Care Services
  - (g) London Borough of Hillingdon Independent Domestic Violence Advocacy Service



- (h) Metropolitan Police
  - (i) Thames Valley Police
  - (j) National Probation Service, London Division
  - (k) School (attended by Lottie's daughter, Betty)
  - (l) London Borough of Hillingdon Education
  - (m) Victim Support
  - (n) London Borough of Hillingdon Homeless Prevention Team
  - (o) Hestia
  - (p) Care UK (provider of out of hours GP services)
  - (q) London Ambulance Service
  - (r) CNWL community services
- 1.8.6 Agencies who reviewed their files and provided information to the Review Panel but no IMR:
- (a) Leeds Teaching Hospital. Lottie presented to Accident and Emergency (A and E) in October 2012 following an overdose. She was seen once by the crisis assessment service but not admitted.
- 1.8.7 Agencies who reviewed their files and notified the Review Panel they had no contact with either Lottie or Bert were:
- (a) Leeds Children's Social Care
  - (b) Leeds and York Partnership NHS Foundation Trust
- 1.8.8 Agencies who reviewed their files and were known to have contact but were unable to retrieve details were:
- (a) Together (mental health provider working with probation)
- 1.8.9 The panel was unable to identify the GP practices Lottie was registered with between June 2009 and May 2012.
- 1.8.10 The chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

## **1.9 Contact with the family**

- 1.9.1 At the start of the review process, the criminal case was ongoing and the trial had not started. As a result, and under guidance from the Senior Investigation Officer (SIO) of the Metropolitan Police, contact with the family and friends of the victim, and with the perpetrator and his family, was not attempted. A letter was written to the family of Lottie, delivered via the police, informing them that the review was underway and giving them an opportunity to review the draft Terms of Reference,

and stating that the independent Chair of the Review would make further contact after the conclusion of the trial.

- 1.9.2 The Family Liaison Officer maintained regular contact with the Independent Chair and with the victim's family throughout this period. A second letter and the Home Office leaflet describing the DHR process and inviting the family's involvement was delivered to them in early 2016 by the Family Liaison Officer.
- 1.9.3 Following sentencing in May 2016, contact was made with Lottie's family and a meeting held with them on 26<sup>th</sup> May 2016. Several members of the family attended (Lottie's mother, step-father, grandmother, and Lottie's aunt and closest friend) and contributed to the discussion. Lottie's brother and sister chose not to participate. An advocate from AAFDA supported the family at the meeting. On the 19<sup>th</sup> October 2016, the Independent Chair received a request from Lottie's grandmother via the AAFDA advocate for an additional meeting. The meeting was held on 8<sup>th</sup> November 2016 and attended by the chair and the advocate. The draft DHR report was shared with the family on 10<sup>th</sup> February 2017.
- 1.9.4 The panel would like to express its sympathy for Lottie's family and thank them for their support and contribution to this process.
- 1.9.5 Bert and Bert's family were also approached and invited to contribute to the review. The Independent Chair met with Dolly, Bert's mother, on the 23<sup>rd</sup> June 2016. Bert also expressed a willingness to be involved in the review. The Independent Chair had planned to meet with Bert on the 8<sup>th</sup> September 2016, however on the 30<sup>th</sup> August she was notified by the prison that he was unwell and therefore could not participate. The chair made contact again on the 12<sup>th</sup> September and the situation remained unchanged but it was agreed that the prison's custodial manager would present key questions to Bert and record his responses. The manager made three visits to Bert to discuss the DHR. Unfortunately, he was transferred between prisons, at short notice, so she was unable to complete the questionnaire with him. Bert was given a copy of the questionnaire to complete and return to her, but this was not returned. Bert's brother, Fred, declined to engage.

## **1.10 Confidentiality**

- 1.10.1 The names used in this report are pseudonyms. They were chosen by the victim's family to protect the identity of everyone involved.

## **1.11 Equalities**

- 1.11.1 The nine protected characteristics as defined by the Equality Act of 2010 have all been considered; they are age, disability, sex, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sexual orientation.

- 1.11.2 Lottie was of white European (British) background. Bert is also of white European (British) background. There was no indication that Lottie's murder or any other incident recorded was motivated or aggravated by ethnicity, faith, sexual orientation, or other diversity factors.
- 1.11.3 Several protected characteristics were considered by the panel to have relevance to this DHR. One of the protected characteristics that does appear to have influenced events was the sex of the victim. Domestic abuse is a gendered crime with the overwhelming majority of victims being female and the perpetrators being overwhelmingly male. Research has also shown that intimate partner homicides disproportionately affect women (ONS, 2014). Recent case analysis of intimate partner homicides has been consistent with research. STADV and the London Metropolitan University<sup>2</sup> noted that the majority of intimate partner homicide victims were female with a male perpetrator (92%) this finding is also reflected in the Home Office recent analysis of intimate partner homicides<sup>3</sup>. Lottie was not married to Bert. Evidence from the Crime Survey of England and Wales indicated that unmarried women are more at risk of domestic abuse than married women, although the highest risk group is separated women. There had been occasions when Lottie had tried to separate from Bert, although it is not known whether this was the case at the time of the murder.
- 1.11.4 Both Lottie and Bert were diagnosed with mental illness, a 'mental impairment' recognised as a disability under the Equality Act of 2010, and had a history of drug and alcohol misuse. The panel considered that these were significant to their presentation, at times, and to the response of agencies to them. Issues that arose from this are reflected in the report.

## 1.12 Dissemination

Recipients who received copies of this report before publication:

Panel Members (listed in **Appendix 3**)  
Family Members  
STADV DHR Team

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<sup>2</sup> Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together*, London: Standing Together Against Domestic Violence and London Metropolitan University

<sup>3</sup> 29/33 intimate homicides had a female victim and a male perpetrator. Home Office (2016) *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*, London: Home Office

## 2. The Facts

### 2.1 Lottie's Homicide

- 2.1.1 *Homicide*: In March 2015, Bert called his mother and told her that he had stabbed Lottie. Bert's mother arrived at Lottie's flat and then alerted the emergency services. Lottie was found in bed with a wound to her neck. She was taken to hospital and pronounced dead later that morning. Bert was arrested and a homicide investigation was commenced.
- 2.1.2 *Criminal Trial Outcome*: Lottie's partner, Bert, was convicted of her murder in May 2016 and sentenced to life imprisonment, to serve a minimum of fifteen years in prison.
- 2.1.3 *Post Mortem*: The post mortem examination conducted in March 2015 determined the cause of death was a stab wound to the neck.

### 2.2 The victim, Lottie

- 2.2.1 Lottie was white, British.
- 2.2.2 Lottie had several siblings as shown on the genogram (**Appendix 5**).
- 2.2.3 At the time of her death, Lottie was twenty-five years old, and a white, single parent. She had given birth to her daughter, Betty, just before her eighteenth birthday. Betty was seven at the time of her mother's murder. Lottie had been in contact with Children's Social Care for many years due to their concerns about her ability to care for her daughter. When Children's Social Care needed to find alternative care for Betty, Lottie's parents were the first recourse. Lottie and her family lived nearby. In June 2014, care proceedings were initiated and it was decided that Lottie's parents would be the primary carers for her daughter. Betty was still in their care at the time of Lottie's death. Betty's father remains involved and in contact with his daughter. Lottie's relationship with her own mother was reported to be volatile and, on occasions, the police were called to verbal and physical altercations between them. Lottie's grandmother described how, even though they loved each other and were very close, they used to clash on occasions.
- 2.2.4 Although a large number of agencies had involvement with Lottie and Bert, only some were aware of Bert's abusive behaviour in the relationship. Lottie had, however, been in a well-known abusive relationship some years earlier with Bert's half-brother, Reg. It also appeared that prior to Reg, Lottie had a relationship with another man, who police believed was stalking her.
- 2.2.5 Lottie was diagnosed with a personality disorder and she was also recorded as suffering from depression at times. She had made several suicide attempts

through overdose and had a history of alcohol and drug misuse, both dating back several years. Although she was known to mental health services, they reported that her engagement was not consistent and her contact was sporadic. She had been discharged from their care three months before her death.

- 2.2.6 Lottie moved repeatedly between different addresses both within and, on occasions, outside the borough. Sometimes this was to flee the domestic abuse she was experiencing and sometimes she was moved because of reports of anti-social behaviour. In the past, she had a problem with some travellers and also received threats from neighbours. Lottie's grandmother described how Lottie sometimes mixed with the wrong people. She often reported feeling threatened and harassed by them. At times her relationship with her family appeared strained. Lottie was unemployed, had never worked, and was in receipt of benefits.
- 2.2.7 Over the time of the review, Lottie had most contact with Children's Social Care and housing services. She did not present consistently to agencies. While she did, in her contact with some agencies, notably the housing team and in the outpatient unit of the hospital, make disclosures about being subjected to domestic abuse, more often she chose not to disclose. Sometimes she was asked and denied being a victim or minimised the difficulties she was experiencing. In February 2014, following an incident, it was recorded by Victim Support that Lottie said 'I am not a victim so why have I been referred?'. While in April 2014, she disclosed to CNWL staff that Bert's recall to prison was the result of a 'domestic, which was overblown by the authorities'.

### **2.3 The perpetrator, Bert**

- 2.3.1 Bert was a twenty-three-year-old white, British, male at the time of the murder. He has a younger brother, Fred, and one older half-brother called Reg who has a record for violent and other crimes, and had been in a relationship with Lottie some years earlier. Bert had a propensity to violence and had previously received a lengthy prison sentence for an unprovoked attack on a motorist. He had no known previous history of intimate partner abuse.
- 2.3.2 Apart from a very brief period when he lived with his father and older half-brother, Bert grew up with and lived with his mother and younger brother. Around the age of thirteen, Bert's behaviour began to deteriorate and there were incidents of violence between him and his brother, Fred. Bert's mother reported that he also started to self-harm and, after being sacked from an apprenticeship for threatening behaviour, at the age of seventeen he was detained in hospital for several weeks. The assault on the motorist followed shortly after.
- 2.3.3 When his mother and brother could no longer cope with his behaviour, he rented a room privately, stayed with friends and latterly stayed with Lottie. He would spend the occasional night with his mother. He sometimes worked as a gardener, builder and with a security agency.

2.3.4 Bert was very well known to some statutory agencies, particularly health, police and probation. He was known to mental health services from the age of seventeen. He was diagnosed with dissociative personality disorder although a diagnosis of psychosis had also been considered previously. He also had a history of drug and alcohol misuse. Bert would present to mental health services for help when in crisis, and often following involvement with the police when he was on bail, but he was generally unable to sustain engagement or remain compliant with medication. Bert was in contact with mental health services at the time of the murder. He also regularly attended A and E, the urgent care centre and his GP. He was well supported by his mother who was his main carer. He appeared to have a quieter phase with no records of violence in the early part of 2015 although, throughout 2014, the frequency and severity of incidents of violence were showing signs of increasing and most recently included attacks on his brother and a minicab driver, as well as Lottie. His mother confirmed that it was likely that there were other incidents, which had not come to the attention of agencies.

## **2.4 Genogram**

2.4.1 A genogram showing the victim's family and the perpetrators family is attached in **Appendix 5**.

## **2.5 Relationship between victim and perpetrator**

2.5.1 The relationship between Lottie and Bert began in September or October 2013 although Bert and Bert's mother had known Lottie several years earlier, as she had been in a relationship with his half-brother, Reg. Both Reg and Bert were abusive in their relationship with Lottie.

2.5.2 In March 2014, Lottie's mother told Children's Social Care that 'Bert is actually a very nice person and has a good relationship with Betty'. Lottie's best friend and aunt described her belief he was perfect for Lottie. Lottie's grandmother said that they 'thought the sun shone out of Bert'. She recalled that he was always 'so polite and so nice'. Lottie's mother was perhaps the one exception. She described having concerns about Bert's relationship with Lottie and about his contact with Betty right from the beginning. As time progressed, Lottie disclosed some problems she was experiencing to her mother and Lottie's mother would say to other family members, 'I know things that you don't know' about Bert. Both families, in interview, gave a very similar description of the relationship. Lottie's step-father described the relationship as 'violent and volatile'. Bert's mother said, 'they were a volatile couple. They should never ever have been together'.

2.5.3 Outside the family, Lottie and Bert's presentation was mixed. In July 2014, Lottie disclosed to Victim Support that she was 'very frightened' of Bert and that same month Bert, himself, disclosed to the police that he had punched Lottie. They were also, however, seen by some agencies as being emotionally and practically

dependent on each other. In April 2014, Lottie said to her social worker that she was missing Bert following his recall to prison as 'he had helped her a lot'. It was also when Bert was in prison that Children's Social Care expressed a high level of concern about Lottie's mental health to CNWL. Bert, himself, described Lottie as a protective factor in his life to CNWL staff and, earlier in the relationship, he was noted to regularly take Betty to school.

2.5.4 The relationship was on-off at times and there was a longer period, between late September 2014 and early November 2014, where the relationship ended and it was recorded that Bert reported to staff that 'I knew I had to end this relationship or I would have ended up assaulting her'. They were reunited by the 8<sup>th</sup> November when an incident in Slough occurred and they were observed by police to leave the hotel 'hand in hand'. While Bert was in prison, Lottie began a new relationship. This ended when Bert was released.

2.5.5 What was of note was that during the last three months of Lottie's life, there were no recorded incidents of violence by Bert. It was also noted by staff that, during that time, Bert had no thoughts of harming anyone. They were last observed together by mental health staff in December 2014 when they both attended Bert's review. It was noted that they had a very positive rapport together and with the clinical staff. In January 2015, Bert described Lottie as a protective factor in his life. On the 19<sup>th</sup> February 2015, approximately two weeks before Lottie's murder, Bert reported no concerns about his relationship with Lottie and that drugs and alcohol were of no concern. At this time he was noted by his psychiatrist to be calm, appropriate and well-kempt with no features of psychosis or depression.

## **2.6 Bert's sentencing**

2.6.1 Bert pleaded guilty to Lottie's murder in May 2015. The sentencing judge instructed that Bert undertake a three-month psychiatric assessment prior to sentencing. In July 2015, Bert's guilty plea was withdrawn. In February 2016, he entered a plea of not guilty. In May 2016, Bert pleaded guilty and was sentenced to life imprisonment and to serve a minimum of fifteen years.

2.6.2 In summing up, the judge said, 'It is accepted that you have a complex personality disorder and there are variations to its precise nature. You are a very dangerous young man and in my view that's particularly so after you've been drinking and taking drugs. Even after extensive treatment it could be decades before you are considered safe'.

## **2.7 Contact with agencies and services**

### **2.8 Metropolitan Police**

- 2.8.1 Both Lottie and Bert were known to the Metropolitan Police.
- 2.8.2 On 26<sup>th</sup> February 2012, Bert was arrested for robbery following an unprovoked attack on a random, male, motorist who had stopped to buy fuel. The attack involved significant violence. He was bailed on 28<sup>th</sup> February with an electronic tag. He damaged his tag, which was a breach of his bail conditions, in March 2012. On 1<sup>st</sup> June 2012, he was convicted and sentenced to 27 months in a Young Offenders Institute.
- 2.8.3 Between 2014 and 2015, Bert came to the notice of the Metropolitan Police for incidents of domestic abuse related to Lottie on four occasions. There were also two incidents during this time that related to assaults on his younger brother, Fred.
- 2.8.4 Bert was wanted by both Thames Valley Police and the Metropolitan Police for offences at the time of Lottie's murder. Bert was subsequently convicted for criminal damage and assault on a police officer in relation to an incident in the Thames Valley area and, on the 11<sup>th</sup> May 2016, received six weeks imprisonment for each offence, to run concurrently. An outstanding arrest by the Metropolitan Police in relation to an assault on a minicab driver was discontinued.
- 2.8.5 **Incidents prior to November 2013.**
- 2.8.6 Prior to 2009, Lottie came to the notice of the Metropolitan Police for a number of incidents unrelated to domestic abuse. However, there were also six domestic abuse related incidents, involving Lottie and her parents and an ex-partner, but none involving Bert. In 2009 and 2010, Lottie came to the notice of the Metropolitan Police on five occasions as a victim of domestic related incidents, four of which involved Bert's half-brother, Reg, and one involved a different ex-partner.
- 2.8.7 On 15<sup>th</sup> January 2010, an incident involving Lottie and Reg was recorded to have resulted in an Independent Domestic Violence Advisor (IDVA), Multi-Agency Risk Assessment Conference (MARAC) and Multi-Agency Public Protection Arrangements (MAPPA) referral by the police. Lottie was referred to the MARAC on the 11<sup>th</sup> February 2010 and the case was closed on the 15<sup>th</sup> April 2010. There are no records of a MAPPA referral being made and the panel has been unable to retrieve the MARAC minutes, which have been archived. Lottie was referred to and supported by the IDVA service. The relationship between Lottie and Reg ended in 2010.
- 2.8.8 In 2012, there were three domestic abuse incidents involving Lottie and her mother and step-father. All of these cases were closed without charge. Lottie also came to the notice of the police because of non-domestic abuse incidents including harassment by others and being the victim of burglary.



- 2.8.9 In March 2013, the police were called to an incident involving Lottie and her mother. Lottie received a police caution for common assault.
- 2.8.10 **Incidents involving Lottie and Bert: November 2013 – July 2014**
- 2.8.11 On 5<sup>th</sup> November 2013, Lottie was arrested for child neglect following a call to the police because a male had been seen throwing a plant pot at her front door, causing a window to smash. When the police arrived, Lottie was reported to be drunk and Betty was awake. Officers found a suicide note from Lottie in the kitchen. A Child Coming to Police Notice Report (Merlin) was shared with Children’s Social Care. The male was not identified but, during the interview, Lottie referred to her relationship with Bert. This was the first police record of their relationship.
- 2.8.12 On 10<sup>th</sup> February 2014, the first incident of domestic abuse involving Lottie and Bert was recorded by the Metropolitan Police. Lottie called the police because Bert was refusing to leave her home. She reported that Bert had threatened to burn the house down and kill her. Lottie declined to engage with the attending officers. The officers did not complete a Domestic Abuse Form (124D) but did complete a skeleton (an outline, completed without Lottie’s involvement) Domestic Abuse and Stalking and Honour Based Violence (DASH) risk assessment. Lottie’s daughter was recorded as not being present and a Merlin was not completed. Lottie was assessed as standard risk and the Detective Sergeant directed that Bert should be arrested. Lottie declined to provide the officers with a statement. Bert was arrested two weeks later but because of insufficient evidence, no further action was taken.
- 2.8.13 On the 4<sup>th</sup> July 2014, Bert called the police and informed the operator that he had just hit his girlfriend, Lottie. Officers attended, but Lottie refused access. They returned later and did gain entry. They found Bert hiding at the rear of the property and he was arrested on suspicion of assault. Lottie had no visible injuries, declined to engage with the 124D and DASH risk assessment and was assessed as standard risk. The following day Lottie denied she had been assaulted and Bert had no memory of making the call and also denied the assault. The case was closed because of insufficient evidence.
- 2.8.14 On the 13<sup>th</sup> July 2014, the third incident involving Lottie and Bert in a twelve-month period was recorded. Lottie called 999 four times between 03:31 and 03:47 hours. In the first call she stated that Bert had assaulted her and then left. She then called and said there were black people in the road and she felt unsafe. On the third call, she stated that a male had walked up the road and that “she is going to have to go as she couldn’t sit there and wait for him to come back and murder her”. In the final call, she also said she had locked herself out when she came back from the pub where she’d been assaulted. When police attended and forced entry, they found Lottie asleep in her bedroom holding a large knife. Officers reported she was intoxicated with scratches to her face and shoulders. She did not wish to cooperate with the police. She was assessed as medium risk but no DASH risk assessment or secondary risk assessment was recorded. Lottie’s daughter was

now living with her grandparents and was not present during this incident. A Merlin was not completed. It was directed that Bert be arrested for assault.

- 2.8.15 The investigation of this incident was allocated and re-allocated three times, leading to a delay of 39 days before Lottie was contacted. On 23<sup>rd</sup> August 2014, the investigation was, eventually, allocated to a trainee detective constable (TDC) as the Officer in the Case (OIC). The arrest enquiry was not detailed in the Crime Recording Information System (CRIS) report.
- 2.8.16 On 25<sup>th</sup> August 2014, the OIC made numerous attempts to contact Lottie. On the 5<sup>th</sup> September 2014, he spoke to Lottie. Lottie declined to provide a statement but she did tell the OIC that she had been housed in a place of safety out of borough and she had been talking to the IDVA about on-going issues. Lottie admitted she was scared of Bert. The OIC noted that as Lottie was out of borough and had no contact with Bert, there was no immediate risk to her. Lottie terminated the call. On the same day, Bert called the OIC to say he would hand himself in. He did not and he was not arrested for this assault.
- 2.8.17 On 9<sup>th</sup> September 2014, the OIC made further attempts to contact Lottie without success. He did speak to the IDVA who reported that they were unable to share Lottie's address because of confidentiality issues.
- 2.8.18 There was no further investigation until 8<sup>th</sup> December 2014, 89 days later, when the OIC spoke to Lottie. She again declined to provide a statement and the offer of safety measures. No MARAC referral was completed for Lottie and the case was closed the following day because of insufficient evidence.
- 2.8.19 **Incidents involving Bert, his brother Fred, and Lottie: November 2014**
- 2.8.20 During November 2014, three domestic abuse incidents involving Bert were recorded. The first involved a confrontation with his younger brother, Fred, when Bert pinned him to the ground. In answer to the question by the police, 'is the abuse happening more often and getting worse?', Fred replied 'yes'. After initially providing a statement, during the secondary investigation he told the police he didn't wish to take it further. The case was closed. Ten days later, the same brother called police following a verbal argument with Bert. He didn't want to support a police investigation but wanted the matter 'logged'. The case was closed.
- 2.8.21 On 26<sup>th</sup> November 2014, the fourth domestic abuse incident between Bert and Lottie, and the third incident that month, occurred. Lottie was asleep in bed when her door buzzed. She thought it was her brother and opened the door, but Bert appeared in her bedroom shouting. Lottie called the police and Bert left. She told the officer that she had been moved to the flat after suffering domestic violence from Bert. She declined to answer the 124D DASH risk assessment and was assessed as standard risk. Her daughter wasn't present as she was still living with her grandparents and no Merlin was completed. In answer to the secondary investigator Lottie stated she had been moved to the address after violence towards her from neighbours. She declined help with obtaining a non-molestation order and was recorded not to be concerned that Bert knew where she lived. The

case was closed. At this time, Bert was still wanted for the assault on the 13<sup>th</sup> July 2014.

**2.8.22 Incident involving Lottie and her brother, Stanley: December 2014**

2.8.23 On 4<sup>th</sup> December 2014, police were called to an argument between Lottie and her brother. She declined to engage, was assessed as standard risk, no offences were identified and the case was closed.

**2.8.24 Incident involving Bert and a minicab driver: December 2014**

2.8.25 The final recorded incident involving Bert occurred on 26<sup>th</sup> December 2014. Bert was identified as the sole suspect in the assault of a minicab driver causing Actual Bodily Harm (ABH) injuries. He was wanted for this, non-domestic abuse incident, at the time of Lottie's murder.

**2.8.26 Lottie's murder: March 2015**

2.8.27 In March 2015, the police were called to Lottie's address. Bert was present, arrested and subsequently charged with her murder. He was sentenced to life imprisonment, to serve a minimum of fifteen years. He was also charged with criminal damage arising from an incident in Slough and received six weeks imprisonment. The arrest arising from the incident on the 13<sup>th</sup> July 2014 was discontinued.

**2.9 The Metropolitan Police Service Directorate of Professional Standards (DPS) investigation**

2.9.1 After Lottie's murder, the DPS undertook a review of the circumstances around the 26<sup>th</sup> December 2014 incident and the subsequent delay to Bert's arrest.

2.9.2 On 26<sup>th</sup> December 2014, police attended Lottie's mother's address. The police recorded that the property was searched but Bert wasn't located, although the family dispute this. Lottie's mother confirmed that Bert was Lottie's boyfriend but he had left the property following an argument. They were unable to provide any contact details for Bert. Police conducted local enquiries and searched the local area without success.

2.9.3 On 3<sup>rd</sup> January 2015, the minicab driver victim provided a statement including a different suspect name and a mobile phone number. The police called the number; Bert answered and confirmed his name.

2.9.4 After making two further attempts to locate Bert on 7<sup>th</sup> and 9<sup>th</sup> January, the police submitted a subscriber check to the mobile phone company on the 27<sup>th</sup> January 2015. On 28<sup>th</sup> February, the result further supported the suspicion that Bert was the suspect. On 2<sup>nd</sup> March 2015, Bert was placed on the Police National Computer (PNC) as wanted in relation to this offence.

2.9.5 The Metropolitan Police made a further visit to Lottie's mother's address on 5<sup>th</sup> March 2015. She confirmed that Bert did not live at that address and he was no

longer welcome there. She also said she was unsure whether Lottie was still in contact with Bert.

## **2.10 Thames Valley Police**

2.10.1 Both Lottie and Bert were known to Thames Valley Police.

2.10.2 During the timeframe of the review, from January 2009 to March 2015, Bert and/or Lottie came to the attention of Thames Valley Police on four occasions.

2.10.3 The first, on 14<sup>th</sup> March 2013, was in relation to theft of lead from a roof in Slough, Berkshire. Bert was interviewed but no further action was taken because of insufficient evidence.

2.10.4 On 13<sup>th</sup> September 2013, two business partners were kidnapped and robbed by four ex-employees over a grievance. Bert was implicated in the case and arrested on the 9<sup>th</sup> November 2013. An identification procedure failed to identify him and it was concluded that Bert was not involved in the offence.

### **2.10.5 Incident involving Bert**

2.10.6 On 24<sup>th</sup> October 2014 police were called to a hotel in Slough. South Central Ambulance Service reported to police that Bert had smashed a glass bottle over his own head and was bleeding. When the police attended, Bert was in the hotel room with a female. Although not identified as Lottie, it was the same room that Lottie was living in during the following incident (8<sup>th</sup> November 2014). Both parties were cooperative and Bert explained that he had recently left a mental health facility, hadn't been taking his medication and had self-harmed. It was recorded that Bert's partner had the opportunity to talk about any issues with Bert but did not disclose anything. Police conveyed him to a walk-in centre.

### **2.10.7 Incident involving Lottie and Bert**

2.10.8 The fourth contact, and the only incident involving Bert and Lottie reported to Thames Valley Police, was on the 8<sup>th</sup> November 2014 at the same hotel in Slough as the incident the previous month, October 2014. A member of staff called the police reporting that people were 'breaking the room', the occupants were 'still throwing something at each other or breaking something', and there had been complaints of shouting. They confirmed that the room was rented to a female via Hillingdon Council and her 'boyfriend' was in the room, against the terms of the contract. At some point earlier that night, until approximately 0200 hours, two other men had also been present in the room. It was believed that they were a male friend and Stanley, one of Lottie's brothers.

2.10.9 When police attended they were shown a smashed door pane in the hotel's front door. Inside the room they could hear a male and female talking loudly, sounding 'quite agitated'. Both Bert and Lottie shouted at the police asking them to go away. When taken outside, Lottie told officers 'I'm fine' and when asked what happened, she said, 'Basically nothing', and went back into the room, slamming the door.

- 2.10.10 While the officers were attempting to view the CCTV footage to establish who was responsible for the damage to the door, Bert and Lottie left the building hand in hand, laughing. The officers subsequently found that considerable damage had been caused to the room and logged that 'lots of knives', alcohol and cannabis related kit was also found. It was subsequently confirmed that one kitchen knife was seized and one Stanley knife was also found.
- 2.10.11 Shortly after, Bert and Lottie were found and arrested on suspicion of criminal damage. Bert resisted arrest and assaulted an officer. He had cuts and swelling to his hands. He disclosed mental ill health and that he felt safe with Lottie around. Lottie appeared drunk and/or high on drugs and was hostile to the officers. There were multiple abrasions on her arms and a cut on her hand. In interview, she stated that she had been with Bert for over a year and, while they generally got on, there had been previous fights. She said that nothing like the incident that happened that day had happened before. She said that the knife found at the incident belonged to her but she didn't recall how the blade got bent.
- 2.10.12 Bert and Lottie were released on conditional bail, although Lottie's bail was later dropped. Bert had a bail condition not to attend Slough or contact either of the named witnesses directly or indirectly. Because the incident was dealt with as a criminal damage incident and not dealt with as domestic abuse, a DASH risk assessment wasn't completed. Officers notified the emergency duty team about the incident and their efforts to ensure Betty's safety. Following the arrest, the officers checked the whereabouts of Lottie's daughter who was named on the hotel contract. She was confirmed to be with her father.
- 2.10.13 A witness statement was taken from Lottie's brother, Stanley, on the morning following the incident. He stated that Bert had phoned at 0300 hours and said 'everything had gone mental'. Lottie later called him and asked him to meet her 'as Bert's gone mental, hurry up, please just hurry up'. Stanley arrived in Slough town centre at 0830 as police were chasing Bert and Lottie. He saw them getting arrested. A further statement was taken from Stanley on the 2<sup>nd</sup> December 2014 when he confirmed that when he left Lottie and Bert there was no damage to anything in the room, other than the existing damage to the sink.
- 2.10.14 A second statement was taken from the hotel receptionist who had made the initial call to the police. At the time of the call, he had not disclosed that he had been verbally abused by Bert after saying he would call the police. It was subsequently disclosed that Bert had 'chased him off' downstairs in a threatening manner and so he had left the accommodation block through the front door. On his return, with officers, he noted that the window, which had been intact, was now broken.
- 2.10.15 Some five weeks later, on the 14<sup>th</sup> December 2014, the Investigating Officer (IO) took statements from two witnesses. Another resident of the hotel claimed he heard a male and female arguing. The male shouted 'Why are you lying to me?' and 'I'm going to fucking kill you'. He thought that female had locked herself in the bathroom, was crying and that he heard the sound of splintering wood. Later he heard the female run from the room screaming and then heard glass smashing in

the room. He heard the female crying outside the room for about five minutes before going back in. The police arrived shortly after.

- 2.10.16 Bert failed to attend for charging on 19<sup>th</sup> December 2014. He wasn't successfully traced. The IMR author found that the dates of the arrest attempts or the addresses visited to trace Bert had not been recorded. There was no record of any attempt to contact the Metropolitan Police. On 20<sup>th</sup> January 2015, Thames Valley Police flagged Bert as wanted on the PNC.
- 2.10.17 In court on the 11<sup>th</sup> May 2016, Bert was charged with the offences of criminal damage and resisting arrest arising from this incident and sentenced to six weeks imprisonment.

## **2.11 Independent Domestic Violence Advocacy Service (Hillingdon - HIDVA)**

- 2.11.1 Hillingdon IDVA Service provides advice and support to victims at medium to high risk of harm from intimate partners, ex-partners or family members in order to secure their safety and also the safety of any children.
- 2.11.2 Lottie was in contact with the Hillingdon IDVA service between January 2010 and July 2014. She was first referred to them by Hillingdon police after Reg, a former partner and Bert's half-brother, had been harassing and threatening her. He made further threats to her from prison. She was risk assessed by the IDVA (with a score of 17 risk factors) and referred to MARAC in January 2010. The panel was unable to retrieve details of this referral as the records had been archived. Over the following three years there were other referrals to the IDVA service where Lottie mainly received advice and help with housing, but no further referrals to MARAC.
- 2.11.3 There were two face to face contacts between Lottie and the IDVA which related to Bert. On 8<sup>th</sup> July 2014, Lottie was referred to the IDVA service by Victim Support in relation to Bert, in response to the second incident of domestic abuse between Lottie and Bert on 4<sup>th</sup> July. Although Lottie attended to speak to the IDVA, it was recorded by the service that she 'failed to engage with them'. She was assessed as being at high risk (with a score of 23 risk factors and 1 vulnerability) of further violence and domestic homicide. The HIDVA records stated the following that 'Lottie is considered high risk not only due to the level of violence but because of her inability to be proactive in achieving safety and as she leads a chaotic and unstable life this increases her risk of serious harm'. A safety plan was completed on the 11<sup>th</sup> July, which included a MARAC referral. She was offered a TecSOS phone, which she declined, and advised to consider a non-molestation order.
- 2.11.4 On 14<sup>th</sup> July 2014, the IDVA saw Lottie who reported that she had been a victim of another assault, the second that month, over the weekend (on the 13<sup>th</sup> July 2014). She stated that Bert had assaulted her and she was seen to have two black eyes and her face was swollen. She said that she didn't want the police to attend, as she didn't want the suspect to come back and murder her. It was recorded that

Lottie declined to go to a refuge because of her mental health issues and she was instead given money to pay for a Bed and Breakfast (B&B). The record notes that the IDVA made a referral to Hestia, who provide floating support to victims of domestic violence, to provide Lottie with support and that the IDVA would also refer Lottie to MARAC. However, it was also recorded that Lottie did not wish to engage because 'she didn't feel she was in a domestic violence relationship'.

- 2.11.5 On the 30<sup>th</sup> July 2014, the IDVA spoke to Lottie on the telephone. This was the final contact between the IDVA and Lottie. It was recorded in Lottie's file that she was now living in a B&B in Slough. It was recorded that she had not seen or heard from Bert and she would not return to the relationship. She was known to be engaging with social services and housing, and it was considered by the IDVA that her risk had reduced and no MARAC referral was required. No risk assessment was recorded to support this decision.
- 2.11.6 The next file note was on 25<sup>th</sup> September 2014 following a request for information from the homeless team. It stated that Lottie received a 'last night warning' from housing from the B&B in Slough as she had been threatening other residents. It was also believed that Bert had been staying with her. There were documented discussions between housing and the IDVA about the potential risk to Lottie of her moving back to her former address with sanctuary scheme while maintaining her relationship with Bert. The IDVA concluded that 'Lottie needs to take some responsibility for her own safety (extracted from HIDVA records)', that she would be risk assessed again if she returned, and she would also be referred to MARAC.
- 2.11.7 Another file note on 20<sup>th</sup> October 2014 indicated that Lottie had moved to a new address in the Hillingdon area, not her former address, and had been strongly advised not to give this address to anyone.
- 2.11.8 The final file entry was on 10<sup>th</sup> November 2014, following Lottie and Bert's arrest in Slough. It noted that Lottie had now been evicted and wouldn't be rehoused by Hillingdon Housing. Housing had advised her to contact Refuge, the women's aid charity, and that they 'would speak to Sanctuary to see if they can do anything'.
- 2.11.9 In December 2014, the IDVA team manager retired. Lottie had been her client since the referral in 2009. Despite several attempts, a new IDVA had been unable to make contact with Lottie. The case was open at the time of Lottie's death.

## **2.12 Domestic Abuse Floating Support Service (Hestia)**

- 2.12.1 Hestia provides short-term support to victims of domestic abuse, often with the purpose of helping victims rebuild their lives after domestic abuse.
- 2.12.2 Hestia's only contact with Lottie was between March 2012 and April 2012.
- 2.12.3 On 14<sup>th</sup> March 2012, Lottie was referred to Hestia from the domestic violence helpline. Contact was established and Lottie disclosed that she was living in an unsafe environment and she was concerned about her own safety and that of her

child. She did not attend a follow-up meeting or respond to subsequent contacts. Her file was closed in April.

2.12.4 There was no record of the referral by the IDVA service in July 2014.

### **2.13 National Probation Service (Ealing, Harrow and Hillingdon)**

2.13.1 The Probation Service's contact with Bert began in May 2012, following a robbery at a petrol station the previous February.

2.13.2 The IMR stated that probation service provided a pre-sentence report following a violent assault and robbery of a random, male, motorist at a petrol station following an evening of drinking and drug taking. During interview, Bert disclosed that he had committed other such offences but hadn't been apprehended. In the report, Bert was confirmed to have a diagnosed 'dissocial personality disorder'. There was no recommendation for treatment. He was sentenced on 1<sup>st</sup> June 2012 to twenty-seven months imprisonment in a Young Offenders Institute. He had no previous convictions and was eligible for release under licence, half way through his sentence.

2.13.3 On 17<sup>th</sup> December 2012, he was released subject to a Home Detention Curfew (HDC) at his father's address. In addition to the standard conditions, Bert was required to cooperate with any mental health treatment deemed appropriate. He was referred to MAPPA automatically. His licence was due to expire on the 14<sup>th</sup> June 2014.

2.13.4 Due to reasonably successful engagement, on 13<sup>th</sup> February 2013, his MAPPA status was reduced from level 2 to the low risk category (level 1). He was also referred to Together, the forensic mental health worker linked to the probation service.

2.13.5 Between March and July 2013, Bert was offered seven appointments with the mental health worker, but he did not attend five of them. He continued to attend his probation officer appointments.

2.13.6 On 9<sup>th</sup> August 2013, Bert moved from his father's address to his mother's. On 24<sup>th</sup> September 2013 he met with the Together mental health worker who was concerned about his mental health and referred him to A and E. His probation officer appointments were increased to weekly.

2.13.7 On 9<sup>th</sup> October 2013, his mental health appeared to have improved. He mentioned his relationship with Lottie to his probation officer for the first time. On the 14<sup>th</sup> October 2013, checks with the police and Children's Social Care were requested by probation because of concerns about an indirect risk that Bert may pose to Lottie and her daughter as he had reported staying at Lottie's house on occasions. The risk related to a concern, expressed by Bert, that he was being pursued by others who wished to do him harm. He was reminded that her address wasn't approved for licence supervision purposes and he could not stay there. A response



was received from the police on the 19<sup>th</sup> October 2013, but there was no record of any response at that time from children's services.

- 2.13.8 On 24<sup>th</sup> December 2013, Bert's probation officer made a referral to Children's Social Care stating that Bert was under his supervision for a violent offence (robbery) and that there were mental health, alcohol and drug issues linked to the offence. It went on to describe how Bert has sometimes reported that he is being pursued by people he refuses to identify who want to do harm to him and noted that 'Bert often stays over with Lottie and her daughter. I am requesting a full risk assessment to ensure that we have a safeguarding plan in place'.
- 2.13.9 Bert continued to engage only partially with the mental health worker. After several missed appointments, on 22<sup>nd</sup> January 2014 he did attend and again presented as unwell. He was referred to the Hillingdon Assessment and Brief Therapy Team (ABT). He was reported to be angry that the home visit to Lottie was still outstanding. On 31<sup>st</sup> January 2014, Lottie's address was assessed as suitable for licence supervision by the supervising officer in probation.
- 2.13.10 On 18<sup>th</sup> February 2014, Bert was recalled to custody because of an allegation of domestic abuse against Lottie (on the 10<sup>th</sup> February 2014) and his lack of cooperation with the mental health requirements of his licence. He was returned to prison on the 25<sup>th</sup> February 2014 and released, at the end of his sentence, on the 21<sup>st</sup> June 2014. This was the end of Bert's contact with the probation service.
- 2.13.11 Note: 'Together' have been unable to recover any records of their contact with Bert.

## **2.14 Central and North West London NHS Foundation Trust (CNWL)**

- 2.14.1 CNWL is a NHS provider of mental health, physical health, sexual health, addictions, eating disorder and learning disability services. They provide a range of mental health services across Milton Keynes and the London Boroughs of Brent, Harrow, Hillingdon, Kensington and Chelsea, and Westminster.
- 2.14.2 Both Lottie and Bert were known to CNWL mental health services. Lottie was discharged from their care in December 2014, but Bert was still in receipt of care and treatment from CNWL's mental health services at the time of the murder.
- 2.14.3 CNWL undertook an Internal Investigation into the homicide. The objectives were:
- (a) To evaluate the care and treatment of patients Lottie and Bert.
  - (b) To assess the adequacy of that care and treatment and formulate recommendations if indicated.
  - (c) To complete an investigation report for presentation to CNWL's Trust Board within agreed timeframes.
  - (d) To complete an investigation report for presentation to the DHR Review Panel within agreed timeframes.

- 2.14.4 The Internal Investigation Report incorporated the DHR terms of reference and a draft report was presented to the DHR panel on the 1<sup>st</sup> March 2016. The report was finally approved and shared with the panel on the 13<sup>th</sup> January 2017.
- 2.14.5 **Lottie's contact with CNWL**
- 2.14.6 Lottie's first contact with CNWL mental health services was on the 10<sup>th</sup> January 2013 when she was brought by ambulance to Hillingdon Hospital following an overdose. She reported that she had been experiencing intrusive thoughts in relation to believing that 'people are out to get her or kill her'. Her partner accompanied her; he was not identified. He reported that she had been trying to kill herself with a knife. She was assessed in A and E by the duty psychiatrist and referred to the Home Treatment Team (HTT).
- 2.14.7 She remained under the HTTs care until 23<sup>rd</sup> January 2013. During this time, she reported feeling unsafe in West Drayton due to on-going problems with people in the area. She disclosed having been the victim of domestic abuse in 2012. She was diagnosed with an adjustment disorder related to on-going social issues. While under the care of the HTT, Lottie's GP referred her to the ABT but this was put on hold. Lottie's mental state was assessed as being stable, she was compliant with medication, and had no psychotic symptoms or suicidal ideation at the point of discharge.
- 2.14.8 In March 2013, Lottie was assessed by the ABT and Hillingdon Drug and Alcohol Service (HDAS). She was mildly depressed and had stopped her medication. She declined help and cancelled her follow up appointments with both the ABT and HDAS.
- 2.14.9 In September 2013, Lottie contacted ABT requesting a self-referral. She didn't want to be referred by her GP because she had some 'issue' with the GP. Her request was declined and she was told to make an appointment with her GP for him to assess her and consider a referral.
- 2.14.10 On 10<sup>th</sup> December 2013, Lottie was referred to ABT by her GP. The referral was triaged and a routine appointment offered in February. Lottie was unable to attend because her daughter had chicken pox so a further appointment was arranged in March.
- 2.14.11 On 27<sup>th</sup> March 2014, Lottie attended accompanied by her sister and her daughter's social worker. She said she had been 'fine' until her partner, Bert (referred to by his first name only), went to prison. She stated that his prison sentence was the result of a 'domestic which was overblown by the authorities'.
- 2.14.12 On 25<sup>th</sup> April 2014, ABT received a call from Lottie's daughter's social worker asking for an earlier appointment for Lottie because she had been having anger outbursts more frequently. This was declined but a welfare check was attempted. Lottie did not respond. On the 15<sup>th</sup> May 2014, the same social worker again called the ABT stating that Lottie needed to be 'sectioned'. She had had a physical altercation and damaged her property. She was also seen walking around with

knives. The team were unable to contact Lottie. It was agreed to invite the social worker to the next planned review.

2.14.13 At the planned review on 13<sup>th</sup> June 2014, the social worker was invited but failed to attend. It was noted that Lottie now had a diagnosis of Personality Disorder (unspecified). No substance misuse issues or immediate risks were identified. She was prescribed Quetiapine (an antipsychotic drug) and referred for a psychological consultation. She declined an anger management course. The team confirmed with the social worker that Lottie had attended her review.

2.14.14 In December 2014, Lottie reported to ABT that she remained compliant with her medication but it wasn't having any therapeutic benefit. She reported feeling depressed, anxious and tired. She was offered an urgent appointment on the 18<sup>th</sup> December, which she attended accompanied by her boyfriend, Bert. At the appointment Lottie reported on-going anger management issues and disclosed that she had recently been arrested for criminal damage and was currently on bail. Her medication was changed to Semisodium Valproate (a mood stabiliser), she accepted a referral to anger management and her case was closed.

#### 2.14.15 **Bert's contact with CNWL**

2.14.16 Bert had a longer history of contact with CNWL mental health services. In May 2010, aged seventeen, he was admitted as an inpatient to the Adolescent Unit, Priory Hospital. It appeared to have been precipitated by a period of violent and aggressive behaviour including altercations with others. He was diagnosed with Attention Deficit Disorder (ADD) and Conduct Disorder. For the remainder of this year, Bert was under the care of the Early Intervention Service (EIS) and he was allocated a Care Coordinator under the Care Programme Approach. It was reported that he continued to have poor impulse control and to fight with his brother. When he became eighteen, he was transferred to an adult psychiatrist. He was medication compliant and his mood settled. At this time, he was employed by a security company.

2.14.17 On 20<sup>th</sup> March 2011, Bert was taken to Hillingdon A and E and assessed by a psychiatric liaison nurse. He was threatening that he 'may kill a member of his family' and that voices were telling him to 'kill his mother and girlfriend'. The girlfriend referred to here was not Lottie. He was discharged home but attended A and E again in April 2011 where he was offered an informal admission. He declined and returned to live with his parents.

2.14.18 In August 2011, Bert threatened to assault his doctor. His medication was changed to Diazepam (a tranquilizer used to treat anxiety) and no psychotic symptoms were noted.

2.14.19 In January 2012, Bert was reviewed and reported an altercation with his father over Christmas. In March, Bert was seen by the EIS team while on bail, following his arrest for assault on a 'garage attendant'. It was noted that he 'did not seem particularly bothered about the incident and seemed prepared to go to prison'. At the end of the month, he presented to Hillingdon A and E and stated that he

- ‘wanted to kill someone’, and he had fantasies about cutting people up and eating them, he claimed he had shot a cow and killed a horse. He ripped off his electronic tag. The psychiatrist noted ‘antisocial personality traits’.
- 2.14.20 In January 2013, following his release from prison, Bert’s mental state was assessed as stable. He was abstinent from drugs and alcohol. The team manager attempted, unsuccessfully, to liaise with Bert’s probation officer. He was discharged from the EIS in February 2013 and a letter was sent to probation.
- 2.14.21 In September 2013, Bert’s probation officer raised concerns about his mental state with his GP. The same month, Bert was also advised by his probation officer to attend A and E as he reported feeling very low. He said there was ‘no hope for the future in terms of employment, relationships, or having a normal life’. He reported a recent suicide attempt and stated he had access to firearms through his friends. His extensive forensic risk history of violence to others was noted, along with his incidences of self-harm and illicit drug use. Bert’s request for informal admission was agreed because of the risk history, but he later reported feeling ‘much better’ and he returned home that evening. CNWL obtained Bert’s MAPPA referral and documentation from the probation service.
- 2.14.22 For the next few months Bert engaged well with the HTT. He told the team he had considered committing a crime in order to return to prison. He was encouraged to manage his anger and reported using a punch bag. He made reference to Lottie, stating that he was enjoying the company of his girlfriend and was helping her with childcare. There was no record of any contact between CNWL and Children’s Social Care at this time.
- 2.14.23 On 23<sup>rd</sup> January 2014, the mental health worker in the probation service, employed by Together, referred Bert to ABT because he was experiencing psychotic symptoms, suicidal thoughts and had ‘head butted’ someone. He was seen urgently, prescribed sodium valproate (a mood stabiliser) and diagnosed with dissocial personality disorder.
- 2.14.24 In April 2014, a file note was added confirming that Bert had breached his bail conditions and been recalled to prison. He was discharged from ABT.
- 2.14.25 In June 2014, on his release from prison, Bert presented to the ABT office. He was told to register with his GP.
- 2.14.26 On 19<sup>th</sup> September 2014, Bert attended A and E and told the psychiatric liaison nurse that he had had an argument with his girlfriend and he knew he had to end the relationship or he would have ended up assaulting her. He reported experiencing more angry outbursts over the previous two months and that he had moved back to his mother’s home, and out from the flat he had shared with his girlfriend. The records did not confirm who the ‘girlfriend’ was. He was admitted informally and it was noted that the risk to others was ‘potentially very high’. He stayed on the ward one night and then sought to discharge himself. He was given two days’ home leave to his mothers and then discharged back to the HTT.

- 2.14.27 Bert engaged well with the HTT and found work as a gardener. He was discharged from the HTT back to ABT for follow up.
- 2.14.28 Bert was seen by ABT on the 9<sup>th</sup> January 2015, accompanied by his girlfriend (presumed to be Lottie). He stated that he felt like 'shit' and was worried about going back to prison and was waiting to be interviewed by the police following two separate assaults. He was risk assessed and described his mother and girlfriend as protective factors and reflected that his last admission in September 2014 had followed an argument with his girlfriend (presumed to be Lottie but not identified during the consultation). He said that he was upset at that time because she had told him that she would leave him if he didn't find employment. His mental state was noted to be stable and he was recorded as having traits of both dissociative personality disorder and emotionally unstable personality disorder. It was explained that medication had a limited role but, on request, he was prescribed haloperidol (an antipsychotic) and sodium valproate (a mood stabiliser). It was suggested he self-refer for anger management and support with cannabis use.
- 2.14.29 On 19<sup>th</sup> February 2015, Bert was reviewed and noted to be calm. Bert acknowledged that he found it difficult managing his emotions and had an, 'all or nothing response', but he also reported having no concerns regarding his relationship with his girlfriend. His next review appointment was arranged for 30<sup>th</sup> June 2015.

## **2.15 Central and North West London NHS Foundation Trust (CNWL) Community Health Services**

- 2.15.1 CNWL community health services provide treatment and support for people with physical health care problems in a community setting. They include community nurses, health visitors and school nursing.
- 2.15.2 Betty and Lottie had been known to the health visiting service from the time of Betty's birth.
- 2.15.3 In 2008 and 2009 concerns were recorded about domestic violence perpetrated by Reg against Lottie.
- 2.15.4 In 2010 another perpetrator of violence, who was believed to be stalking Lottie, was also identified in Betty's records. The health visitor made several home visits during this year. On 3<sup>rd</sup> February 2010, Lottie was referred to the children's centre for counselling and support regarding domestic violence. Between June and December 2010, the health visitor made several attempts to see Lottie but it was recorded that she did not attend. In 2011 it was again recorded that Lottie did not return phone calls or respond to letters or home visits.
- 2.15.5 In March 2012, Betty was transferred to the school nursing service. The school nurse received notification from Hertfordshire that Lottie and Betty had moved back into the local area following Lottie's eviction from a refuge.

- 2.15.6 On 14<sup>th</sup> January 2013, an Emergency Safety Net meeting was held. It was attended by the liaison health visitor and prompted by Lottie's repeat attendance at A and E following two overdoses. Referrals to social care and the psychiatric home treatment team were recorded.
- 2.15.7 In November 2013, there were several entries in the notes referring to an incident on the 5<sup>th</sup> November 2013 (the first known incident of domestic violence between Bert and Lottie) but referencing 'further details unknown'.
- 2.15.8 On the 10<sup>th</sup> February 2014 (also the day of the first reported incident of domestic violence), the school nurse attended the child in need meeting held at the school. It is recorded that "mother did not attend and is not working with professionals or the child in need plan. Betty is reported to be happy living with her mother and her mother's partner Bert".
- 2.15.9 The following day, on the 11<sup>th</sup> February 2014, Betty had a health assessment with the school nurse and stated that she was scared when her mother and Bert argued. She reported that they had argued the previous day when her mother had told Bert to leave. Bert had broken furniture when he was angry. She stated that Bert had threatened that the next time Betty went to her father's, he was going to stab her mother and set fire to the house.
- 2.15.10 On the 12<sup>th</sup> February 2014, the school nurse spoke to Betty's social worker about the meeting with Lottie planned for that day. She clarified that Lottie was to be asked to sign an agreement that Bert was not to be allowed in the property.
- 2.15.11 On the 10<sup>th</sup> March 2014, the school nurse attended the initial case conference. Lottie also attended. An extensive list of concerns raised by agencies was recorded and included: Betty's school attendance; Betty had been exposed to domestic violence between her mother and Bert in the past; Lottie's mental health; concerns that Lottie may not engage with social care and promote change; Lottie's reluctance to engage with HDAS; and that Betty had a raised BMI and her health needs such as immunisations and dental care were not being met. It was recorded that Lottie became confrontational and angry towards professionals. The child protection plan included Lottie and Betty to attend domestic violence work with Hestia. It was also recorded that the probation officer voiced his concerns about Bert being allowed to reside at the family home once he was released from prison, and it was agreed that there would be a joint risk assessment with probation and social services relating to Bert before his release in June 2014.
- 2.15.12 On the 24<sup>th</sup> March 2014, the school nurse attended a core group meeting. It was recorded that Lottie was abusive to the school nurse. The summary of the core group discussion included Lottie's reluctance to engage with Hestia as she felt that previous domestic violence issues had been resolved. She also stated that she didn't want Betty to attend the parallel course as it would bring back memories of domestic violence. The school nurse reported that she had met Betty in school and she had stated that 'she was only 1 out of 10 happy, which was due to Bert'. (NB. Bert had been recalled to prison on the 25<sup>th</sup> February 2014).

- 2.15.13 On the 2<sup>nd</sup> April 2014, Betty was seen in school by the school nurse. She reported being 10 out of 10 happy.
- 2.15.14 On the 30<sup>th</sup> April 2014, a case conference was held and attended by the school nurse. The potential for a legal planning meeting was raised by the social worker. Lottie was recorded to be angry during the meeting.
- 2.15.15 On the 10<sup>th</sup> May 2014, Betty was seen in school by the school nurse. She again reported being 1 out of 10 happy. She reported that 'her boyfriend is horrible to mummy which makes her mad' (NB. Bert was in prison). She said that she was staying with her grandmother and hadn't seen her mother for a long time.
- 2.15.16 On the 2<sup>nd</sup> June 2014, a case conference was held and attended by the school nurse. Lottie did not attend but her mother and uncle did. It was noted that Betty had settled into her grandmother's home and was happy. Betty's exposure to domestic abuse between her mother and Bert was also discussed. It was noted that Betty was to be 'protected from Lottie's associates who frequent her home' (NB. Bert was in prison). Lottie was not to be allowed to collect Betty from school without supervision.
- 2.15.17 On the 19<sup>th</sup> June 2014, a core group meeting was held and attended by the school nurse. Lottie did not attend but her mother did. It was recorded that Lottie had a new boyfriend (NB. Bert was in prison). Her mother stated that he is 'nothing but trouble ... and he is even worse than the last boyfriend who is still in prison'.
- 2.15.18 On the 10<sup>th</sup> September 2014, Betty was seen in school by the school nurse. No concerns were noted.
- 2.15.19 On the 16<sup>th</sup> October 2014, a core group meeting was held and attended by the school nurse. Lottie did not attend but her mother did. The notes recorded 'a meeting arranged for the weekend had to be cancelled as Lottie was assaulted'. Lottie was noted not to be engaging with the child protection plan and had been abusive to professionals.
- 2.15.20 On 23<sup>rd</sup> October 2014, it was recorded that Betty was happy in school.
- 2.15.21 On the 4<sup>th</sup> November 2014, there was a case conference but no family was in attendance. It was noted that Lottie was still in a relationship with Bert who had been violent to her.
- 2.15.22 A core group meeting on 17<sup>th</sup> November 2014 was cancelled. The next one was held on 4<sup>th</sup> March 2015. Lottie did not attend but her mother and step-father did. This was described as a difficult meeting. Lottie's mother was much more positive about Lottie's involvement with Betty, against the professionals concerns. There was a disagreement between the social worker and Betty's grandfather over an incident in which Betty had been choking. The social worker reported that he was carrying out risk assessments on Lottie and also Bert's mother's boyfriend. Lottie was recorded to be unhappy about this.

## **2.16 Hillingdon Urgent Care Centre, Greenbrook Healthcare**

- 2.16.1 The Urgent Care Centre at Hillingdon Hospital opened in October 2013. Its role is to provide quick treatment to patients who do not require the full A and E service.
- 2.16.2 Bert presented to the Urgent Care Centre on five occasions between October 2013 and September 2014. His first attendance was on 19<sup>th</sup> October 2013 when he had sustained a hand injury after punching a wall. He did not wait for treatment but returned two days later with his mother, on the 21<sup>st</sup> October 2013, this time stating he had sustained the injury after punching staff in his house (NB it is unclear where this was). He was diagnosed with a soft tissue injury.
- 2.16.3 On the 24<sup>th</sup> June 2014, he attended accompanied by his brother and a mentor from the prison service. He had been released from prison and asked for a repeat prescription of Ritalin (a stimulant used to treat ADHD and conduct disorder) and Risperidone (an antipsychotic). He was given a prescription for Risperidone only and told to contact his GP.
- 2.16.4 On the 13<sup>th</sup> July 2014 (the same day as the third identified incident of domestic violence) he attended with his mother. He reported being involved in a fight and having pain in his hands and nose. He received general advice.
- 2.16.5 His final attendance was on 18<sup>th</sup> September when he described feeling 'on the edge' for six weeks. He was referred to the psychiatric liaison team for assessment.
- 2.16.6 There was no contact with Lottie.

## **2.17 Hillingdon Hospital NHS Foundation Trust**

- 2.17.1 Hillingdon Hospital is the only acute hospital in Hillingdon. It provides Accident and Emergency, inpatients, day surgery and outpatient clinics.
- 2.17.2 Both Lottie and Bert were seen separately in the hospital, and all but Lottie's final attendance preceded their relationship. There is nothing in the records that indicated that, at the time of Lottie's final attendance, their relationship was known.
- 2.17.3 Between 2009 and 2011, Bert presented on six occasions for mental health issues, an overdose and injuries following acts of violence.
- 2.17.4 On 29<sup>th</sup> March 2012, Bert presented to A and E, accompanied by his mother, and was assessed by the mental health team. His mother, Dolly, described how he had become increasingly frustrated, which culminated in him ripping off his electronic tag. She described calling the mental health crisis line who advised her to take Bert to Hillingdon Hospital A and E, where the psychiatric team could be accessed. He reported feeling a danger to himself and others. He stated that he "wanted to kill someone". He described fantasies about cutting people up and eating them. Dolly recalled that, as soon as they arrived in A and E, the hospital security was called and Bert became more hostile. She reflected on the lack of sensitivity by



staff in handling Bert at this time and how unsupported she felt ... 'I thought, why have I got to fight like this. They don't make it easy for you'. It was established that Bert did not have a 'marker' on his notes to indicate a security risk, but the CNWL Liaison Psychiatry Service joint operational policy<sup>4</sup> includes recognising the need for additional security where indicated because of a person's presentation and potential risks to themselves and others. It was recorded in the notes that the mental health liaison nurse undertook an assessment and discharged Bert. The assessment could not be found in Bert's notes.

- 2.17.5 The next day, the 30<sup>th</sup> March 2012, Bert attended A and E again, having been transferred there after presenting at the Riverside Centre (CNWL's acute inpatient wards). This time he was accompanied by his mother and two police officers. Bert was reported to have asked for help and wanted to be sectioned so as to be kept safely away from other people. He made threats that if he was not admitted he would kill someone and bring their head to A and E. He was assessed by a psychiatrist and it was noted that despite feeling angry and hostile, there were no psychotic symptoms but there were antisocial personality traits. A decision was recorded in his notes that, if he presented again in A and E over the weekend, he would not be seen by the psychiatric liaison team. He was discharged into the care of the police. Bert was then arrested and placed on remand before being taken to court later that day.
- 2.17.6 On 21<sup>st</sup> December 2012, Lottie attended A and E accompanied by her father. She was brought in by ambulance following an overdose. She informed staff that she had a five-year-old child but the records do not indicate whether a referral was made to Children's Social Care. On 10<sup>th</sup> January 2013, Lottie again attended A and E following an overdose. She was accompanied by her ex-partner. Lottie reported that she wanted to kill herself before someone else did.
- 2.17.7 On 5<sup>th</sup> September 2013, Bert again attended A and E with injuries he reported sustaining in a fight. He received treatment. He attended later that same month, on the 24<sup>th</sup> September 2013, and complained of hearing voices and thoughts of hurting others. He was assessed by the mental health liaison team and discharged.
- 2.17.8 The final recorded attendance was by Lottie on 10<sup>th</sup> October 2014 when she was seen in the outpatient dental clinic. She disclosed that she had a personality disorder and had been a victim of domestic violence.

## **2.18 Out of Hours GP Service, Care UK**

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<sup>4</sup> Hillingdon Hospital Liaison Psychiatry Service, Joint Operational Policy, Version 4.3, June 2015.

- 2.18.1 Hillingdon GP Out of Hours Service provides advice, information and treatment for NHS patients who become unwell during the hours when their GP practice is closed. In Hillingdon the service is provided by the independent provider, Care UK.
- 2.18.2 Bert had three recorded contacts with this service although the first was in 2007 and outside the scope of this review.
- 2.18.3 In the second, on 16<sup>th</sup> September 2010, he presented with an allergic reaction to an over the counter medication.
- 2.18.4 The third contact was on 24<sup>th</sup> September 2013 when he presented with a worsening of his mental health problems. He said he felt unable to cope and was agitated. On examination he complained of hearing voices and was preoccupied with ideas of self-harm and harming others. He was referred to A and E to see the psychiatric liaison team.
- 2.18.5 There was no contact with Lottie.

## **2.19 London Borough of Hillingdon Housing (Homeless Prevention Team)**

- 2.19.1 The Hillingdon Homeless Prevention Team provides housing advice, homelessness assistance and maintains the housing register.
- 2.19.2 Lottie was well known by the service. There was more limited contact with Bert.

### **2.19.3 Lottie and Housing**

- 2.19.4 Lottie's first contact was in 2006 when she had to leave her mother's home and was accommodated in a number of interim placements.
- 2.19.5 It is known from the GP records that Lottie was briefly accommodated in a refuge in Hertfordshire around May/June 2012.
- 2.19.6 At some point Lottie moved to housing association accommodation in the London Borough of Hillingdon.
- 2.19.7 In January 2013, Lottie presented at Hillingdon Housing needing accommodation for herself and her daughter after fleeing domestic violence (the perpetrator was unknown, but was not Bert). She was placed in a refuge on an interim basis before being allocated a two-bedroom house in a different area of Hillingdon, but near her family, a few days later.
- 2.19.8 On 7<sup>th</sup> July 2014, following the assault by Bert on the 4<sup>th</sup> July, Lottie contacted Hillingdon Housing by telephone stating that her ex-partner, Bert, had recently been released from prison for domestic violence. He had presented at her property and assaulted her. She mentioned that her daughter had moved to stay with her grandmother and that she needed to move. Three days later she presented to

housing stating that she couldn't return to her property because of domestic violence from her ex-partner who had been released from prison. On the 14<sup>th</sup> July, Lottie was interviewed by the homeless team and offered temporary accommodation in a B&B. Lottie was subsequently moved to other B&Bs. There is one record of a move being prompted by a complaint by another resident because of her antisocial behaviour.

- 2.19.9 On 20<sup>th</sup> August 2014, Lottie was moved to temporary accommodation in Slough. Her daughter remained with her grandmother in Hillingdon.
- 2.19.10 At the end of August, and 'in view of Lottie's domestic violence and mental health needs', the management transfer request was agreed. The supporting report included a comprehensive report from the IDVA dated 14<sup>th</sup> July 2014. It was noted that in view of the IDVA's report and supporting evidence from the police, that Lottie could not return to her previous address. It was agreed that Lottie be moved to a one-bedroom property on a temporary basis while she bids for a two-bedroom property.
- 2.19.11 On 29<sup>th</sup> August 2014, a call was received from Stanley advising that Bert was staying with Lottie in her B&B and that there is a warrant out for his arrest. He identified himself as Stanley, Lottie's brother although he was unable to confirm her date of birth. No information was provided to Stanley, but he was advised that a note would be made on the file, which effectively confirmed that there was a file for Lottie. This information was not passed on to the community housing team who were the case-workers for Lottie at that time.
- 2.19.12 On the 18<sup>th</sup> September 2014, homeless prevention received a note from corporate fraud following a routine visit to the B&B in Slough. It noted that 'Lottie is continuing a pattern of extremely negative behaviour within B&Bs'. They also recorded evidence that 'she had breached her tenancy by allowing other adult males (possibly the perpetrator of domestic violence to her) to stay overnight'. There was no record that it was considered that Lottie may have been subject to domestic violence and had no choice but to let him stay.
- 2.19.13 A week later, on 25<sup>th</sup> September 2014, the community housing team leader contacted the IDVA by email seeking their views. Recent events in the B&B were described, including hostility to neighbouring residents and male adults staying overnight, and the decision to 'last night' Lottie was outlined. It repeated the concern that Bert, the perpetrator, was staying at the B&B. The options of returning Lottie to her home via sanctuary scheme or placing her in a refuge were presented. The email stated 'As always in cases of domestic violence we take great heed of supporting evidence provided via HIDVAS and this case is no exception.... I am very conscious of the repercussions for Lottie's personal safety in making this decision and should be obliged for your views and indeed any intelligence that Lottie is with Bert as this would clearly negate the management transfer status re. housing'.

- 2.19.14 Lottie remained in the B&B in Slough and was given a 'last night' on the 9<sup>th</sup> November 2014, following her arrest for criminal damage. On the 13<sup>th</sup> November 2014, Lottie visited her previous property, a two-bedroomed flat, which had been vandalised and was uninhabitable. She was then shown and accepted a new, one-bedroom property, close to her parent's house, in Hillingdon.
- 2.19.15 On 25<sup>th</sup> November 2014, Lottie telephoned housing to report that unknown people had been banging on her windows. Her brother had been in a fight with a group of men and she was concerned that her property was now compromised. She was advised to contact the HIDVA and seek help assessing the risks and identifying any additional measures which were needed.
- 2.19.16 On 20<sup>th</sup> February 2015, Lottie approached her housing officer requesting a move back to her previous address so that she could be reunited with her daughter.
- 2.19.17 **Bert and Housing**
- 2.19.18 On the day of his release from prison, the 21<sup>st</sup> June 2014, Bert approached housing. He was advised to stay with his mother while further medical assessments are done and appropriate accommodation identified. On 25<sup>th</sup> June 2014, he was housed in interim accommodation. On 18<sup>th</sup> July 2014, the medical advisor recommended that 'general needs accommodation would be inappropriate. The applicant would seem unable to maintain a tenancy.' On 6<sup>th</sup> October 2014, it was noted that Bert had not turned up to the B&B and his homeless application was closed.
- 2.19.19 Bert attended housing again on 12<sup>th</sup> November 2014 and it was recorded that he had 'spent some time staying with friends until he was sectioned' (the CNWL records refer to an informal admission in September 2014). He was not provided with interim accommodation and he threatened to commit suicide.
- 2.19.20 Bert's mother reported that, at times, Bert rented a room privately, stayed with friends and latterly stayed with Lottie. He would also spend the odd night with his mother.

## **2.20 London Ambulance Service (LAS)**

- 2.20.1 The London Ambulance Service's (LAS) had four recorded contacts with Lottie. The first was on the 21<sup>st</sup> December 2012 when Lottie called 999 stating that she needed help, she was depressed and no one liked her. It was documented that Lottie stated that Irish travellers were going to kill her. She had taken an overdose of prescribed medication, but she said this was to help her relax and not a suicide attempt. Although Lottie's daughter wasn't present in the house, a safeguarding referral was made for her. Lottie was taken to Hillingdon Hospital.
- 2.20.2 On the 9<sup>th</sup> January 2013, an ambulance attended to Lottie's daughter, Betty, who was unwell. She was taken to Hillingdon Hospital.

- 2.20.3 The following day, the 10<sup>th</sup> January 2013, an ambulance was called after Lottie took an overdose of prescribed medication. Her friends reported that they were concerned for her safety as she was talking to herself, had paranoia, and she had hacked her sofa and tried to kill herself with a knife. An adult safeguarding referral was made for her.
- 2.20.4 The final contact with LAS was in March 2015 when they were called to Lottie's address following the fatal stabbing.

## **2.21 Victim Support**

- 2.21.1 Victim Support is an independent charity helping people cope with the effects of crime, by providing free and confidential support and information.
- 2.21.2 During the period of review, Victim Support received nine referrals for Lottie.
- 2.21.3 The first contact was in 2010 when it was established that the IDVA was supporting Lottie. Between 2012 and early 2014, six referrals were made by the Metropolitan Police which were all recorded as non-domestic violence incidents such as criminal damage, burglary and communication act offences. During this time contact was established with Lottie, but she declined support.
- 2.21.4 During 2014, the service received two referrals from the Metropolitan Police. The first concerned the second identified domestic violence incident on 4<sup>th</sup> July 2014. On the 7<sup>th</sup> July 2014, contact was made with Lottie and she asked for help with her accommodation. She stated that she was frightened of living in her home as the alleged incident involved her ex-partner – who had just come out of prison – harming her. She says he knows where she lives and is very frightened. Lottie was risk assessed (she scored 12 on the CAADA DASH risk assessment) and she was referred to the IDVA service.
- 2.21.5 A few days later, on 13<sup>th</sup> July 2014, Victim Support received another referral from the police in relation to the third identified incident of domestic violence. It was established that the IDVA service was supporting Lottie and the case was closed.

## **2.22 General Practitioners (GP)**

- 2.22.1 During the time of the review, Lottie was registered with at least two GP practices and Bert with five.
- 2.22.2 **Lottie and GPs**
- 2.22.3 The panel was unable to identify the practices that Lottie was registered with between June 2009 and May 2012.
- 2.22.4 **GP1**
- 2.22.5 Lottie registered with the practice, in Hertfordshire, between May and June 2012 while she was living in a refuge. She attended the practice on four occasions and

reported being very scared of her partner who had physically assaulted her. The practice did not have access to her full medical notes and no chronology was submitted.

**2.22.6 GP 2**

2.22.7 Lottie and her daughter registered with the practice (the same practice as Bert and number 3 below) on 5<sup>th</sup> November 2012. The practice received notification that Lottie had been assessed in Leeds A and E in October 2012 having taken an overdose. She was noted to be fleeing domestic violence. She was also noted to have a daughter. She had been discharged by A and E, and advised to register with a GP in London. The records were faxed to the social worker who forwarded them to the GP on 6<sup>th</sup> November 2012. The GP called Lottie that day. She had symptoms of depression but had stopped her antidepressants. After three unattended appointments, Lottie attended on the 9<sup>th</sup> November. She said that she could not come on her own. She was restarted on medication.

2.22.8 On the 30<sup>th</sup> November 2012, Lottie was reviewed by the GP. She was accompanied by her step-father. She had on-going symptoms and her medication was increased.

2.22.9 On 19<sup>th</sup> December 2012, Children's Social Care sought information from the GP. On the 20<sup>th</sup> December 2012, Lottie reported that she had lost her medication and was issued with another prescription. On the 24<sup>th</sup> December 2012, following an overdose on 21<sup>st</sup> December 2012, she was telephoned by the GP and reported that she had stopped her medication. She did not keep the following two appointments.

2.22.10 In January 2013, Lottie refused to attend an appointment with the GP. She was referred to the mental health team but declined a referral to Hillingdon Action Group for Addiction Management (HAGAM). On 10<sup>th</sup> January 2013, Lottie was issued with a repeat prescription and took an overdose of the prescribed medication that same day. She was admitted overnight and her medication was changed.

2.22.11 For the following months the GP maintained contact with Lottie, mostly by telephone, and she did not attend several appointments.

2.22.12 On the 6<sup>th</sup> November 2013, a social worker called asking the GP to attend for a mental health act assessment. Lottie was at the police station following a disturbance. The GP was unable to attend and alternative arrangements were made. The following day the GP called Lottie and she asked for a referral to the mental health team. She described being arrested for child neglect. She did not attend an appointment with her GP later that day.

2.22.13 On the 5<sup>th</sup> December 2013, Lottie attended an appointment and mentioned that her partner, Bert, takes her child to school. Lottie demanded Temazepam (generally used for the short-term treatment of insomnia, but often misused and addictive), which was declined. She stormed out.

- 2.22.14 Lottie was next seen when Betty had an appointment in November 2014. Lottie's final attendance at this practice was on 12<sup>th</sup> November 2014, when she attended accompanied by her grandmother. Lottie reported that she had been arrested the previous day and wanted to restart medication. She did not attend her review appointment the following week.
- 2.22.15 On the 30<sup>th</sup> February 2015 (sic), Lottie did not attend for a cervical smear. The practice received correspondence in connection with Lottie and Betty but there was no further contact with her.
- 2.22.16 **Bert and GPs**
- 2.22.17 **GP 1**
- 2.22.18 Bert was registered with GP number 1 from June 2009 until January 2013, prior to his relationship with Lottie. In March 2010 he attended describing symptoms of two personalities, talking to himself and lots of anger issues. He referred to getting angry and punching walls and having severe hand injuries. He reported using cannabis.
- 2.22.19 In March 2010, he described waking to find that he had written all over his arms. He was referred to CNWL. On 6<sup>th</sup> April 2010, Bert's mother called and reported that Bert had attacked his younger brother, Fred, and broken down the front door. On 10<sup>th</sup> June 2010 it was recorded that Bert had been admitted to The Priory Hospital. The following three contacts referred to Bert being reviewed and his mental health being stable.
- 2.22.20 **GP 2**
- 2.22.21 Bert was registered with GP number 2 between 21<sup>st</sup> March 2013 and 22<sup>nd</sup> February 2014. During this time, he attended the surgery on five occasions and saw four different GPs and he also saw a health care assistant. The practice was aware that he'd been in prison (NB. he was released on 17<sup>th</sup> December 2012) but unaware of the reason. They were also unaware of his relationship with Lottie. The first few entries in the records, which included phone calls, related to his mental health and medication.
- 2.22.22 On the 23<sup>rd</sup> September 2013, it was noted that Bert's probation officer called expressing concern about his mental health. She had noted that he had bruising to his hand.
- 2.22.23 There were then two letters relating to the treatment he received at the Urgent Care Centre on the 21<sup>st</sup> October 2013 for a hand injury and that he had also attended on the 19<sup>th</sup> October 2013 but hadn't waited to be seen.
- 2.22.24 On the 11<sup>th</sup> December 2013, Bert attended because his hand was still painful following the hand injury sustained in the fight seven weeks earlier.
- 2.22.25 On 22<sup>nd</sup> January 2014, the practice received a call from Bert's forensic health practitioner (presumably from Together) asking for him to be referred to the ABT as he is 'getting more angry, and having violent fantasies ... he is also getting into

an aggressive state with other people'. The GP offered to refer Bert to the mental health services urgently.

#### 2.22.26 **GP 3**

2.22.27 Bert registered with GP number 3 in February 2014 (NB. Bert was recalled to prison on the 25<sup>th</sup> February 2014). This was the same GP practice that Lottie was registered with but they were registered under different addresses.

2.22.28 Bert was seen only once, for tonsillitis, at the day that he registered. In February the practice was approached by Children's Social Care who were seeking information for child protection. In April 2014 the practice received notification from St George's Hospital A and E where Bert had presented but not waited to be seen.

#### 2.22.29 **GP 4**

2.22.30 Bert registered with GP number 4 in June 2014, after he was released from prison following his recall (NB. he was released on 21<sup>st</sup> June 2014). He attended twice, once in June and once in August 2014, asking for medication, as directed by the mental health team, and when seeking a sick note.

#### 2.22.31 **GP 5**

2.22.32 Bert was registered with GP number 5 between 25<sup>th</sup> November 2014 and March 2015. During this time, he attended the surgery on seven occasions. On his first attendance, on the 25<sup>th</sup> November 2014, he presented as an emergency. He stated that he had been involved in a fight and had sustained two wounds to his arm and chest. He refused to attend A and E and asked to have steri-strips applied instead. He refused to elaborate to the doctor on the incident saying 'he would prefer not to talk about it'. He did, however, disclose details of his recent deterioration and improvement in mental health. It was recorded that there were no features of acute mental illness. The nurse also asked him about the circumstances of the incident but he again refused to give any details.

2.22.33 There followed a further four attendances for minor illnesses and a sickness certificate. On the 29<sup>th</sup> January 2015, he presented with a chest wall injury, which he said was the result of falling off his bicycle. The injuries were consistent with the history and, again, no evidence of acute mental illness was noted.

Bert's final attendance was in March 2015, two days before Lottie's murder, when he asked for medication prescribed by the local community mental health team. A full mental and physical health assessment was carried out and the prescription issued. Dolly recalled that Bert had not been sleeping for two or three days and understood that he had asked the GP for sleeping tablets. She stated that the GP refused to prescribe them. Neither his request nor the refusal was recorded in the GPs notes.

### 2.23 **The School**

2.23.1 The family was well known to the primary school. Lottie, her brothers and Lottie's daughter all attended the same school. Lottie's daughter, Betty, initially attended



- the nursery but left and re-joined the school in September 2012. Between 2012 and 2015, Betty moved between her mother's and her grandmother's homes. Her attendance tended to deteriorate when she lived with Lottie and this was raised on several occasions with Children's Social Care and the Educational Welfare Service. On one occasion, in October 2011, Lottie did not collect Betty from school.
- 2.23.2 The school became aware of Bert when he started bringing and collecting Betty from school. On 6<sup>th</sup> February 2014, Bert claimed Betty was being bullied at school.
- 2.23.3 On 11<sup>th</sup> February 2014, Bert brought Betty to school. The reception staff noticed that both of his hands were heavily bandaged. They asked Bert what he had done. He replied he hurt them. Later that day, Betty disclosed to school staff that Bert and Lottie had been fighting. Bert had kicked a table and Lottie had locked herself in the bathroom. "Bert hurt his hands trying to break the door down". Betty also said that the next time she goes to her dad's; Bert will burn the house down. She repeated this to the school nurse but added that Bert would stab Lottie before he burnt the house. The disclosure was shared with Children's Social Care services who visited the school that day and met with Betty. It was this disclosure which led to Bert's recall to prison.
- 2.23.4 From June 2014 onwards, Betty was cared for by her grandparents and the school had no contact with Lottie or Bert until January 2015, when Lottie sometimes came to school with another family member to collect Betty. In January 2015, she was asked about the argument with Bert the previous year. She claimed it was an argument just like other couples have.
- 2.23.5 The final meeting to be held in school was a core group meeting on the 4<sup>th</sup> March 2015.

## **2.24 Participation Key Work Team (formerly Education Welfare Service), London Borough of Hillingdon**

- 2.24.1 This is the Hillingdon team responsible for children's school attendance, pre-exclusion casework, children missing education and NEET young people case work (young people not in education, employment or training).
- 2.24.2 The Education Welfare Service first became involved with Lottie in November 2011 because of Betty's poor school attendance, which was often as low as 45%. Although Betty's attendance improved, there was further contact in May 2012. Lottie then moved Betty to a school in Hertfordshire.
- 2.24.3 Betty began living with her grandmother and returned to school in Hillingdon later that year and her attendance improved. The service was unaware of any reports of domestic violence.

## **2.25 Children's Social Care, London Borough of Hillingdon**

- 2.25.1 Prior to 2009, Lottie and Betty came to the attention of Children's Social Care on five occasions. All of these contacts related to Lottie's intoxication. There was an additional contact in 2008, by Lottie's mother, to request help for Lottie who she described as suffering from depression and needed help with housing.
- 2.25.2 In November 2009, Betty was first allocated a social worker. Between late 2009 and February 2010, Children's Social Care were actively involved with Lottie and Betty. A written agreement was made between Children's Social Care and Lottie because of concerns around Lottie's alcohol misuse and allowing people into her flat, and Betty's safety and well-being. They were also concerned about Lottie's relationship with Bert's half-brother, Reg, who Portsmouth MAPPA believed was 'a risk to children'. Reg was reported to have more than sixty outstanding arrest summonses and was known to be violent.
- 2.25.3 Throughout the period of the review, Children's Social Care were actively involved with Lottie and Betty as a result of overdoses, alcohol and housing issues. There was also a clear relationship between Betty's very poor school attendance, which was often as low as 45%, and her being in Lottie's care. When Lottie was unable to care for Betty, Lottie's parents were the first recourse to provide care for Betty.
- 2.25.4 On occasions, generally weekends, Betty's father looked after his daughter. There were very few details recorded about Betty's father and he appeared to have had no contact with Children's Social Care throughout the local authority's involvement with his daughter until February 2014.
- 2.25.5 Lottie's engagement with Children's Social Care was recorded to be variable. There were periods when she asked for help, particularly after she took an overdose or requested to be sectioned, but on other occasions she declined offers of help. For example, in October 2011, following an incident when Betty wasn't collected from school, the social worker attempted to complete an initial assessment. It was recorded Lottie was unwilling to set a date for a visit on three occasions. The social worker then attempted to visit the house and suspected that Lottie was in the house but refusing to answer the door so, following a failed phone call, an unannounced visit was made.
- 2.25.6 Following the incident on the 5<sup>th</sup> November 2013, in which Lottie was found by police to be intoxicated and she was arrested for child neglect, Betty was placed in her grandmother's care. Lottie was bailed for four weeks with conditions including no unsupervised contact with her daughter. Betty disclosed to Children's Social Care that Bert had been taking her to school recently and, on that day, they had argued over a mobile phone and Bert had broken a window.
- 2.25.7 During a home visit on the 11<sup>th</sup> November 2013, Lottie expressed that she thought the police had overreacted. On the 14<sup>th</sup> November 2013, Lottie's parents were advised that there would be an Initial Child Protection Case Conference (ICPC). The social worker asked whether Betty's father could care for his daughter full time, but this was discounted by her family. The child protection procedure was explained to Lottie.

- 2.25.8 On the 21<sup>st</sup> November 2013, the children and families assessment report was completed and contained a reference to Lottie and Bert's relationship in which it stated that "Lottie had been a victim of domestic violence in the past, but states that she is not in a domestically violent relationship currently with her partner, Bert". There was no cross-reference to the incident and disclosure made by Betty on the 5<sup>th</sup> November.
- 2.25.9 On the 29<sup>th</sup> November 2013, a written agreement was drawn up about the care of Betty, which was signed by both Lottie and Bert. Lottie didn't agree to attend the drug and alcohol programme referred to in the written agreement but Betty was returned to her mother's care. It is noted shortly after that she was often late to school and her attendance had dipped to around 50%. It was also recorded that a young person who was suspected of using drugs had been staying in Lottie's property.
- 2.25.10 On 16<sup>th</sup> December 2013, the social worker recorded that the case would proceed as a child in need and that monthly visits would be made, both scheduled and unannounced. Around the same time, probation notified Children's Social Care that Bert was on licence for a violent offence and that there were mental health, drug and alcohol issues linked to the offence. They requested that Bert should not stay in the home with Betty and advised that they would undertake a risk assessment regarding the indirect risk that Bert might pose to Lottie and Betty due to a concern that he was being pursued by other people.
- 2.25.11 Betty continued to be managed as a child in need by Children's Social Care but it was recorded that Lottie and Bert's engagement with the plan was poor.
- 2.25.12 On the 20<sup>th</sup> January 2014, the social worker called Lottie to arrange a home visit. On the 27<sup>th</sup> January 2014, the social worker undertook a home visit. There were four other people in the house in addition to Lottie, Bert and Betty. It was recorded that it was clear from their observations that Lottie loved Betty a great amount. The social worker discussed Betty's school attendance and recorded that 'Lottie and Bert also fail to take responsibility for their actions and as main carers for Betty'. The dynamic was noted to change, and be softer and calmer, when Lottie and Betty were alone together with the social worker.
- 2.25.13 On 10<sup>th</sup> February 2014, a professionals meeting involving the social worker, school and school nurse was held. Lottie did not attend. A range of issues were discussed including Betty's school attendance and Lottie's parenting capacity. The relationship between Lottie and Bert was not recorded to have been discussed. This was the same day that the first domestic abuse incident perpetrated by Bert to Lottie was recorded by the police.
- 2.25.14 On the 11<sup>th</sup> February 2014, the day after the first recorded domestic abuse incident, Betty's school raised concerns with her social worker about Bert's abusive behaviour towards her mother.. Betty was recorded as disclosing that 'she felt scared at home when Bert was there'. She said that her mum and Bert had fought after she said she did not want to be his girlfriend. Bert had kicked the table

and spilled hot tea on her mum. Her mum had then gone into the bathroom and Bert had knocked the door down and hurt his hands.

- 2.25.15 The social worker attended the school and met with Betty. She repeated her concerns about Bert's behaviour. Betty stated that she felt scared at home when Bert was there. Children's services held a strategy meeting and the plan included progressing to child protection if Lottie wouldn't engage with the social worker and to get Lottie to sign a safeguarding agreement. Lottie refused to sign a written agreement preventing Bert being allowed into her home and having contact with Betty. Lottie stated that Bert wouldn't be having contact with Betty but she would not sign the agreement. Lottie then left the school with Betty. There was no record of any specialist DV support being offered to Lottie or of a MARAC referral being considered. A police welfare check was requested and they were asked to remove Betty if Bert was present in the house. The same day, Lottie called to cancel the child in need meeting due to take place that day. Children's Social Care then undertook a home visit during which Lottie expressed that she didn't think that Betty was at any risk.
- 2.25.16 Children's services called probation to notify them of the incident of domestic abuse and, a week later, Bert was recalled to prison due to breaching his licence conditions. A police check was also requested with the instruction that Betty was to be removed if Bert was in the home. Betty's case remained open and Children's Social Care proceeded to an Initial Child Protection Conference (ICPC).
- 2.25.17 On the 10<sup>th</sup> March 2014, Betty was placed on a child protection plan under the category of neglect. The ICPC minutes recorded that Lottie's mother stated that 'Bert is actually a very nice person and has a good relationship with Betty'. The minutes also record that Betty will be removed if Bert is in Lottie's house and a plan for a joint risk assessment between probation and children's services of Bert regarding his contact with Betty while in Lottie's home. Lottie was allocated a key worker to help ensure Betty attended school. The minutes of the next core group meeting on 24<sup>th</sup> March 2014 also made reference to a joint risk assessment with probation prior to Bert's release from prison.
- 2.25.18 Over the next few weeks, Children's Social Care remained concerned about unsuitable young people staying in Lottie's home and the presence of illegal drugs. A drugs raid was requested. On the 2<sup>nd</sup> April 2014, Betty disclosed at school that she was hungry when she lived with her mother. This was information was confirmed and passed to children's services.
- 2.25.19 Over the next few weeks there were further concerns about Betty's attendance at school, Lottie smelling of alcohol when she took Betty to school, and unsuitable people taking Betty to school.
- 2.25.20 On 13<sup>th</sup> May 2014, Lottie's mother made a series of serious allegations about Lottie and her care of Betty including intoxication, drug use, 'smashing up her house' and having knives. A legal planning meeting was held and care proceedings were initiated. Lottie did not attend but her mother, Betty's

grandmother, did. By the end of May 2014, it was recorded that Betty was living, permanently, with her grandparents, Lottie's mother and step-father. It was also reported by Lottie's mother, however, that Betty had been living with her since the 9<sup>th</sup> April 2014. Betty remained with her grandparents and was living there at the time of Lottie's murder.

- 2.25.21 In June 2014, it was recorded that Lottie was subject to threats to kill by a new boyfriend, not Bert, who was in prison at this time. During this time, Lottie also described to Children's Social Care that she was missing Bert because he helped her a lot.
- 2.25.22 On his release from prison on 21<sup>st</sup> June 2014, Lottie and Bert were reunited. Betty remained with her grandparents.
- 2.25.23 On the 27<sup>th</sup> June 2014, Lottie and Bert visited Children's Social Care offices. Lottie stated that her mother had been lying about her. There was then a telephone conversation about Betty and Lottie's legal rights.
- 2.25.24 Following the assault on 13<sup>th</sup> July 2014, the third recorded incident of domestic abuse, Children's Social Care was notified by the IDVA. On the 14<sup>th</sup> July 2014, Lottie attended the office and was seen by Betty's social worker. Lottie was seen to have extensive bruising to her eyes and bruising and cuts to her arms. She declined to go to a refuge because she felt that her mental health would suffer and was supported to move to a B&B outside Hillingdon.
- 2.25.25 In September 2014, Betty was described as happy and settled with her grandparents, however it was noted that they had decide to withdraw from a Special Guardianship Order application process because they "don't want to burn bridges with their daughter".
- 2.25.26 On 26<sup>th</sup> September 2014, Lottie called children's services to discuss having Betty returned to her care. She also challenged the restrictions on her having to see her daughter in a contact centre.
- 2.25.27 On 4<sup>th</sup> November 2014, a Review Child Protection Conference (RCPC) was held where it was confirmed that Betty remained subject to the plan. The plan included confirming whether Bert was still in a relationship with Lottie and, if so, then he needed to be risk assessed. The minutes noted that Lottie had told Betty that she is not living with her because of Bert. Lottie did not attend.
- 2.25.28 When informed of the outcome of the meeting, Lottie denied being in a relationship with Bert.
- 2.25.29 Children's Social Care undertook visits to see Betty at her grandparent's house on seven occasions between 4<sup>th</sup> November 2014 and 19<sup>th</sup> February 2015. During a home visit to Lottie's parents, on 2<sup>nd</sup> December 2014, Lottie and Bert were present and complained about the content of the child protection case conference report. Lottie continued to express her wish to resume caring for her daughter and Bert agreed to undertake a risk assessment. Both the grandparents and Betty's biological father supported her returning to Lottie's care at some point in the future.

- 2.25.30 On 19<sup>th</sup> February 2015, an unannounced home visit was made to Lottie's grandparents' house. Lottie was present and it was recorded that she shouted at a social worker about the questions put to Bert in the risk assessment and why he had to be seen three times. The social worker had to leave. On the 26<sup>th</sup> February 2015, the social worker called Lottie and agreed to help her attend a Hillingdon Action for Addiction Management (HAGAM) meeting the following week.
- 2.25.31 On the 23<sup>rd</sup> February 2015, Betty's social worker attended a meeting at the school with Lottie and Betty. No case note or record of this meeting could be found.
- 2.25.32 A few days later, on the 4<sup>th</sup> March 2015, the Team Manager met Lottie and her mother and explained to Lottie that there was no point in undertaking a parenting assessment. At this stage, as she had not engaged with the drug and alcohol service (Hillingdon Drug and Alcohol Service (HDAS)) and remained in an abusive relationship. A core group meeting was held on the same day and it was noted that the social worker was carrying out a risk assessment on Lottie.
- 2.25.33 Before her death, in March 2015, Bert was seen at Lottie's home by a social worker. Lottie was collected by her social worker and taken to attend HAGAM. While in the group, Lottie received a telephone call, appeared distressed and left the group urgently. The social worker later called to check whether the news was serious. Lottie confirmed that she was fine.

## 3. Analysis

### 3.1 Domestic Abuse Definition

3.1.1 The government definition of 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.*

3.1.2 The disclosures made by Lottie and her daughter, Betty, to agencies made it clear that she was a victim of domestic abuse from Bert. This included coercive controlling behaviour, physical abuse and emotional abuse. There were two separate instances where physical injuries were noted by agencies. Other incidents referred to included plants being thrown through windows; arguments over mobile phone; verbal threats; hot tea being spilled over Lottie as she did not want to be his girlfriend anymore; breaking down doors; and Bert turning up unannounced at Lottie's address.

3.1.3 Lottie's mother said, 'I would argue with Lottie about him and say get rid of him. But when you are in that cycle and they manipulate you and put you down, then you are so down that you can't get up. The mental abuse was sometimes worse than the physical'. Lottie's best friend and aunt described how Bert wouldn't let Lottie breathe, "if he walked past her he'd have to cuddle and kiss her every time. He was always on top of her". Lottie's mother stated, "I think she hid a hell of a lot, even from me. She would tell Tina and Stanley, don't say anything to mum and dad. I think she was scared of him because he battered her". The disclosures made by Betty included threats by Bert to burn down the house or stab Lottie, and Bert himself both disclosed physical abuse he perpetrated to the police and also talked to health professionals about the potential for him to injure Lottie.

3.1.4 Lottie herself sometimes minimised or denied the relationship was abusive. This is quite common among high risk domestic abuse victims as it can be part of their strategy for safety. As one researcher posed to professionals encouraging victims to leave, "consider this really important question: can her fear of him

match her trust in you?”<sup>5</sup>. Consequently, the minimisation itself combined with the physical abuse should have alerted agencies to her continued high risk

- 3.1.5 Bert’s mother, Dolly was also aware of the physical abuse in the relationship. She said the relationship was volatile, ‘I knew of one serious assault when he’d said he smashed her up pretty bad. But he was smashed up pretty bad too. I’d been told they’d had a massive row’. She also described how Bert would, following an argument with Lottie, come to her flat and break down, but the next morning Lottie would text and say “I love you” and “off he’d go again”. Dolly said, “I felt she had some hold over him’. She also conceded that there was a lot that went on that she wasn’t aware of. ‘They had many arguments. They were a volatile couple. They should never ever have been together’.

## **3.2 Mental Disorders**

- 3.2.1 The relationship between Lottie and Bert was further complicated by fact that both of them suffered from a mental disorder and, at times, drug and alcohol dependency.
- 3.2.2 Although it’s unclear when, Lottie was recorded to have been diagnosed with an emotionally unstable personality disorder, which is typically characterised by instability of mood and impulsivity.<sup>6</sup>
- 3.2.3 Bert’s primary diagnosis was dissocial personality. A person with dissocial personality disorder typically has deeply ingrained and enduring maladaptive patterns of behaviour that significantly deviate from the way in which the average individual perceives, thinks, feels and, particularly, relates to others.<sup>7</sup> They will typically habitually violate the rights of others without remorse.<sup>8</sup> There is a low tolerance to frustration and a low threshold for discharge of aggression, including violence and a tendency to blame others, or to offer plausible rationalisations for the behaviour bringing the patient into conflict with society. Impulsive behaviour is an established association with this disorder. As in Bert’s case, dissocial personality disorder can co-exist with emotionally unstable personality disorder.
- 3.2.4 An individual with dissocial personality disorder is also liable to exhibit symptoms of other mental health disorders, such as mood disorder (e.g. depression), psychosis (e.g. symptoms such as hallucinations and paranoia) and substance use disorder (e.g. alcohol or cannabis use to excess).<sup>9</sup> Bert had a long and well documented history of making very serious and often heinous threats or statements. For example, in March 2012, Bert presented to A and E and stated

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<sup>5</sup> Monckton Smith, Williams, Mullane, ‘Domestic Abuse, Homicide and Gender’ 2014 p. 110.

<sup>6</sup> International Classification of Diseases, World Health Organisation (WHO), 2016.

<sup>7</sup> International Classification of Diseases, World Health Organisation (WHO), 2016.

<sup>8</sup> Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> ed, American Psychiatric Association, 2013

<sup>9</sup> Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> ed, American Psychiatric Association, 2013



that he 'wanted to kill someone' and that he had put a 6-inch nail to a man's throat the previous day. He also described fantasies about cutting up people and eating them and that he had killed several animals in the past. Psychiatrists had ruled out a formal psychotic illness over the years and, while shocking, these statements were considered to reflect a 'pseudo psychosis' in the context of a complex personality disorder.

- 3.2.5 While a source of some contention during the trial proceedings, the judge, in summing up, stated that 'You told the experts that you acted as you did because you were unable to resist the voices telling you to do it ... Long before March of last year you reported voices telling you to kill, including telling you to kill your own family, the position is doctors just do not agree about it. Ultimately at the time and your ability to form a rational judgement and exercise self-control was not substantially impaired so as to explain your actions'. This aligned with the view of CNWL professionals that Bert had an element of control over his violent behaviour.
- 3.2.6 The success of interventions available to support people with dissocial personality disorders is limited and depends on the individual's level of motivation to engage and commitment to sustain often lengthy involvement with those interventions. Typically, interventions will include group therapy, psychology, family therapy and anger management therapy. Bert was offered referrals to anger management and drug and alcohol services on a number of occasions but he mostly did not engage with these services. It is of note that latterly, in February 2015, when his mental health appeared to professionals to be more stable, he was referred to psychology.
- 3.2.7 There are no licensed medications for use in personality disorder, although medication can be used to treat co-morbid mental health problems such as depression, anxiety and psychosis. Both Lottie and Bert were prescribed medication at times. Compliance was an issue for both of them and the effectiveness of the medication was variable.

### **3.3 Criminal justice services**

#### **3.3.1 Metropolitan Police**

- 3.3.2 In the time that Lottie and Bert were in a relationship, they came into contact with police on five separate occasions, although Lottie's family maintain that there were many other incidents which did not come to the police's attention. Bert's mother also believed it was likely that there were more incidents than were recorded. The first incident on 5<sup>th</sup> November 2013 was not identified by the police as a domestic incident, although the subsequent disclosure by Lottie's daughter clearly indicated that it was. The following four incidents were correctly classified as domestic incidents although none resulted in Bert being charged. Bert was arrested for threats to cause criminal damage after the incident on the 10<sup>th</sup> February 2014. He was not charged for this but he was recalled to prison for failing to adhere to the conditions of his licence. He was arrested for assault following the 4<sup>th</sup> July incident, but no further action was taken. He was not successfully arrested for the assault

on the 13<sup>th</sup> July 2014 and the case was closed because of lack of evidence. The final incident on the 26<sup>th</sup> November 2014 was recorded as a non-crime domestic incident and, because Lottie did not cooperate with the police, the case was closed.

- 3.3.3 On each occasion Lottie declined to provide a statement, answer the DASH risk assessment questions or support a police investigation. The police didn't appear to consider pursuing an evidence based (victimless) prosecution. It also appeared that body worn cameras, which could have helped support a charge, were not commonly in use by Metropolitan police officers at this time. It is noted that their introduction across all front-line officers is planned. On the occasions when a secondary investigation was undertaken, Lottie changed her evidence to implicate her brother or neighbours. This should have aroused suspicion and suggests a lack of awareness among officers about the power and control dynamics of domestic abuse, specifically coercive control.
- 3.3.4 The incident on the 5<sup>th</sup> November 2013 was the first incident of domestic violence perpetrated by Bert against Lottie, identified by Lottie's family. Despite some clear evidence, and Lottie appealing to the police for some help, the incident was not correctly classified so Lottie was not asked by the police about domestic abuse, and no risk assessment was undertaken. Despite her apparent vulnerability, including a risk of suicide, there was no safeguarding referral for Lottie. While it was clearly important for the police to ensure Betty's welfare (and Lottie was arrested for child neglect) it is likely that Lottie felt punished by the police as her daughter was then removed from her care. It was also an early missed opportunity to identify domestic abuse and offer Lottie support from specialist services. Had information been sought or shared by other agencies, Lottie could have been offered support at this early stage. This incident was hugely significant to Lottie, and her family described how this experience undermined her confidence in the police and Children's Social Care and led to her future non- engagement with almost all statutory and non-statutory agencies.
- 3.3.5 The incident on the 13<sup>th</sup> July 2014, shortly after Bert's release from prison, was arguably the most serious of all of the incidents reported to the Metropolitan Police and the most significant in terms of learning points. This was also the only occasion in which Lottie disclosed a previous assault by Bert to the police. The investigation was allocated and re-allocated three times, on the final occasion to a trainee Detective Constable, which led to a delay of 39 days before a secondary investigator contacted Lottie and then there was then a further delay of 89 days before any further investigation. Delays of this sort can create time and space for perpetrators to threaten or influence victims and often lead to no engagement, as was seen here. It can also lead to a lack of momentum in progressing cases. There was no DASH risk assessment recorded and no secondary investigation

undertaken. The Metropolitan Police Toolkit.<sup>10</sup> states that the OIC and supervisor should have considered various investigation strategies including neighbour enquiries, retrieval of 999 recordings, CCTV and the arrest of Bert. The lack of investigation resulted in the case being closed on the 19<sup>th</sup> December 2014 on the basis that Lottie didn't provide a statement and wouldn't support a police investigation, and there was no corroborating evidence. This incident was assessed as indicating a medium risk, despite Lottie having visible injuries, and it also being the third recorded domestic abuse incident in a five-month period, suggesting an increase in the frequency of incidents. There was also evidence of an escalation in the severity of violence, so a higher risk level was indicated and a MARAC referral should have been made on repeat and professional opinion criteria. This was a clear missed opportunity to increase Lottie's safety through a coordinated, multi-agency action plan and arresting Bert. Given Bert's history of violence and forensic record, a referral to MAPPa should have been considered.

- 3.3.6 The circumstances surrounding the management of this incident were reviewed by the Metropolitan Police Hillingdon Borough senior leadership team. A lack of adequate supervision of the investigation, and particularly that of a trainee Detective Constable was identified in the IMR, but it was determined by the senior leadership team that there were no misconduct issues to address but there were learning opportunities and an action plan to prevent a recurrence of the issues was developed.
- 3.3.7 During November 2014, three domestic abuse incidents involving Bert were reported to the police. Two of these incidents involved Bert's brother and one, on the 26<sup>th</sup> November 2014, involved Lottie. There was another significant incident also in November, but in Slough and reported to Thames Valley police, which involved Bert and Lottie. The Metropolitan Police Service was unaware of this until Lottie's death. Notwithstanding, the four incidents involving Lottie and Bert since the start of the year should, in accordance with the local protocol,<sup>11</sup> have prompted a MARAC referral for Lottie. This was another missed opportunity and, again, a referral of Bert to MAPPa should also have been considered.
- 3.3.8 In September 2014, Domestic Violence Protection Orders<sup>12</sup> were introduced. Barring Bert from Lottie's home or, given the domestic abuse also reported by his brother, from his family home, for a fortnight following the incidents in November might have given Lottie the space to consider her options. Lottie's family described her being 'smothered' by Bert and how she repeatedly asked for 'space to sort herself out'. Given Lottie's history of non-compliance with the police and Bert's brother's reluctance to provide evidence, this new order would have allowed the

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<sup>10</sup> Domestic abuse toolkit, four practical toolkits covering initial investigation, initial supervision, secondary investigation and secondary supervision, Metropolitan Police, July 2013.

<sup>11</sup> MARAC protocol for Hillingdon Borough, April 2016.

<sup>12</sup> Evaluation of the Pilot of Domestic Violence Protection Orders, Home Office Science, Research Report 76, November 2013

police to present evidence on their behalf. It does not appear that the use of this order was considered.

- 3.3.9 Aside from for the first incident on the 5<sup>th</sup> November 2013, no Merlin reports were created. Betty was living with Lottie at the time of the first two incidents. She was present during the first incident on 5<sup>th</sup> November 2013 and was in her mother's care and, on the basis of her subsequent disclosures, probably also a witness to the 10<sup>th</sup> February 2014 incident. The attending officers should have undertaken research to identify that Lottie had a child and searched the property. It was possible that Betty could have been a victim of Bert's. Even if not at risk of physical harm, the damaging effects on children of witnessing domestic abuse are well documented.<sup>13</sup> Whether present or not, the Safeguarding Toolkit<sup>14</sup> states that a Merlin report should have been created on each occasion and this was poor practice. As a result, Children's Social Care were not informed about the incident by the police and, had the school not contacted Betty's social worker after the 10<sup>th</sup> February incident, may not have had the evidence necessary to take action to safeguard Betty.
- 3.3.10 The final recorded incident by the police involving Bert was the random assault on the taxi driver on 26<sup>th</sup> December 2014. Bert was wanted for this offence at the time of Lottie's death. Despite Bert and Lottie having a documented history of contact with the police, the only arrest attempt on the day of the assault involved a visit to Lottie's mother's house. They asked for Bert's address and contact phone numbers but no-one knew them. Lottie's family recalled the police calling at their home looking for Bert and that they gave the police Lottie's address. Bert was not found and there was no record of any contact with Lottie or with Bert's mother.
- 3.3.11 There was then a significant delay as a subscriber check with the mobile phone company was undertaken by the Metropolitan Police. Bert was finally added to PNC some ten weeks after the incident. However, it was noted that during this time, Bert was often staying at Lottie's address, seen by Betty's social worker, and in regular contact with his mental health team. It was argued during the panel discussions that agencies such as CNWL would not be able to service the volume of requests from the police for routine information of this sort and that, while serious, it would not be proportionate to request such information for a crime of actual bodily harm. This does not negate the argument that the police were already aware of Lottie's whereabouts, that Bert was attending regular appointments at CNWL, that both Bert and Lottie were in contact with Children's Social Care, and the relationship between Lottie and Bert was known. Indeed, the family recalled that Lottie's brother made a number of calls to 101, when he knew Bert was

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<sup>13</sup> Intimate partner violence: what are the impacts on children? Bedi G, Goddard C. *Aust Psychol* 2007; p 66–77.

<sup>14</sup> Safeguarding Children Toolkit, London Safeguarding Board.

- wanted, reporting Bert's whereabouts. It does not appear that these were shared with the investigating officers.
- 3.3.12 Bert was known to have a forensic history, had been known to MAPPA, had a history of drug and alcohol misuses, and there was a well recorded and escalating pattern of violence from Bert to Lottie, random members of the public, and his brother. This should have been enough to create professional curiosity, a more concerted effort to trace Bert, and would warrant calling a professionals meeting and contact with MAPPA.
- 3.3.13 Had the recently introduced The Single Point of Access (SPA) service (para. 3.5.23) been available at the time, it would, had professionals been curious, have provided a means of checking Bert's whereabouts with CNWL.
- 3.3.14 Nevertheless, the panel did consider the issue of preventability and, had Bert been arrested for the 26<sup>th</sup> December 2014 assault, the police would have needed to conduct an interview and identification parade, which might have taken some weeks to arrange. The victim of the assault had also left the country following the incident. So, had Bert been found and had the CPS supported the case, he would have most likely been bailed at the time of Lottie's murder.
- 3.3.15 The next arrest attempt for the 26<sup>th</sup> December 2014 assault was in March 2015, two days before Lottie's murder. Bert's mother, Dolly, described how stressed Bert was about the risk of arrest arising from the assault. She encouraged him to 'turn himself in' but he refused because he did not want to return to prison. In the week before the murder he had not slept and she was concerned for his safety. The police, again, called at Lottie's parent's house trying to locate Bert. There was no record of them visiting Lottie's or Bert's mothers' houses. They were unsuccessful in locating him and Bert was still wanted by the police at the time of Lottie's murder.
- 3.3.16 After Lottie's murder, the Directorate of Professional Standards undertook a review of the circumstances around the 26<sup>th</sup> December 2014 incident and the subsequent delay to Bert's arrest. The case was referred to the Independent Police Complaints Commission who determined that a local misconduct investigation was indicated. The investigation was completed and no misconduct issues were identified. However, performance issues were identified with two officers and these are now being managed within the service.
- 3.3.17 **Thames Valley Police**
- 3.3.18 It is noted that Thames Valley Police undertook a thorough review of their practice and provided a comprehensive IMR as part of the DHR process.
- 3.3.19 Bert came to the attention of the police on several occasions, but the key incident involving Thames Valley Police was that which occurred on the 8<sup>th</sup> November 2014. Bert was still wanted by police for this incident at the time of Lottie's murder.
- 3.3.20 When the initial call was received by the police, it was appropriately classified for an immediate response because of the unknown risk to property or person. It was not classified as a domestic incident at the outset and this remained the case

throughout the investigation. The two attending police officers were interviewed as part of the IMR process and it was noted that neither considered a domestic angle at the time. This was because Lottie was reluctant to leave the hotel room, was hostile to the police officers, and she stated that there were no problems. She was interviewed separately, on the small landing outside the room, and despite the officer offering to tilt his camera away from Lottie, she refused to engage and stormed back into the bedroom. Both Bert and Lottie appeared to be under the influence of a substance. Shortly after, Bert and Lottie were seen leaving the hotel, laughing and hand in hand. As a result, and because the officers focus was on evidence to support an arrest for criminal damage, no DASH risk assessment was completed. It is, however, known that victims do often return to perpetrators of domestic abuse and the police officers involved should have considered this possibility. Under new Home Office Counting Rules<sup>15</sup> it is possible that this incident might now be classified as a domestic incident from the outset.

- 3.3.21 Had officers spoken to the original caller and undertaken some room to room enquiries at the time they may have uncovered at an earlier stage the crucial information gathered six weeks later from the neighbour which clearly pointed to a domestic incident. It is unclear whether the failure to identify the incident correctly at this point altered the final outcome but this was a missed opportunity to arrest Bert and, in the short-term, he did go on to commit three further incidents of domestic abuse shortly after.
- 3.3.22 The absence of a DASH risk assessment also meant that no risk management plan was developed and referrals to other appropriate statutory and voluntary agencies did not occur so no further intervention with either Lottie or Bert was triggered. It was a few hours later, and with some persistence on the part of the attending officer, before it was established that Betty, who was named on the hotel contract paperwork, was located and confirmed to be safe. It was recommended that a Child Protection Occurrence be created but this was not done. However, had the incident been classified as a domestic, an automatic referral to children's services should have resulted and the enquiries would have been expedited. It would also have, almost certainly, led to bail conditions being imposed on Bert which would have included a 'non-contact' provision to minimise the risk to Lottie.
- 3.3.23 The point at which this incident should definitely have been considered as domestic abuse was following the statement taken from the neighbour on the 14<sup>th</sup> December, 36 days later. The Thames Valley Police IMR identified several significant factors which were not picked up at this time:
- (a) A statement from a witness on the night suggested that Lottie was at risk from Bert as he called saying everything's 'gone mental', which was corroborated

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<sup>15</sup> Home Office Counting Rules for Crime (HOCR) guidelines and National Crime Recording Standards (NCRS), July 2015

by Lottie who stated she called the witness to tell him to 'hurry up', suggesting she also felt she was potentially at risk. This statement was not followed up.

- (b) Both parties had injuries which were consistent with a domestic violence altercation.
- (c) A statement from a neighbour about what was heard, coupled with damage suggested a potential domestic violence altercation. This was not probed.
- (d) The comment by Lottie in interview regarding a history of arguments with Bert was not questioned further despite the room, which was Lottie's home at the time, being smashed up and she had visible injuries.
- (e) Both parties behaving in an evasive manner.
- (f) The witness confirming he heard sounds of an altercation and what sounded like Lottie being shut in the bathroom and in a distressed state.
- (g) Damage to the room apparently being caused by the large knife seized from the room.

3.3.24 The Thames Valley IMR concludes that this failure to correctly classify this incident was the result of the individual judgement of several people involved in the investigation rather than a systemic problem. It made two recommendations for action which are included in the appendix. The panel, however, was concerned that front-line officers appeared not to understand the dynamics of domestic abuse, including coercive control. Since December 2015, all public facing Thames Valley police staff now receive three-hour classroom based input on domestic abuse. This training has a focus on coercive control and on the investigation of the recently introduced Section 76 offences (controlling or coercive behaviour in an intimate or family relationship).

3.3.25 In addition, the IMR also identified that the member of hotel staff who made the initial call to the police and was chased off 'aggressively' by Bert, should have been recorded as a separate offence of 'Fear or Provocation of Violence Offence'. While a low-level offence for which Bert would have only been fined or possibly received a short period in custody, it is crucial that offences of this nature are correctly recorded to enable full risk assessments and planning to be undertaken.

3.3.26 In terms of preventability, attempts to trace Bert were unsuccessful and not recorded, and he was not arrested until Lottie's murder. Had he been charged with the criminal damage offence and/or the fear of violence offence, it is likely he would have been bailed. Had he been remanded and given a custodial sentence, it is also highly likely that he would have been released a few weeks later. Again, while he would have been free at the time of Lottie's murder, what cannot be known is whether a custodial sentence might have given Lottie some space to successfully end the relationship with Bert.

3.3.27 In conclusion, this should have been dealt with as a domestic related incident rather than criminal damage. This would, in turn, have triggered secondary

investigation checks, risk assessment (and possibly a MARAC referral) and further exploration of Bert and Lottie's relationship. Had Bert been successfully charged, he would have been imprisoned, most likely for six weeks as he was in May 2016<sup>16</sup>, and this may have led to a different outcome for Lottie.

3.3.28 Thames Valley Police have recently set up a project called SaVE (Safeguarding, Vulnerability and Exploitation) to further increase awareness of staff and officers to the importance of looking at different safeguarding angles of an incident. Between January and April 2016, the programme was rolled out and includes training, a tool to support identification and recording, and auditing, to increase the awareness of staff and officers on the different safeguarding angles of incidents and improve practice.

3.3.29 Lottie's family described how Lottie felt, at times, that 'no-one wanted to help her', and they themselves didn't know where to go for help. In November 2016, Thames Valley Police launched a week-long campaign #SafeAtHome to flag the help available for victims, their families and friends. The campaign will also highlight work within the force, including coercive control and the training officers will receive, and there will be a focus on the voice of the child and where they can seek help and support.

### 3.3.30 **Metropolitan Police and Thames Valley Police**

3.3.31 During the review, communication between police forces was identified as an issue. At the time of the 8<sup>th</sup> November 2014 incident, Thames Valley Police did not know that Metropolitan Police were investigating Bert in relation to a domestic incident between him and Lottie on 13<sup>th</sup> July 2014, or that Lottie had been rated as a 'high risk' of further violence and domestic homicide. Neither was it known by Thames Valley Police that the Metropolitan Police were also trying to locate Bert in connection with an assault on a minicab driver on 26<sup>th</sup> December 2014. The reasons for the delay are described in para. 2.9.4 but it meant that Bert wasn't circulated as wanted on PNC for the 26<sup>th</sup> December 2014 incident until March 2015, a few days before Lottie's murder. Similarly, Bert was not circulated as wanted on PNC by Thames Valley Police for the 8<sup>th</sup> November 2014 incident until after he failed to turn up for bail on the 19<sup>th</sup> December. A 'wanted' file was submitted on the 20<sup>th</sup> January 2015, in accordance with the Thames Valley Police Persons Wanted protocol<sup>17</sup> for someone wanted for a criminal damage incident, but the Metropolitan Police were unaware until that date that Bert was wanted following the incident that had taken place in Slough on the 8<sup>th</sup> November 2014.

3.3.32 Both police forces use local crime recording systems (Thames Valley Police use Niche and the Metropolitan Police use CRIS) with the capability to flag reports as domestic incidents. Both forces have policies or guidance to support their use. In

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<sup>16</sup> 6 weeks to run concurrently with his longer sentence for murder.

<sup>17</sup> Thames Valley Police Persons Wanted by Police Protocol, April 2012



common with all police forces, they both also use PNC. Warning signals can also be added to PNC to ensure that officers and staff are better informed when deployed to an incident or dealing with a subject in custody. Domestic incidents, or any other crime, are not recorded on PNC unless connected to someone who is wanted for or arrested for an offence. PNC is not a crime recording system but will contain details of offences linked to individuals when they are arrested.

- 3.3.33 PNC is available nationwide and, as in Bert's case, enables other police forces to access information about warning signals, wanted, and arrest conviction for subjects who move around the country. A Police National Database (PND) check enables information from all of the other systems used by individual forces to be accessed and can be undertaken as part of a secondary investigation. At the time of the incident in Slough, 8<sup>th</sup> November 2014, Bert had warning signals on PNC for violence, self-harm and mental health. The disposal page did include details of Bert's previous arrests, by the Metropolitan Police, for domestic abuse in the cases where they were closed with no further action. As Bert hadn't been convicted of domestic abuse, there were no convictions recorded on the disposals page. There were also no warning signals on PNC for Lottie. It was acknowledged that PNC is an old system and the format of the information is not particularly user friendly, which could mean that some officers focus more on the convictions than non-conviction pages.
- 3.3.34 Thames Valley Police checked PNC in relation to Bert and Lottie during and following their arrest and continued to conduct periodic PNC checks throughout the investigation. The 'Wanted' file was circulated on the 20<sup>th</sup> January 2015. However, Thames Valley Police did not check PND because it would have been disproportionate to the offence of criminal damage or non-crime domestic offence that they were investigating.
- 3.3.35 However, in their IMR, Thames Valley Police explored why the opportunity was not taken to add further warning signals to PNC for Bert or Lottie following the Slough incident to alert officers nationwide of risks in the future and concluded that there can be some confusion among staff about their use. The IMR recommended the training for student officers in relation to PNC related matters should be reviewed. All officers should be reminded of the policies relating to Warning Signals and Information Flags on PNC and Niche. In recognition of the fact that the list of Warning Signals was not up to date following the 8<sup>th</sup> November 2014 incident, it was also noted that opportunities for adding information to the system might be missed and it was recommended that The Gen 212 prisoner handover package should be revised to include a section for Warning Signals. Prompts should be given for officers to consider existing Warning Signals, check whether justification exists for additional Warning Signals or Information Flag and request as necessary.
- 3.3.36 The Metropolitan Police Directorate of Professionalism Review confirmed that, in March 2015, when Bert has been identified as the suspect in the assault of the minicab driver on the 26<sup>th</sup> December 2014, police intelligence indices were

searched and arrest enquires at relevant addresses were undertaken. Enquiries conducted during the Thames Valley IMR could not confirm whether they had notified the Metropolitan Police when they conducted arrest attempts in their area (Hillingdon) in relation to the 8<sup>th</sup> November 2014 criminal damage incident. Doing so would have created a Metropolitan Police 'CAD' reference number/log which may helped to build up a picture that Thames Valley Police were looking for Bert. However, it would have been unusual for extensive interagency liaison to have taken place for what was classified as a low-level offence.

- 3.3.37 Similarly, following the assault on the minicab driver on the 26<sup>th</sup> December 2014, the Metropolitan Police's focus was on establishing the identity of the suspect. Having identified Bert, it was acknowledged that a secondary investigation could have highlighted the potential for information to be held by other police forces regarding Bert's whereabouts and potentially identified Bert's domestic violence history. Bert was circulated as 'wanted' on the PNC in March 2015. A PND check was not conducted, as it is not routine practice in cases involving actual bodily harm.
- 3.3.38 A retrospective search of PNC confirmed that Bert had no convictions for domestic assault on Lottie but there were references to his arrest for domestic abuse in those cases which were closed with no further action. It is important to note here that both Bert and Lottie used several alias' which made accurate record keeping by the police and other agencies difficult.
- 3.3.39 In July 2015, Thames Valley Police updated their policy in July 2015 on Wanted Persons – Circulation and Procedures. This new guidance clearly describes when to circulate 'wanted' markers on PNC. This policy should now ensure that high risk suspects, including domestic violence suspects, are actively pursued.
- 3.3.40 Thames Valley Police have recently, in July 2016, undertaken a strategic review of domestic abuse within the area in response to the 2014 HMICs review Everyone's Business: improving the police response to domestic abuse<sup>18</sup> which will, in turn, inform future operational response. The Metropolitan Police have similarly launched Operation Dauntless<sup>19</sup> a continuous improvement programme which provides practical toolkits to frontline staff to improve service delivery.
- 3.3.41 From January 2015, Operation Dauntless<sup>20</sup> was introduced by the Metropolitan Police to enable the flagging of prolific, cross border, serial and high risk domestic abuse perpetrators. Of significance is that the criteria for flagging includes being a named suspect five or more times in the past 12 months or multiple incidents reported to the police on a single occasion. Bert would have met both of these criteria. There is also a provision for professional judgement. In the future, this information should be accessible by other forces. Had this been available at the

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<sup>18</sup> HMIC Everyone's Business; improving the police response to domestic abuse, HMIC, 2014.

<sup>19</sup> Operation Dauntless, Metropolitan Police, January 2015.

<sup>20</sup> Operation Dauntless, Metropolitan Police, January 2015.

time, both forces could have had a more focused and coordinated response and the case should have been afforded a higher priority. In 2012, Thames Valley Police introduced a similar project for their area. This has now been replaced with a new programme, which confirms the top 100 high risk victims and suspects, and reviews the PNC flags every three months.

3.3.42 Apart from a brief period of time in late 2014, Lottie appeared to know of Bert's whereabouts and may, had she been asked, have been able to advise police. She also, at times, reported feeling frightened by the risk of violence from Bert and sought to avoid contact with him. There was no evidence that the Metropolitan Police made regular contact with Lottie during their investigation to update her on progress, in line with the Victim's Charter.<sup>21</sup> Given Lottie sought the help of the police on several occasions, more regular contact of this sort may have enabled the police to develop a more positive relationship with Lottie and may have helped locate Bert. The panel recommends that the Metropolitan Police audit the use of the Victim's Charter.

3.3.43 Overall, there was a sense that identifying, prioritising and pursuing offenders with outstanding charges relating to violent and domestic violent offences did not appear to be given sufficient priority by the police at this time. While there is an indication that this has changed since Lottie's murder, the DHR makes two recommendations for audits to ensure that these changes have been embedded in local practice.

#### 3.3.44 **National Probation Service**

3.3.45 Bert was released from prison on licence on the 17<sup>th</sup> December 2012 under the terms of a Home Detention Curfew (HDC). He was recalled to custody on the 18<sup>th</sup> February 2014 following an allegation of domestic abuse against Lottie on the 10<sup>th</sup> February and his failure to cooperate with the mental health requirements of his licence.

3.3.46 The management of the licence was poor. The following issues were identified in the IMR:

Failure to enforce licence conditions with sufficient timeliness;

Failure to visit and assess proposed accommodation address for licence supervision purposes;

Failure to provide a planned pattern to the supervisory appointments;

Failure to robustly oversee the mental health condition of the licence, and;

Failure to liaise effectively with partner agencies, particularly Children's Social Care and mental health service.

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<sup>21</sup> Controlling or Coercive Behaviour in an Intimate or Family Relationship, Statutory Guidance Framework, Home Office, December 2015

- 3.3.47 The probation officer knew of the relationship between Bert and Lottie in October 2013 and on 31<sup>st</sup> January 2014 Bert was authorised to reside at Lottie's address. The probation officer would have been unaware of the domestic abuse incident in November 2013 as it had not been classified as such by the police. Within two weeks of Lottie's address being authorised, on the 10<sup>th</sup> February 2014, an incident of domestic abuse took place. Children's Social Care contacted probation and Bert was recalled to custody. It is commendable that probation confirmed the recall, on the basis of this incident and that he was failing to cooperate with the mental health conditions, despite there being no charge as a result of the incident. It is equally possible that, had the licence been more robustly managed then Bert may well have been recalled earlier or cooperated more fully with the mental health requirements of his license.
- 3.3.48 On the 31<sup>st</sup> January 2014, the supervising officer visited Bert at Lottie's address to assess him for licence supervision purposes. The officer was aware that Betty also lived at the address and had approached Children's Social Care in December 2013, describing the nature of Bert's offence, the licence conditions and requesting 'a full risk assessment to ensure that we have a safeguarding plan in place'. This was in response to Bert's disclosure that he was at risk from people who were pursuing him and a concern that this might place Lottie and Betty at indirect risk. No response from Children's Social Care was recorded but Lottie's address was still approved. The decision to authorise Lottie's address without appropriate input from Children's Social Care services was inappropriate, potentially placing Lottie and Betty at risk.
- 3.3.49 One of the unforeseen consequences of recalling Bert to custody was that he was then released at the end of his sentence without any planning by a statutory agency or indeed any notification to other agencies. Because Bert wasn't charged with the assault on Lottie, the MAPPA interest also ended. The probation service IMR makes a recommendation that 'when an offender is released at the end of their sentence, such that no supervision takes place post release, the appropriate partner agencies are notified of the release date and arrangements'. In this case, it meant that there was no opportunity for anyone, such as the IDVA, to attempt to engage Lottie and develop a safety plan with her. Her family noted that 'while he was recalled to prison, she began to get her bits and pieces together and get on with her life'. She also disclosed feeling fearful of Bert, sought rehousing, and was physically assaulted by him within two weeks of his release.
- 3.3.50 It was noted that during 2014, the National Probation Service was subject to a major reorganisation. For a period of time the workforce was unsettled and there was a reduction in the level of staff available.
- 3.3.51 The probation services involvement with Bert ended almost nine months before Lottie's murder.

### **3.4 Health Services**

3.4.1 Both Lottie and Bert were known to local mental health services and also regularly attended local services with physical health issues.

#### **3.4.2 GPs**

3.4.3 Aside from in 2012 when Lottie was living in a refuge, Lottie had relatively little contact with her GP. When she did attend appointments, despite clearly having difficulties in relation to caring for her daughter and her mental health, she was not asked about her relationships or domestic violence. She didn't attend her GP, or any other health service, when she had physical injuries. GP 3, with whom both Lottie and Bert were registered for a short period of time, made no connection between them because they were both registered under different addresses. On the 5<sup>th</sup> December 2013, Lottie attended an appointment and disclosed that she had been arrested for child neglect. She made reference to her partner, Bert, and that he took her daughter to school. This would have presented an opportunity to ask Lottie about the relationship and her home situation. Given the circumstances of her arrest, Lottie may have responded to this enquiry positively. Lottie also missed many appointments with her GP, ten were recorded between 2012 and 2015, but this didn't appear to prompt further enquiry or any curiosity among staff. As time progressed, and as with other services, Lottie engaged less and less. She last saw her GP in November 2014, four months before her murder. She did not attend the surgery for a cervical smear on the 30th February 2015 (sic).

3.4.4 In their analysis of thirteen DHR cases, Neville and Sanders-McDonagh<sup>22</sup> found that GPs were the only stakeholder group that both victims and perpetrators were 'consistently and actively engaged with'. In the timeframe of the review, and despite repeatedly changing address, Lottie was registered with three practices. She was registered with one practice between 2012 and her murder, so the entire time that she had a relationship with Bert. This should have enabled the practice to more fully understand the complexities of her life, identify risks, and provide proactive support.

3.4.5 Guidance produced by the Royal College of General Practitioners, Identification and Referral to Improve Safety (IRIS) and CAADA includes a list of 'health markers' that should prompt an enquiry about domestic violence. GPs are urged to ask about abuse where a review of the medical record reveals that a patient has: a history of psychiatric illness; alcohol or drug dependence; and a history of depression, anxiety, failure to cope and social withdrawal. Other indicators of domestic violence include homelessness and repeatedly missed appointments.<sup>23</sup> Lottie ticked all of these boxes. In addition, her GP knew that she had been the

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<sup>22</sup> Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs, Neville and Sanders-McDonagh, 2014

<sup>23</sup> Domestic Homicide Review (DHR) Case Analysis, Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly, June 2016

victim of abuse in a previous relationship because it was recorded in her notes. This lack of awareness and/or interest among primary care practitioners in the dynamics of domestic violence meant that opportunities to engage with and support or refer Lottie to specialist services, safeguarding adults or the MARAC weren't identified.

- 3.4.6 Between 2009 and 2015, Bert was registered with five different practices. His mother explained that this was a result of him regularly changing address. There was no evidence that he was ever removed from a GPs list because of his behaviour. Bert often attended as an emergency, often on the day that he registered. On one occasion, in June 2014, this was because he had been released from prison three days earlier, and had neither sufficient medication nor a GP. He first approached the ABT office on the 23<sup>rd</sup> June 2014 seeking medication, but was advised to register with a GP. He duly registered with GP 4, a practice now occupying accommodation which had previously been used by the walk-in centre. He was seen on the 24<sup>th</sup> June 2014 but was not issued with any medication and was advised to contact secondary care services. That same day, Bert attended the urgent care centre and was issued with one of the two medications he requested. He was advised to see his GP for the other one. As he had completed his sentence, he received no further support from probation although he did refer to a prison mentor who his mother confirmed was helping Bert with housing. Dolly described how, 'When he came out of prison there was nothing set up for him. I contacted the mental health team, he had no meds. He had someone who helped with housing but no-one else helped. I did all of the chasing – where is the meeting, who is looking after him, who is he seeing?'. Given his history of violence and long standing diagnosis of dissocial personality disorder, and that he had been receiving treatment in prison, it is of concern that he appears to have been released without a GP, sufficient medication or a clear route to access it. It appears from the chronology that he next accessed medication, from GP 4, on 14<sup>th</sup> August 2014. Bert is known to have assaulted Lottie twice in the intervening period. It is recommended that clear arrangements for prisoners discharged at the end of their sentence to access primary health care services and receive necessary medication are agreed.
- 3.4.7 Between 2009 and early 2013, Bert was registered with GP 1. His mother described how supportive the practice was and how they developed a good relationship with her and Bert. During this time, Bert also attended the Out of Hours GP service on three occasions. On the third visit, Bert described how he was preoccupied with ideas of self-harm and harming others. He was referred to A and E, but it was noted in the IMR that his history of violence wasn't known, because patients' records aren't available to the service, and in this case there was no record of Bert being asked.
- 3.4.8 Bert then went on to register with a further 4 GP practices. Although his electronic medical records would follow him, these frequent changes meant that they weren't always available to the practice at the point of consultation and the older paper records are no longer transferred. As Bert tended to attend as an emergency and

see the duty doctor, there was also little continuity of care. Taking all of these factors together, this meant that no one GP had developed a relationship with Bert in recent years or necessarily understood his history. Lottie's GP 1, similarly noted that while she was registered with them they didn't have access to her full notes because of the delay in receiving them from her previous GP. The panel was unsuccessful in retrieving Lottie's full primary care history, but given she moved repeatedly because of domestic violence it is likely that this situation occurred elsewhere too. Unless victims are asked and disclose domestic violence, without comprehensive and timely transfer of patient's records, opportunities for intervention are lost.

- 3.4.9 GP 5 noted that Bert always presented as an emergency and was therefore seen and assessed by the duty doctor. In their IMR they said, 'whilst there was a concern at this first appointment on 25<sup>th</sup> November 2015 that the patient was unwilling to disclose further details about his wounds, it was felt that he was within his rights and as the wounds were superficial and not life-threatening and as the patient appeared to have full insight it was felt at the time that we had an obligation to respect patient confidentiality'. The notes did, however, record that Bert had described that his injuries were sustained in a fight. This was the same day that Bert's brother, Fred, called the police to notify them of the second assault by Bert. The following day the fourth incident of domestic violence by Bert to Lottie occurred. The same practice did acknowledge that, 'with the benefit of hindsight it could appear from the brief period that Bert was registered with us that there was evidence of a tendency to violence and a further evaluation of the circumstances and a further risk assessment might have been appropriate. There was no evidence that patient lacked insight or mental capacity, and we did not feel that we had any mandate to investigate further'.
- 3.4.10 Bert was a frequent attender and these attendances offered opportunities for effective engagement between the GP and Bert.<sup>24</sup> Most of his appointments were in connection with his mental health issues as he sought referrals, prescriptions or sick notes. However, during the timeframe of the review, Bert attended his GP on four different occasions with physical injuries, usually to his hands. This history would have been available to the practices and should have been a cause for concern and prompted further enquiries but it appeared that each consultation was seen in isolation. There was only one detailed record of him being asked about his injuries, but he refused to describe the circumstances. On this occasion, he also refused to attend A and E for treatment. There were also records of him visiting his GP and describing violent fantasies or aggressive incidents. One of the practices was aware that he had been in prison, but didn't know what for. There was a belief in some practices that the risks Bert posed were being managed by

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<sup>24</sup> Thames Valley Police Persons Wanted by Police Protocol, April 2012

the community mental health team and therefore sat outside their area of responsibility.

- 3.4.11 Despite a history of physical injuries, frequent attendance, Bert's disclosures about violence and serving a prison sentence, his diagnosis of dissocial personality disorder and contact with mental health services, there appeared to be a general lack of curiosity about Bert and his life and a lack of understanding about the responsibility that GPs have to safeguard their patients and others. There was no record of any discussion about his domestic situation, or any concern about the potential risks that he posed to others, specifically his partner or close family. There was no record of any discussion at any time about Lottie. As a result, opportunities to ask Bert about domestic violence and involve the police, CNWL or refer him to specialist perpetrator programmes were lost.
- 3.4.12 The last contact that Bert had with any service before Lottie's murder was with his GP (number 5), in March 2015. On that day, his seventh visit since November 2014, he consulted a doctor asking for repeat medication prescribed by the local community mental health team. The surgery hadn't received any correspondence from the team, but Bert brought a copy of a letter addressed to his previous GP. He was prescribed the medication and the GP notes indicate that a full physical and mental health assessment was undertaken and no additional management was considered necessary. There was no record of Bert asking for, or being refused, sleeping pills. It appears that this was a routine consultation.
- 3.4.13 GPs in Hillingdon receive training from the Clinical Commissioning Group (CCG) on safeguarding which includes domestic abuse and there is an explicit joint commitment statement between the CCG and local practices on safeguarding children and vulnerable adults. There does, however, appear to be a widespread lack of awareness among local practices of domestic abuse and the health impact and risks it poses. Indeed, it was notable that none of the practices involved with either Lottie or Bert made any recommendations for change in their IMRs. Equally, none of the six practices involved mentioned the IRIS programme; an evaluated and cost effective intervention programme for use in primary care, or any other domestic abuse risk assessment tools.

### **3.5 Central North West London Mental Health NHS Partnership Foundation Trust (CNWL)**

- 3.5.1 CNWL provides mental health and a range of community based physical health services in Hillingdon. The community health services in Hillingdon were integrated into CNWL in April 2011. The DHR panel received two submissions from CNWL – an Internal Investigation report for mental health services and an IMR for community health services.
- 3.5.2 **CNWL mental health services**



- 3.5.3 In response to the incident and in accordance with their serious incident procedure, CNWL undertook an Internal Investigation. The Internal Investigation incorporated the DHR Terms of Reference. The final report contained thirteen recommendations but only the five most relevant to the DHR have been included. On meeting Bert's mother, Dolly, it became apparent to the Independent Chair that Dolly considered herself to be Bert's carer. She had not been involved in the Internal Investigation; this omission has now been addressed. The final report was presented to NHS England and approved for circulation to the panel on 13<sup>th</sup> January 2017.
- 3.5.4 The Internal Investigation concluded that there were elements of both Lottie and Bert's care that were less than ideal, but the care delivery problems identified were not considered to have contributed to Lottie's death. The review analysed each care and delivery problem in an attempt to identify why it happened i.e. the contributory factors. The thirteen recommendations made are intended to tackle these factors by improving systems and preventing them recurring.
- 3.5.5 The inquiry was convened on behalf of the CNWL trust board to carry out a comprehensive, Internal Investigation in accordance with the Serious Incident Framework (2015). There was no challenge to the diagnoses of Bert's mental disorder as a result of the investigation. Similarly, in his summing up, the judge said of Bert, 'It is accepted that you have a complex personality disorder and there are variations to its precise nature'. It is noted that no coroner's inquest was conducted.
- 3.5.6 Within the mental health services provided by CNWL, both Lottie and Bert's main contact was with the Assessment and Brief Therapy Team (ABT). This team sits at the beginning of the care pathway and provides mental health and clinical risk assessment, referral and sign posting to other services. The team provides a small number of sessions before referring on or discharging back to primary care. The team holds cases collectively and patients, who are assessed not to meet the Care Programme Approach criteria, do not have an allocated care coordinator. Lottie had only limited contact with services other than the ABT, and even with the ABT, she only had two face-to-face contacts. While Bert had historically had contact with other services, since 2013, he was also seen mostly by the ABT although he had some limited contact with inpatient services and the Home Treatment Team (HTT). As a result, no single professional had a consistent relationship with either of them over the timeframe of the review and this contributed to the team having a limited view of the wider context of Lottie's life.
- 3.5.7 The CNWL IMR considered whether mental health services had missed opportunities to safeguard Lottie from domestic abuse. Opportunities were identified. In January 2013, Lottie disclosed that she felt threatened by travellers and was reluctant to go to the police. The IMR found that this was a missed opportunity to raise a safeguarding alert for Lottie, but also for her daughter, Betty. Had safeguarding procedures been followed, other agencies involved with Lottie and her daughter would have been involved in formulating the risk assessment

and risk management plan. While this preceded Lottie's relationship with Bert, it would have enabled agencies to more fully understand her history of domestic abuse and her social circumstance which might have led to a greater awareness among mental health professionals of her vulnerability and the risk that Bert later posed to her. It is, of course, unknown whether Lottie would have cooperated with the process, but had she been appropriately supported she may have agreed.

- 3.5.8 Around the same time, Lottie disclosed to a psychiatrist that she had a history of domestic abuse and had been living in a refuge, which had led her to have panic attacks. This was not explored with her and would have provided valuable context for her future care and also suggested referral to specialist domestic violence agencies. The IMR identified that the silo (narrow) approach adopted by professionals involved with Lottie led to missed opportunities to engage with and identify risks to her and Betty from Bert. Further exploration with Lottie by the psychiatrist to understand the relationship between Lottie's mental health issues, drug and alcohol misuse, and domestic violence would have been beneficial.
- 3.5.9 In March 2014, Lottie disclosed that her boyfriend was back in prison following a 'domestic'. She named Bert but the link between Lottie and Bert, and that they were both known patients, wasn't made by the team. It is acknowledged that Lottie's presentation may have been misleading as she described the domestic abuse as 'overblown by the authorities', spoke positively about Bert, and described how her panic attacks only returned after Bert had gone back to prison. However, minimisation of this sort is common among victims of domestic abuse and, had routine enquiry followed, Lottie may have felt able to make disclosures which, together with Bert's forensic history, the recent known incident of domestic abuse, on-going issues with drug and alcohol misuse, and the escalating pattern of violence and aggression to Lottie and others should have prompted an IDVA referral.
- 3.5.10 Bert attended Lottie's last appointment with the ABT with her. At this point there was no doubt that the two patients were in a relationship, and it was known that Lottie had contact with her young daughter, and that Bert had a history of violence and had been in prison for assault. Given these factors, there should have been more professional curiosity about the risk of domestic abuse to both Lottie and Betty, and some concern about Bert attending the appointment with Lottie and whether it was preventing her from disclosing abuse. It would also have been good practice for their individual care-planning to have been considered by the ABT team and appropriate risk assessment and management plans developed. Contact with Children's Social Care would also have provided valuable information to help ensure Betty's safety, particularly in view of the fact that Bert was known to have significant difficulty managing his anger in the context of drug and alcohol misuse.
- 3.5.11 It was noted that there was limited contact between the ABT and Children's Social Care, despite the potential risks. Of particular concern was an incident in which Lottie was reported to be yielding a knife; this was not shared with any other

agency. Rather than 'think family' and consider the impact of Lottie and Bert's issues and the domestic abuse on Betty, Lottie and Bert were viewed by the service as individuals rather than a family unit. The lack of effective communication between agencies was well documented and clearly illustrated by the following: in 2014, Betty's social worker sent a written invitation to request ABT representation at a case conference for Lottie and Betty. The team did not attend. The ABT then requested that the social worker attend a review, but she did not attend. It was reported that the ABT was under considerable pressure at this time due to a high level of work load so the established arrangement where members of the team were allocated statutory agencies to liaise with was not functioning. This contributed to the breakdown in communication and, as a result, a lack of collaborative working across organisations. The CNWL Internal Investigation report recommends that 'The Community Mental Health Team should develop robust systems of communication with children and families social services'. The panel's view is that the sharing of information between agencies as a whole is weak and an inter-agency protocol agreed by the SHP is essential.

- 3.5.12 During 2014 Merlin reports were not routinely sent to ABT. This has now been rectified and should help raise awareness among professionals in relation to vulnerable patients and children in their care. Similarly, some recording and information sharing problems were identified by CNWL and GPs in their IMRs. In one case, a clinical entry relating to Bert wasn't made until almost six weeks after the consultation. The trust standard was for an entry to be made within 72 hours and, at the time, communication sent to the referrer within 5 days. This standard has now been revised to two weeks.
- 3.5.13 The Internal Investigation concludes that the approach to Lottie was limited by focusing on her alone. By not addressing her daughter's needs or the potential risks from Bert, information from other agencies was omitted and opportunities to engage Lottie or escalate her case to adult safeguarding or the MARAC were lost.
- 3.5.14 As noted above, Bert had an extensive but sporadic history of contact with CNWL services. Over the years he made several claims of a criminal nature, including having 'access to firearms' and harming animals and people, which, together with a significant forensic history and drug and alcohol misuse should have prompted a referral to, and liaison with, MAPPA. It is acknowledged that the reference to fire arms was within the context of Bert threatening to harm himself, but CNWL agreed that this should, given Bert's history of making claims and describing fantasies of harming others, have been more fully explored to assess the risk posed.
- 3.5.15 Bert also made a number of explicit threats against others and these should have been reported to the police. These referrals did not happen and neither was he referred for a forensic assessment. These two sources of vital information, together with the escalating history of violence and threats of violence, were missed opportunities to identify and manage the risks Bert posed. However, it is also important to note that there was little indication from the chronology that, until Lottie's murder, the recorded incidents of domestic abuse or physical violence

followed these claims and indeed they often coincided with other life challenges or stressors, such as when he was wanted by the police, when Bert approached services seeking support or admission.

- 3.5.16 Despite the potential risk of violence, it was not possible for CNWL mental health services to detain Bert under the Mental Health Act. He was assessed on several occasions and found not to meet the criteria for detention. Despite this, and at his request, it is notable that he was offered an informal admission to hospital on several occasions. These admissions were always very brief and Bert would discharge himself, often within the same day. CNWL have identified that they did miss opportunities to refer Bert to MAPPa or contact the PNC. Bert would have met the criteria for a referral and, in recognition of his past history, and the verbal threats of violence to others, escalation to MAPPa, a multi-agency forum, could have enabled a sharing of information across agencies and the development of a risk management plan. CNWL did attempt to engage him in psychological therapies to help him moderate his violent responses to external stressors, but Bert found it difficult to commit to what would have been lengthy periods of therapy. It is the uncomfortable fact that, with no other options available, Bert was then left to be dealt with by the criminal justice system.
- 3.5.17 CNWL acknowledged that there was limited awareness of MAPPa and poor understanding amongst the teams involved with Bert about the referral criteria and threshold for MAPPa. The Trust is currently revising its MAPPa policy and creating an easy guide to support staff in relation to the referral criteria and referral procedures. The panel, however, considered that this issue was not limited to CNWL and the absence of escalation to appropriate multi-agency fora was a recurrent theme identified which needs to be addressed across the partnership.
- 3.5.18 Both Bert and Lottie used illicit substances and were referred, but never consistently engaged, with substance misuse services. It was apparent that a number of Bert's violent offences occurred when he was under the influence of drugs and/or alcohol but this was not recognised as a factor that significantly increased the risk of serious harm to Lottie and others. The judge in summing up stated that 'you are a very dangerous young man and in my view that's particularly so after you've been drinking and taking drugs'. It is understood that Bert had been using illicit substances on the night that he murdered Lottie.
- 3.5.19 In their review of homicides, Neville and Sanders-McDonagh's<sup>25</sup> found that mental ill health, substance misuse and domestic abuse was a common, sometimes called 'toxic', combination so services should be alert to the increased risks to victims and should assess accordingly. This applies to both the misuse of prescription and illegal drugs. In some cases, it appears that perpetrators are reluctant to address drug and alcohol misuse but instead use it as an excuse for

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<sup>25</sup> Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs, Neville and Sanders-McDonagh, 2014

abusive behaviour or as a way to cope with negative feelings about it. Similarly, little was known about Lottie and whether the domestic abuse or her mental health problems impacted on her ability to engage with substance misuse services although it was notable that Lottie had, with the support of Children's Social Care, begun to attend HAGAM, the local service, in 2015. There was a general lack of awareness and/or interest in this area by services, which increased the risk of harm to Lottie and others.

- 3.5.20 Bert's final contacts with CNWL were in January and February 2015. In January a comprehensive mental state examination was recorded and Bert was noted to be anxious about being interviewed by police about two assaults but described Lottie as a protective factor. In February, Bert was reviewed and noted to be calm. There was therefore no sense to mental health professionals that the risk was any higher at this time than in the past and no sense of Lottie being at increased risk either. However, had Bert's most recent pattern of violence, which had also included violent assaults on his brother and a member of the public, and his social circumstances been better understood, the panel consider that it would have been reasonable to conclude that further serious violence could have been predicted and that the risks to Lottie were elevated because they were intimate partners.
- 3.5.21 People with dissocial personality disorder pose a challenge to services yet no specialist services for people with personality disorders were available within Hillingdon. While most perpetrators with mental illness are not in contact with services in the year before the offence, Bert was.<sup>26</sup> This should have increased the opportunity for the service to assess and identify any risks to Lottie and others. In this case, the risks were significantly heightened by the misuse of drugs and alcohol by Bert. However, it is well evidenced and the National Institute for Clinical Excellence (NICE) guidance on antisocial personality disorder: prevention and management<sup>27</sup> recommends that services across agencies link together to manage the risks posed by this group. This lack of a coordinated response was a missed opportunity and the panel has recommended that these NICE guidelines are implemented. In addition, new guidance by NICE on severe mental illness and substance misuse (dual diagnosis) for health and social care services is currently in development. It is important that these are also adopted locally once available.
- 3.5.22 Since Lottie's murder, CNWL have undertaken a service review and launched two new, combined Community Mental Health Teams aligned to Hillingdon GP practices; Hillingdon North and Hillingdon South, to support greater collaboration. The ABT's function has been incorporated into this new team. The team's arrangement aims to ensure greater consistency and the ability to 'hold' more complex cases before decisions are agreed. It also means that relationships

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<sup>26</sup> Mental illness and domestic homicide: a population based descriptive study. Oram et al. *Psychiatric Services in Advance*. July 1, 2013.

<sup>27</sup> Antisocial personality disorder: prevention and management, National Institute of Clinical Excellence (NICE) guidelines, January 2009, updated March 2013

between patients living in the same area should be more readily identified. Specialist link workers to establish more robust partnerships with other services will be introduced. There will also be a requirement for the team to undertake a robust, comprehensive and holistic assessment of a patient's full range of needs and risks.

3.5.23 SPA has also recently been launched by CNWL. It offers mental health triage for routine, urgent and emergency referrals, information and advice 24 hours a day, 7 days a week, and 365 days per year. It incorporates the CNWL Out-of-Hours Urgent Advice Line (UAL) which provides out-of-hours crisis support and advice to people in Hillingdon and other areas. People can refer themselves, or make enquiries on behalf of a family member or friend. The team will also take referrals from GPs, statutory services such as the police and LAS, and non-statutory services such as housing associations, as well as other professionals. The team consists of qualified clinicians who are knowledgeable about different services and options. This helps callers to be directed to the most appropriate service to meet their needs. Had this been available, it could have provided invaluable support to Bert and his mother, Dolly, on a number of occasions, but particularly on his release from prison in June 2014.

#### 3.5.24 **CNWL Community Health Services**

3.5.25 Hillingdon Child Community Health Services provide services including health visiting, school nursing, paediatric occupational therapy, speech and language therapy, and a community paediatrician team.

3.5.26 In the timeframe of the review, Betty, Lottie and Marge received services from both the health visiting and school nursing services.

3.5.27 Health visiting services typically work with children under the age of 5 years. The service was in contact with Betty from the age of one, following notification by the police of a domestic dispute involving Lottie. The records suggest that attempts to engage with Lottie were largely unsuccessful and Betty was rarely seen. The health visiting service was aware of other agencies concerns about the use of drugs and alcohol, and Lottie's mental health.

3.5.28 In March 2012, when Betty was 5 years old, her notes were transferred to the school nursing team. Betty was seen regularly by the school nurse for health assessments in school after she became subject to a children in need plan. On 11<sup>th</sup> February 2014, Betty disclosed witnessing domestic abuse to the school nurse. She promptly passed this information to social services.

3.5.29 During 2014, Betty was subject to a child protection plan. The school nurse regularly attended case conference and core group meetings but, despite being aware of the concerns about Lottie and the potential risks to Betty, did not instigate a MARAC referral.

- 3.5.30 The panel discussed the fact that Lottie had not attended any of these meetings in the year prior to her murder and it was noted that, while this was not good practice, it was not uncommon. There appeared to be an acceptance of this and there was no indication that a plan to address Lottie's lack of involvement was discussed by professionals.
- 3.5.31 Despite having merged in 2011, the mental health and community services information systems and client records in CNWL are still held separately. This meant that the school nursing service was unaware of Bert's and Lottie's contact with mental health services, Bert's forensic history, and was unable to access their risk assessments. Similarly, it meant that information known to the community services about the relationship between Lottie and Bert, domestic violence, and potential risks to Lottie and Betty weren't shared with the mental health team. CNWL are currently introducing a new, single, information system, which should be operational by the end of 2017.

### **3.6 Hillingdon Urgent Care Centre, Greenbrook Healthcare**

- 3.6.1 Hillingdon Urgent Care Centre was established in October 2013 and provides treatment for minor injuries and illnesses with an urgent need but not requiring full A and E services. There was no record of any contact with Lottie but between October 2013 and September 2014 Bert attended five times. This level of repeated attendance over such a short period of time should have prompted further investigation. While it is not intended that patients use the Urgent Care Centre for regular and repeated appointments, it is known that some patients, particularly those living more chaotic lives, such as Bert, do. While it is understandable, it is a concern that the IT system, ADAstra, used in the Urgent Care Centre is not an on-going consultation system so that previous consultations are not linked meaning that repeat attendances are not readily or easily identified. It is also of note that this system does not link with Hillingdon Hospital's IT system. The need for better systems to support information sharing is a theme explored later in the report.
- 3.6.2 Of the five attendances, three of these were due to injuries, which he disclosed he had sustained while fighting or punching things, and two related to mental health issues. His mental health needs were well addressed at the centre including an appropriate referral to the on call psychiatric team. It is of particular note that Bert attended with injuries to his nose and hand, accompanied by his mother, on the 13<sup>th</sup> July 2014, the same day that he is now known to have assaulted Lottie. There was not, however, any recorded evidence that his social situation was assessed despite presenting with injuries resulting from self-disclosed violent acts so opportunities to assess the risk to Bert himself or the risk to others, and refer to children's safeguarding or safeguarding adults were missed.
- 3.6.3 On the 24<sup>th</sup> June 2014, Bert attended the urgent care centre seeking a prescription for medication. He had recently been released from prison and had visited his GP,

the mental health team and finally the urgent care centre where Bert was issued with a prescription for one of the two medications requested and he was referred back to his GP.

- 3.6.4 The lack of medical support for Bert following his release from prison is addressed in 3.4.6.
- 3.6.5 The Urgent Care Centre does not have an operational policy on domestic violence and has not adopted the Central and North West London NHS Foundation Trust policy. The panel recommends that this should be developed as a matter of urgency.

### **3.7 Hillingdon Hospital NHS Foundation Trust**

- 3.7.1 Both Lottie and Bert attended Hillingdon Hospital A and E department on a number of occasions for both physical and mental health issues. Between March 2011 and March 2012, Bert presented to A and E on seven occasions. Three of these attendances were for injuries sustained during fights or other physical violence. This level of violence should have raised a concern for Bert's safety and the safety of others. For a young man, this was also an unusually high attendance rate, which should have prompted further investigation and a call to CNWL. It is also notable that during March 2012, following Bert's arrest in February for a serious and violent assault on a motorist, he attended A and E twice reporting that he was a danger to himself and others. On the second occasion he described heinous acts and asked to be sectioned so he would be kept safely away from people. This could have been a call for help or a tactical move to attempt to avoid being charged by the police. Either way, there was a lack of curiosity in Bert and why he was repeatedly presenting. It was acknowledged during the panel discussion that a man is less likely to be asked whether injuries were the result of domestic violence. The staff in the hospital focused on Bert's mental health and he was assessed and not considered sectionable by the mental health team so he was discharged into the care of the police. This was an uncomfortable position for hospital staff, as reflected in the IMR, who felt that the CNWL plan of care was inadequate in addressing the risk to others. As it happened, Bert did not go on to commit further violence for some time, but the lack of understanding and agreement about risk management between Hillingdon Hospital and CNWL at that time was concerning. There is now a fully integrated psychiatric liaison service operating within the hospital and joint protocols<sup>28</sup> operational across the liaison service and A and E staff.
- 3.7.2 Lottie also attended A and E on several occasions. Of note was her attendance in December 2012 when she described being at risk of injury from someone else. Other IMRs clarified that this was a reference to a traveller whom she owed money.

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<sup>28</sup> Hillingdon Hospital Liaison Psychiatry Service, Joint Operational Policy, Version 4.3, June 2015.



Similarly, in October 2014, Lottie disclosed in an outpatient clinic that she had been the victim of domestic violence. On neither occasion did the staff make further enquiries with Lottie or with other agencies, she was not referred to any other agencies, and her relationship with Bert was not identified. It was highlighted to the panel that Hillingdon Hospital currently uses a paper based record system which does not easily facilitate the sharing of information between hospital based services. The risks arising from this arrangement were also highlighted in the recent DHR, 'Charlotte'.

- 3.7.3 At this time, Hillingdon Hospital didn't have a policy on domestic violence, but guidance for staff was contained within both the safeguarding children and adults policies.<sup>29</sup> It does not appear that the processes were followed to safeguard Lottie or Bert. A domestic violence and abuse policy is currently being written and will include a domestic violence flowchart to support professionals to follow the appropriate steps. Further training of staff is also planned.

### **3.8 London Ambulance Service (LAS)**

- 3.8.1 LAS had three recorded contacts with Lottie. All were in accordance with the operational policy. What was of note, however, was that over the timeframe of the review, they were the only agency to make an adult safeguarding referral for Lottie. There was, however, no record of this referral being received within Hillingdon Council so it didn't trigger further enquiries to be made and, as a result, didn't reach the multiagency safeguarding system. While this referral predated Lottie's relationship with Bert, successful intervention at this time may have prevented the abuse which occurred later.

### **3.9 London Borough of Hillingdon, Housing**

- 3.9.1 The homeless prevention team provides housing advice, homelessness assistance and maintains the housing register.
- 3.9.2 Lottie was well known to the team following her first contact in 2006 when she presented as homeless. In the past she had been assisted with a number of interim accommodations after she disclosed that she was fleeing domestic abuse from a previous partner. In 2013, Lottie was housed in a council property in the borough. It is understood that this property was a two-bedroomed house which had been adapted under the sanctuary scheme. Her family described her being very happy and settled there. She lived there until July 2014 when she presented herself to housing disclosing domestic violence from her then ex-partner, Bert, who had recently been released from prison. In accordance with the local procedure<sup>30</sup> Lottie was initially offered and refused a place in a refuge, before

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<sup>29</sup> Safeguarding Children and Young People Policy, Hillingdon Hospital NHS Trust, 2014

<sup>30</sup> Domestic Violence Procedures for Housing Services, Hillingdon, December 2012.

being placed in a series of temporary accommodations locally. She was then placed in B&B accommodation outside the borough, in Slough. In November 2014, Lottie was offered interim council accommodation, a one bedroomed flat, back in the local area.

3.9.3 Lottie disclosed domestic violence on several occasions to the team when seeking help with accommodation, and the perpetrator, Bert, was also recorded but there is no indication that a CAADA DASH risk assessment was ever completed as part of the initial enquiry procedure or as an ongoing case, in line with the local procedure.<sup>31</sup> While her risk level was sometimes considered to have changed, for example it was assumed to have reduced when she was placed in a B&B, it wasn't reviewed using the CAADA DASH tool as her circumstances changed. Decisions about whether to leave or stay in a relationship are complex and multi-faceted, but it is well established that a women's risk of violence significantly increases at the point of separation.<sup>32</sup> Had a risk assessment been completed at the outset, or at several other key times, agencies would have had a more accurate assessment of risk and a referral to MARAC would have been indicated. The Safeguarding Vulnerable Adults Policy<sup>33</sup> defines a vulnerable adult as 'a person 18 years or over, who may or may not be in receipt of community services and who, by reason of a disability, mental or physical, is unable to protect themselves from significant harm or exploitation'. The housing policy<sup>34</sup> goes on to describe that, in considering whether to refer a client to safeguarding, the officer should consider the person's capability to take action to safeguard themselves, their level or type of disability and how it makes them more at risk. According to this policy, a referral to adult safeguarding was also indicated but not pursued.

3.9.4 There was evidence in the chronology that the housing team assessed Lottie as in priority need and responded quickly to her requests for help with housing. They also actively sought input from colleagues such as the IDVA officer and Lottie's social worker when making decisions in her best interest. What was less evident was an understanding of Lottie's particular needs. Lottie stated that she felt unable to go to a refuge because of her mental health needs. She had lived in one before and reported that the environment had caused her to have panic attacks. No specific refuge was recorded, but it would almost certainly have required her to move further away from her family, and in particular her daughter. This would have increased her isolation, reduced the support available from her family and potentially further impacted on her mental health. It is also unlikely, given her particular needs, that a refuge would have accepted her. The current housing policy does not adequately address these dynamics.

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<sup>31</sup> Domestic Violence Procedures for Housing Services, Hillingdon, December 2012.

<sup>32</sup> Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs, Neville and Sanders-McDonagh, 2014

<sup>33</sup> London Policy and Procedure to Safeguard Adults from Abuse, 2011

<sup>34</sup> Domestic Violence Procedures for Housing Services, Hillingdon, December 2012.

- 3.9.5 Lottie's family were very clear that Lottie had been very settled and happy living in her two-bedroomed house. She approached housing and asked for accommodation because she was fleeing Bert and the domestic violence. Her step-father recalled helping her move to Slough and Lottie said she wanted to get right out of the way so no-one could find her. He said they talked about it and, 'I said, Lottie you don't need this any more. Lottie said, well I'm out of the way now. I don't know how Bert found her. It might have been through some friends. All she wanted to do was get away and get Betty back'. Her family described how when, in the past, Lottie had been subjected to domestic abuse from Bert's half-brother, Lottie had moved and successfully ended the contact with him. They believed that she wanted to repeat this. Bert's mother recalled that Bert joined Lottie in Slough as soon as she moved there.
- 3.9.6 There was a recurrent pattern: Lottie would be rehoused as a result of domestic abuse and then Bert would follow her. In September, the housing officer noted that he was 'very conscious of the repercussions for Lottie's personal safety' but asked the IDVA for any 'intelligence that Lottie is with Bert as this would clearly negate the management transfer status re housing'. This demonstrates a lack of understanding about the dynamics of domestic abuse and the particular dynamics of the relationship between Lottie and Bert. The repeated requests for help and rehousing suggest that Lottie was attempting to end the relationship but she was, according to her family, also frightened of Bert and, when he found her, she took him back. Rather than reduce the risk to Lottie, frequently rehousing her to enable her to leave Bert may, without adequate risk assessment, have actually increased the risks to her. It was noted in the chronology, and in Betty's disclosure, that's Lottie's expressed desire to leave Bert, preceded incidents of violence.
- 3.9.7 Despite the ongoing risks from Bert, Lottie expressed a strong preference to remain within the local area so that she could maintain contact with her family and daughter. The housing team latterly accommodated her preference rather than attempt to move her out of borough via the West London Domestic Violence Reciprocal Arrangement. It can't be known whether Lottie would have agreed to this but she had agreed in the past. When Lottie moved back into the local area in November 2014, she was accommodated in a one bedroomed flat. Immediately prior to this, Lottie was accommodated for a few days in a B&B, close to Bert's home address. Given the history of domestic violence and Bert's persistence in tracking down Lottie, this was inappropriate. It is not clear how they reconnected but, according to her family, he 'wormed his way back in'. Because the flat was considered to be interim accommodation, it was not modified under the sanctuary scheme. Having previously lived in a house modified under the sanctuary scheme, Lottie's disclosures to the team and a well-documented history of domestic abuse in her housing records this should, even without a recent risk assessment, have indicated a high level of risk and, since she lived there for several months, the necessity for her flat to be adapted to provide her with additional security. Had Lottie been risk assessed and referred to MARAC, a safety plan including accommodation with sanctuary scheme or a placement out of borough might well

have been recommended. However, because Lottie and Bert were together again in 2015, it seems likely that Bert would have been staying with Lottie on the night of her murder. It is unclear whether additional security in the flat, or accommodation out of the local area would have ensured her safety, but it could have.

- 3.9.8 Bert first approached housing after he was released from prison in June 2014. He was advised to stay with his mother until his medical assessment was completed. As has already been noted, Bert could not live with his mother because he had a difficult, and at times violent, relationship with his brother. Whether there were also potential risks to his mother was not assessed, although in interview she didn't recall ever feeling at risk. He was then offered temporary accommodation but the tenancy was cancelled when he failed to attend. He subsequently undertook a medical assessment and in July 2014 it recommended, 'I note his psychological issues, drug and alcohol abuse, self-harm, and forensic history. I have no doubt that some sort of mental health supported housing is necessary in this case'. Despite this, in August 2014, Bert presented himself as homeless again and was again placed in temporary accommodation. He again failed to turn up. There was no evidence of any communication between housing and mental health services, despite the risks to Lottie being well known and the need for specialist housing having been identified.
- 3.9.9 In November 2014, he again approached housing stating he was still homeless and had exhausted all of the friends he could stay with. It appeared from the records that the housing team were unaware that Bert had been recalled to prison because of domestic violence against Lottie, that he couldn't return to his mother's house, or that he had been medically assessed, but this was all key information because when he was released he had nowhere to go, but back to Lottie. The local housing procedure does not provide any guidance on specific considerations when accommodating perpetrators of domestic abuse. It is recommended that Hillingdon Housing review the local housing procedures and develop guidance on specific considerations when accommodating perpetrators of domestic abuse.
- 3.9.10 Hillingdon Housing has a clear procedure on domestic violence. Despite Lottie clearly and frequently disclosing domestic violence in her contact with the service, the procedure was not rigorously followed.

### **3.10 London Borough of Hillingdon, Children's Social Care**

- 3.10.1 The London Safeguarding Board's three imperatives for safeguarding children living with domestic abuse and violence<sup>35</sup> are to protect the child; to support the

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<sup>35</sup> Safeguarding children affected by domestic violence and abuse, London Safeguarding Children Board, fifth edition, 2016

mother to protect herself and the child; and to hold the abusive partner to account for his violence and provide him with opportunities to change.

- 3.10.2 From March 2014 onwards the service recognised the potential risk Bert posed to Betty and acted to ensure Betty's safety. It also attempted to provide assertive support to Lottie although her engagement remained poor throughout. The service was less good at recognising the challenges Lottie was dealing with as a result of domestic abuse, how this impacted on her parenting abilities, how protecting Lottie would help protect Betty<sup>36</sup> or on holding Bert to account for his violence.
- 3.10.3 Lottie and Betty were known to Children's Social Care since 2007, a few months after Betty's birth. In the early years the contact was mainly because of alcohol related issues. As time progressed, the contact concerned Betty's attendance at school, Lottie's relationship with Bert's half-brother, Reg, unsuitable people staying in the family home, and Lottie's use of drugs and alcohol. At times Betty would stay with her grandparents. The IMR identified a number of failings in the areas of record keeping, assessments, and case management.
- 3.10.4 Since 2007, Lottie was known to have had relationships with at least four men. There was little background information recorded other than the referrals made by police and probation, and no analysis about the nature of their relationships. At least two of these men were known to use drugs.
- 3.10.5 Betty's father was known to care for his daughter on occasions, usually at the weekends. There was no record of any assessments or checks made on him, his partner and their child. Betty was staying with her father on the night of Lottie's murder.
- 3.10.6 In November 2013, Children's Social Care became aware of Lottie and Bert's relationship, although it is understood to have begun a month or two earlier. Very early on, Lottie's parents reported that they experienced Bert as abusive and threatening to them and their family, although they also later reported that they liked him and he had a good relationship with Betty. This change of opinion, or inconsistency, should not have been taken at face value but explored further as coercive control often involves an element of grooming the family or friends. The family reported liking Bert and thinking he was good for Lottie, although her mother, Marge, described mistrusting him.
- 3.10.7 That same month, Betty made the first disclosure at school about witnessing domestic abuse between Bert and Lottie. On the 6<sup>th</sup> November 2013, following Lottie's arrest on suspicion of child neglect, a house visit was undertaken to Lottie's mother's house. The social worker met with Betty who described what had happened the previous day. She said that Lottie had wanted Bert to leave but he didn't want to go. When he returned he was abusive and broke the window. She

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<sup>36</sup> Kelly et al, Domestic Violence Matters, Home Office, 1999.

said that Bert hadn't hit Lottie. This incident was considered by Lottie's family to be hugely significant to Lottie and her future engagement with agencies.

- 3.10.8 On 29<sup>th</sup> November 2013, Lottie and Bert signed a written agreement for Betty to be returned to her mother's care. The IMR acknowledges that the timing of this was questionable and that no clear history was taken on Bert's criminal or mental health background. This was signed by both Lottie and Bert, and resulted in Betty being returned to her mother's care. It also contained a reference to Lottie and Bert's relationship in which it stated that "Lottie had been a victim of domestic violence in the past, but states that she is not in a domestically violent relationship currently with her partner, Bert'. Again, given Lottie's history of having had previous abusive relationships and the risk that Betty would be taken into care, this denial should have been explored further.
- 3.10.9 On 24<sup>th</sup> December 2013, Children's Social Care was notified by probation that Bert was on license for a violent offence and that they were undertaking a full risk assessment because Bert had applied for Lottie's address to be approved for license supervision. Probation expressed their concern that Bert was being pursued by other people and this could place Lottie and Betty indirectly at risk. There was no record of the earlier request from probation, made on the 14<sup>th</sup> October 2013, having been received. On the 31<sup>st</sup> January 2014 probation visited and approved Lottie's address despite apparently having no response from Children's Social Care.
- 3.10.10 Betty's second disclosure was on the 11<sup>th</sup> February 2014. Although Children's Social Care had not received a Merlin notification from the police about the incident, the school did notify them by making a child protection referral. Betty also described being worried about Bert's behaviour, strangers visiting the house, a horror film and that she feels scared at home when Bert is there. The chronology suggests that legal opinion could have been sought at this stage. Despite,
- (a) This being the second significant incident involving Lottie and Bert in a few months, and Lottie's denial that she is in an abusive relationship with Bert,
  - (b) That the probation service had in October and December 2013 contacted Children's Social Care requesting input into a risk assessment and safeguarding plan because of concerns about Bert's violent history and mental health, alcohol and drug issues; and his self-reported threats from others;
  - (c) That Betty had been returned to her mother's care, despite Lottie refusing to attend the alcohol/drug programme included in the written agreement, and general poor engagement with the children in need plan;
  - (d) That Lottie declined to sign a written agreement to prevent Bert being allowed in the home and having contact with Betty;
  - (e) Betty's continued poor school attendance and her disclosures regarding Bert;

it was a week later before a strategy meeting was held on the 19<sup>th</sup> February 2014. At the meeting, it was decided to progress to an ICPC which resulted in Betty being placed on a child protection plan under the category of neglect. Children's Social Care did share the details of the incident and Betty's disclosure with probation and this, together with Bert's lack of compliance with his licence conditions led to his recall to prison on the 25<sup>th</sup> February 2014.

3.10.11 While Bert was in prison, and during March and April 2014, Lottie attended the initial case conference meeting (10<sup>th</sup> March 2014); core group meeting (24<sup>th</sup> March 2014); and case conference meeting (30<sup>th</sup> April 2014). The proposed plan discussed on the 10<sup>th</sup> March 2014 included:

- (a) Betty arriving at school on time;
- (b) Lottie to work meaningfully with professionals and engage with the social worker;
- (c) Lottie and Betty to attend domestic violence work with Hestia;
- (d) Betty to see a dentist and have her immunisations updated;
- (e) Lottie to agree to announced/unannounced visits by the social worker, and;
- (f) Risk assessment to be carried out by social services and the probation team relating to Bert's release from prison in June.

3.10.12 It was noted in the records of the subsequent two meetings that Lottie was reluctant to engage and cooperate with the plan. It was also recorded that, on one occasion, Lottie was reprimanded by the chair for being abusive to professionals.

3.10.13 Children's Social Care reported that they continued to try to engage Lottie but failed and, in May 2014, her mother made serious allegations about the care of Betty, which led to care proceedings being initiated. It was at this point that a RCPC was held which resulted in a decision to initiate care proceedings. It is unclear exactly when, but sometime between April and June 2014, Betty had moved to live with her grandparents. It is noted in the IMR that Lottie's parents' social history, the nature of their relationship, and whether they had any previous issues with drugs and alcohol was not explored. This was recognised as poor practice.

3.10.14 Lottie next attended a meeting with Betty's social worker on the 23<sup>rd</sup> February 2015. This meeting was held at the school and no record was available of the meeting in the case notes.

3.10.15 In March 2015, a few days before Lottie's murder, Marge and Henry attended a core group meeting. Notes of the meeting were also not available from Children's Social Care, but they were from the school nurse. It was noted that this was a difficult meeting as Marge was now much more positive about Lottie's involvement with Betty. Lottie's lack of engagement with the child protection plan was discussed. It is unclear exactly when it started, but it was recorded at that meeting that the social worker was, at Lottie's request, carrying out a risk assessment on

both Lottie and Bert. Both Lottie and Bert were unhappy about the process and the relationship with the social worker was difficult. It is understood that this process has not started earlier because Betty was now living permanently with her grandparents.

- 3.10.16 While the chronology identified a number of occasions when Lottie had not engaged with services, particularly Children's Social Care, by walking out of meetings or obstructing home visits, Lottie's family challenged this. They described several instances where Lottie was unaware of meetings that had been arranged or when professionals had, in their view, behaved inappropriately. It seems likely that some problems occurred because of poor record keeping by Children's Social Care, as identified in the IMR, and Lottie's family suggested that her frequent change of address meant that correspondence probably failed to reach her. No records or case notes of the meeting held at the school on the 23<sup>rd</sup> February 2015 or the final core group meeting for Betty held at the civic centre in March 2015 were retrievable within Children's Social Care suggesting that there are still significant problems with record keeping.
- 3.10.17 It is also possible that some of the attempts to force a separation between Lottie and Bert, such as signing an agreement preventing Bert being allowed in her home were simply impossible or unrealistic, because of the abuse to which she was being subjected, for Lottie to implement. Lottie's grandmother was very clear that, latterly, Lottie wouldn't have wanted to leave her flat as it was near to her mother and daughter. It is likely that, at times, Lottie felt that she was being asked to manage Bert and any risks that he may have presented to her and Betty. Lottie's family described that Lottie felt that social services was putting 'obstacles' in the way and not helping her. The panel considered that, given the abuse and Lottie's vulnerability, the expectations that some agencies had for Lottie, as stated in the children protection plan, were unrealistically high and this, together with the removal of her daughter, almost certainly led to her disengagement. The agencies didn't know Lottie well and failed to grasp the impact that the domestic abuse and the other factors in her life had on her ability to respond to the conditions of the plan.
- 3.10.18 The three central imperatives<sup>37</sup> of any intervention for children living with domestic violence are: to protect the child; to support the mother to protect herself and her child; and to hold the abusive partner accountable for his violence and provide him with opportunities to change. In reviewing the actions of Children's Social Care, it is clear that from March 2014 onwards, that the service recognised the potential risk Bert posed to Betty and acted to ensure Betty's safety. They were less effective at supporting Lottie and holding Bert, himself, to account.

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<sup>37</sup> Kelly et al, Domestic Violence Matters, Home Office, 1999



- 3.10.19 While it appeared that Betty was not subjected to physical violence, she was at risk and did witness domestic violence by Bert on at least two known occasions<sup>38</sup> which should, in accordance with the local protocol, have triggered a MARAC referral.<sup>39</sup> Lottie also had a well-documented history of domestic violence in previous relationships although it is unknown whether Betty witnessed this too. In May 2014 the information was collated and Betty reached a case conference. Prior to that, there was no mention of domestic violence in any of the initial assessments, or apparently any curiosity about Betty's poor school attendance and whether that was indicative of another problem in Lottie's life. There was also limited evidence of proactive engagement with other agencies to help collate a holistic view of risk to Betty or Lottie. For example, despite knowing that Bert had been recalled to prison in part because of the assault on Lottie, and witnessed by Betty, Children's Social Care was unaware when Bert was released from prison and whether or not he was subject to any conditions. It is acknowledged that Betty was, at this time, living with her grandmother, but the families lived nearby and it appears that Lottie had sporadic and unauthorised contact with Betty. For example, it was reported by Bert's mother that Lottie and Bert took Betty away for a weekend to Butlin's in February 2015. Children's Social Care were not made aware of this holiday.
- 3.10.20 Between August 2014 and December 2015, the department went through a period where the majority of Service Manager and Team Manager posts were not recruited to permanently. There was also a very high turnover of staff, a loss of information, knowledge, and information systems, and a significant proportion of posts were filled with locum staff. It is understood to now be improving. While Children's Social Care was focused on ensuring Betty's safety, the service was less good at recognising the challenges Lottie was dealing with as a result of domestic abuse and supporting her with them. Children's Social Care was largely unaware of the level of domestic abuse between Bert and Lottie and at no point was a CAADA DASH risk assessment completed, despite it being 'the agreed toolkit for social work practitioners in Hillingdon and all agencies in Hillingdon who are signed up to the MARAC process in Hillingdon'.<sup>40</sup> As a result, there were few attempts to engage with Bert, or hold him to account, as perpetrator of that abuse and Lottie wasn't referred to the MARAC.
- 3.10.21 The Multi-Agency Safeguarding Hub (MASH) became operational on 1<sup>st</sup> April 2015 and now means that information from different agencies can be shared quickly so social workers can build up a better picture of the child's life from the outset. The

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<sup>38</sup> Intimate partner violence: what are the impacts on children? Bedi G, Goddard C. *Aust Psychol* 2007; p 66–77

<sup>39</sup> MARAC protocol for Hillingdon Borough, April 2016

<sup>40</sup> Domestic Violence Procedures for adult's social care services and children and young people services, Hillingdon HADIA.

aim of the MASH is prevention and early intervention; to identify risk and harm to allow timely and appropriate interventions (including referral to Children's Social Care or Adults Service if necessary). This makes it easier for social workers to decide on the best type of intervention needed to protect the child and support the family. The MASH brings together a core membership which includes Children's Social Care, Adults Services, Police, Probation, Education, Housing, Youth Offending Service, Drug and Domestic Violence services and Health. An early, holistic approach would undoubtedly have helped in this case.

### **3.11 The school**

- 3.11.1 Lottie and her family were well known at Betty's school because she, and her siblings, had also been pupils there. Betty attended the school since September 2012. On occasions, the school had concerns about Lottie and, at times, her ability to care for Betty and regularly made contact with Betty's social worker and the educational welfare services. That said, they managed to maintain a good and positive relationship with Lottie's family. They received the key disclosure from Betty about the incident in February 2014 and duly reported it to Children's Social Care. They did not report the threat to kill which Betty disclosed, to the police, and this was a missed opportunity to safeguard Lottie. The school had very limited contact with Lottie after Betty moved to live with her grandparents.
- 3.11.2 At some point (the exact date couldn't be retrieved) in late 2013, Bert, on occasions, collected Betty from school. Lottie's family were understandably concerned that no restriction appeared to have been placed on Bert, despite his history of violence to Lottie and others. The school reported that Lottie had notified them that she was happy for Bert to collect Betty. They also noted that, at that time, they knew nothing about Bert's criminal background. He stopped collecting Betty from school in February 2014, around the time she disclosed the incident of domestic abuse. It was also in February 2014 that the school nurse became aware of the concerns of other agencies about Bert.
- 3.11.3 In their IMR, the school noted that they don't receive Merlin reports so are often unaware of domestic abuse within families known to the police and other agencies. They also identified that the process for referring to other agencies was unclear and expressed some frustration about having to repeatedly make referrals when agencies failed to accept their concerns. It is recommended that the MASH arrangement addresses the information sharing needs of schools and education services.

### **3.12 London Borough of Hillingdon, Education**

- 3.12.1 The education welfare service interest in Lottie and Betty was focused on her school attendance and, in her early years, Betty's frequent change of school. It appears that the educational welfare officer did not pursue any lines of enquiry

around domestic abuse or other problems that may be affecting Betty's attendance with Lottie. It was identified that the educational welfare officer's family lived in the same neighbourhood as Lottie's family and she appeared reluctant to address these issues with the family. This was a missed opportunity for further investigation and the case should have been allocated to another officer without a professional conflict of this sort.

### **3.13 Specialist services**

### **3.14 Victim Support**

- 3.14.1 During the period of the review, Victim Support received nine separate referrals for Lottie from the Metropolitan Police, six of which were for non-domestic violence incidents and Lottie did not engage with the service. The final two referrals were during July 2014 and in response to the two recorded incidents of violence by Bert to Lottie. Victim Support completed a CAADA DASH risk assessment for Lottie and, because the level of risk was high (score of 12), followed their operational procedure and referred Lottie to the IDVA service, on the basis of professional judgement. This was one of the few risk assessments undertaken by anyone other than the police and it was notable that, unlike those done by the police, Lottie engaged with this one. After the second July incident, Lottie's file was closed because the IDVA service was already involved.
- 3.14.2 In 2014/15, two changes were made to the service's procedures. The first was to close the loop so that victims who don't engage are referred back to the Community Safety Unit (CSU) and not lost to the system. Secondly, repeat victims, such as Lottie, are highlighted on the IT system and trained volunteers now offer specialist support. Both of these changes could have been beneficial to Lottie.
- 3.14.3 More recently, Victim Support has made further changes to their Operating Procedure to ensure that it meets the Leading Lights<sup>41</sup> requirement for quality community based domestic abuse services. This review clarifies that high-risk cases are defined by a score of ten or more or professional judgement, and those scoring fourteen or more will be referred to the IDVA service. It also clearly identifies the different responsibilities of Victim Support and the IDVA service and the arrangements for the effective transfer of victims between the respective services.

### **3.15 Hestia – Hillingdon Domestic Abuse Floating Support Service**

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<sup>41</sup> Leading Lights, quality accreditation by Safelives; the gold standard for community-based domestic abuse services

- 3.15.1 Hestia provides short-term support to victims of domestic abuse, often with the purpose of helping victims rebuild their lives after domestic abuse. In 2012, Hestia made several attempts to engage Lottie in the floating support service but was unsuccessful. The service was terminated but the referring agency was not advised.
- 3.15.2 According to the records, and in accordance with the care pathway for the delivery of on-going support, Lottie was again referred to Hestia in July 2014 by the IDVA service. Hestia had no record of receiving these referrals. Although Lottie had not engaged with the service previously, this was one of the occasions when Lottie declared that she had ended her relationship with Bert so the timing of this referral was appropriate. Skilful and independent intervention and support by a non-statutory sector organisation at this time may have been successful and was, potentially, a missed opportunity. It is of concern that the IDVA service failed to notice that the referral had not been received.

### **3.16 Hillingdon Independent Domestic Violence Advocacy Service (HIDVA)**

- 3.16.1 The purpose of Hillingdon IDVA (HIDVA) is to address the safety of victims at medium to high risk of harm from intimate partners, ex-partners or family members, in order to secure their safety and also the safety of any children.
- 3.16.2 Lottie had been known to the IDVA for some years because of her abusive relationship with Bert's brother, Reg.
- 3.16.3 Lottie was initially referred to the service in 2010 while in a relationship with Reg, Bert's step-brother. She engaged well and undertook a risk assessment. She was assessed as high risk (17 risk factors were identified) and, in accordance with the operational policy<sup>42</sup> was referred to MARAC.<sup>43</sup> Despite Lottie's daughter, Betty, witnessing domestic violence, there was no record of a referral to Children's Social Care at this time. The risk to her daughter wasn't therefore assessed.
- 3.16.4 There were then long gaps where there was no contact between Lottie and the IDVA service. The IMR notes that no welfare checks were undertaken during this time so it was not known whether the risks to Lottie had changed or a safety plan had been implemented.
- 3.16.5 The next contact with Lottie was on 8<sup>th</sup> July 2014 following a referral by Victim Support who had assessed Lottie and found her to be at high risk of serious harm. It is of note that while Lottie would not engage with the police at this time, she had engaged and completed a CAADA DASH risk assessment with Victim Support (and scored 12) and then cooperated with the IDVA service. On the 11<sup>th</sup>, the IDVA service also assessed Lottie, using a different risk assessment tool, and found her

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<sup>42</sup> HIDVA Service Delivery Policy (undated)

<sup>43</sup> MARAC protocol for Hillingdon Borough, April 2016.

to be at high risk with a score of 23 risk factors and 1 vulnerability. A safety plan was drawn up with Lottie which included a referral to Children's Social Care and MARAC. The plan was largely actioned, although the referral to MARAC wasn't made within the 48 hours of completing the risk assessment in accordance with the HIDVA policy.<sup>44</sup>

- 3.16.6 Lottie was then assaulted again by Bert on the 13<sup>th</sup> July, the second assault in a ten-day period.
- 3.16.7 On the 15<sup>th</sup> July the IDVA was notified by Children's Social Care that Lottie had been seen by Betty's social worker that day with bruises and scratches on her face. The IDVA officer confirmed that she would 'put Lottie's case on the MARAC pile for the next months meeting'. Two weeks later Lottie's case was removed from 'the pile' because the IDVA and her manager considered that the risk had reduced. There was no record of a risk assessment to support this decision. It was recorded that Lottie has stated that she had not seen or heard from Bert, that she was now in B&B accommodation away from Hillingdon, the relationship with Bert had ended, and she was engaging with housing and social services. This decision was based on very limited information and was poor practice. The local policy states that risk should be reassessed or updated if there has been any change of circumstances.<sup>45</sup> Had they risk assessed Lottie, sought the views of the police or housing, for instance, or considered the history of the relationship between Lottie and Bert, and the likelihood to Lottie of returning to Hillingdon to be near her daughter and family, then significant risk remained and a referral to MARAC was still indicated. There was no further direct contact between Lottie and the IDVA service and, again, no record of any welfare checks.
- 3.16.8 In July 2014, the IDVA noted 'Lottie is at high risk ... because of her inability to be pro-active in achieving safety ...'. Indeed, as part of the safety plan, Lottie had been advised to get a non-molestation order against Bert. Lottie had agreed to this but it was later noted that she did not attend the appointment with her solicitor. The IMR reflected that 'it is understandably frustrating to work with clients who are not proactive or fail to engage', but this is common among victims of domestic abuse, particularly those at high risk and subject to coercive control. A lack of current engagement should in itself be a cause for professional concern. In Lottie's case, her ability to keep herself and her daughter safe was further compounded by such as mental illness, homelessness, and drug and alcohol abuse, all of which made her particularly vulnerable and weren't acknowledged or adequately addressed. It is victims like Lottie that require the greatest and most proactive support from specialist services. It is essential that services do not victim-blame as this can provide a significant barrier to women seeking support. Indeed, it did appear that as Lottie was subject to more domestic abuse and Bert's violent behaviour more generally increased, she disengaged further from services and

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<sup>44</sup> HIDVA Service Delivery Policy (undated)

<sup>45</sup> HIDVA Service Delivery Policy (undated)

her risk increased. The absence of a coordinated response meant that this pattern was not identified and a lack of proactive engagement by the IDVA officer or regular welfare checks on Lottie meant there were few opportunities for positive support or intervention. The local HIDVA service delivery policy<sup>46</sup> refers to providing 'victims in crisis a swift and proactive service', but this approach wasn't consistently evident in this case. The IMR recommends that IDVA carry out regular welfare checks on clients where there is a high risk of harm but they are failing to engage with services.

- 3.16.9 Over the four years that Lottie was known to the IDVA service there was considerable correspondence with other, particularly statutory, agencies. It was evident that the other agencies believed that Lottie was engaging with IDVA and that the service was, to an extent, coordinating support for Lottie. This was clearly not the case as her contact with them was, at best, limited and latterly non-existent. In fact, the final contact between Lottie and the IDVA was on the 20<sup>th</sup> July 2014, almost nine months before her death. It was also unclear when Lottie's case was 'open' or 'closed' to the IDVA service. More active management of the IDVA caseload would provide greater clarity to other agencies, and ensure that responsibility isn't inappropriately transferred to the IDVA. There is some ambiguity about the focus for the IDVA service (is it both medium and high risk cases?) and a clearer commissioning strategy and revised operational policy including thresholds, response times and exit strategies should also help target these valuable resources to those assessed as at highest risk.
- 3.16.10 The IDVA service was, during the timeframe of this review assessed by Safe Lives (formerly CAADA) to be underfunded and therefore understaffed. Some short-term funding in 2015 has increased the staffing levels but a permanent solution and a comprehensive commissioning strategy addressing the provision of specialist domestic violence services is necessary. The appropriateness of the HIDVA service being managed by Children's Social Care should also be reviewed. This can present a serious conflict of interest, particularly where children are involved and, although not evidenced this time, could reduce the level of engagement by victims.

### **3.17 Multi Agency Risk Assessment Conference (MARAC)**

- 3.17.1 Lottie was referred to the MARAC in 2010 but the DHR was unable to retrieve the records. She was not successfully referred at any other time, despite it being indicated on a number of occasions. As a result, this DHR does not address the effectiveness of the Hillingdon MARAC. It was, however, noted that the MARAC Protocol for Hillingdon<sup>47</sup> is out of date, for example referring to Primary Care

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<sup>46</sup> HIDVA Service Delivery Policy (undated)

<sup>47</sup> MARAC protocol for Hillingdon Borough, April 2016.

Trusts, which have not existed since 2013, and therefore does not appear to have been subject to recent review.

- 3.17.2 Similarly, because Lottie was not successfully referred to adult safeguarding, despite several IMRs identifying instances when it was indicated, this DHR does not address the effectiveness of these arrangements, nor the effectiveness of the connection between the arrangements for domestic abuse and adult safeguarding.

## 4. Conclusions and recommendations

### 4.1 Predictability

- 4.1.1 In the light of the information available to this review from the IMRs, the integrated chronology, the discussions in panel meetings and the meeting with the victim and perpetrators family it seems likely that, if the work had been carried out across the agencies in accordance with good practice, and national and local policy at the time, it should have been possible to predict that Bert's violence would continue to escalate and he would seriously injure or kill someone. The severity of the violence was increasing and so too was the frequency. In addition, Bert's mother described how in the week before Lottie's murder, Bert had been stressed about the warrant out for his arrest and the risk that he would be imprisoned for the assault on the minicab driver. He hadn't been sleeping and, she said, that when this had happened before, 'after two or three days, something is going to go'. This 'all or nothing' response was known to CNWL.
- 4.1.2 In March 2015, before Lottie's murder, the Metropolitan Police called at Lottie's mother's house looking for Bert in connection with the assault. It is likely that this was related to the call that Lottie then received, and caused her such distress, while attending HAGAM. This was the same day that Bert visited his GP.
- 4.1.3 Bert's mother described how, towards the end, her son was crying out for help. She described how, despite having a what she described as a 'volatile relationship' with Lottie, Bert loved Lottie and she didn't consider that her death was inevitable. 'I wasn't expecting what happened. I was seeing my son at breaking point. He'd had enough. I was expecting a call to say that he'd killed himself'.
- 4.1.4 Given Bert's most recent pattern of violence, which had also included violent assaults on his brother and a member of the public, it is reasonable to conclude that further serious violence could have been predicted. It could not have been

predicted with certainty whom the victim would be, but the risks to Lottie were elevated because they were intimate partners.

## **4.2 Preventability**

- 4.2.1 Both Lottie and Bert had extensive contact with local agencies over several years and a significant number of missed opportunities during that time have been identified. It has also been identified that a number of agencies failed to share information or follow local procedures on a number of different occasions so that while Lottie was known by some agencies to be at high risk there were a significant number of missed opportunities to refer her to the MARAC or specialist services. Similarly, while Bert was identified as the perpetrator of domestic abuse by some agencies, he was never apprehended or charged for domestic violence. What cannot be known, however, is how Lottie might have responded had the risks been recognised and services collaborated to support her. While she had engaged with the MARAC process in the past, as time progressed, Lottie became more disenfranchised from services, almost certainly as a result of her daughter being removed from her care and there being no realistic prospect of her being returned.
- 4.2.2 The outcome might have been different if any risk assessments had been based on the full background information about the perpetrator, including his history of violence and aggression, dissocial personality disorder, and drug and alcohol misuse, and had sought information from the wide range of other agencies involved in his care. It also seems likely that Lottie's history of domestic abuse and her complex presentation, including self-harm, drug and alcohol misuse, emotional personality disorder, other criminal acts, chaotic lifestyle, lack of engagement, homelessness and the fact that she remained in an abusive relationship meant that she appeared to be considered, by some agencies, difficult to work with. Her grandmother described how 'she was very stubborn and wouldn't accept help. She didn't want them taking over. She thought they were invading her life. Everyone was confusing her too. It was all too much and she couldn't work out who everyone was'. At times, some agencies appeared to lose sight of what they were there for and treated Lottie as a problem rather than a person who needed help. There was undoubtedly some organisational fatigue as agencies reported seeing the same patterns repeat themselves and struggling to know how best to intervene. There were also times when the relationship between individual professionals and Lottie was difficult. As a result, the ability of some agencies to engage with Lottie were also limited. Her family described how she felt unsupported and no single professional had successfully developed a good relationship with her. 'We wanted Lottie to have Betty back so they could be the family they wanted to be. But they were not helping her build the bridge. Either they were putting obstacles in the way or they weren't doing anything'. As time went on, she engaged less and less with agencies because, as her family reflected, 'she just felt, go away. It isn't worth talking to anyone'.



- 4.2.3 Her vulnerability wasn't widely recognised and most agencies failed to see the overall picture, and failed to understand the dynamics of the coercive control and physical violence carried out by Bert. Because of this, agencies demands on Lottie or expectations of her were, at times, unrealistic and the panel considered that this, in part, explained the reason for Lottie's lack of engagement. Kelly<sup>48</sup> suggests that this pattern whereby women make many attempts to leave but keep returning to abusive partners often reflects a belief that a partner will change or there is an absence of practical alternatives or effective protection. Specialist services should have understood where Lottie was in her experience of domestic abuse and, had she had more contact with them and been better known by them, been able to tailor their intervention accordingly.
- 4.2.4 As the risk assessments were often lacking, together with the complexity of Bert's presentation and Lottie's apparently poor engagement, agencies were not able to predict the level of risk and danger that he posed to Lottie or anyone else. Lottie's family expressed their frustration with some services, 'There was so much there that they could have grabbed onto and prevented it. To push him away. When he was recalled to prison, it was for domestic violence. It's not as if they didn't know that. It was in their reports'. The family was also frustrated that no-one came and asked for their views about how best to support Lottie. As they pointed out, they knew her circumstances and understood her better than anyone else.
- 4.2.5 Although it could not have been predicted that Bert would kill Lottie, it could have been predicted that he would carry on to behave violently and abusively and in view of his past history of random acts of violence and established domestic violence, it is very likely that the behaviour would have continued to escalate further posing significant risks to Lottie, his brother and the wider public.
- 4.2.6 Lottie was not offered effective protection from Bert. Even if the response had been effective and action had been taken to control Bert's behaviour by the agencies, for example by prosecuting him, it is still possible that he could have found another opportunity to assault Lottie. Despite being recalled to prison for domestic violence, he assaulted her shortly after his release. However, it might have given Lottie the breathing space she needed to successfully end her relationship with him. Equally, Bert did disclose to the police and obliquely to health professionals that he had abused Lottie. This could have presented an opportunity to engage him in a perpetrator programme but, even had this been recognised, there was no specialist provision for perpetrators available in the local area. His mother, Dolly, described him as 'crying out for help' and, often his only option was to seek an admission to hospital.
- 4.2.7 The services provided to Lottie were not effective in keeping her safe. What cannot, however, be concluded is whether, had the services been better coordinated, her needs been escalated, realistic and practical alternatives offered,

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<sup>48</sup> Kelly et al, Domestic Violence Matters, Home Office, 1999.

and fewer opportunities missed, Lottie could have engaged effectively with agencies to ensure her safety and prevent her murder.

### **4.3 Issues raised by the review**

#### **4.3.1 Systemic failures**

4.3.2 There were two domestic homicides in Hillingdon in 2015, both resulting in Domestic Homicide Reviews. The first DHR related to 'Charlotte' and has recently received Home Office approval and been published. There was also a domestic homicide in Hillingdon in 2013, which did not result in a DHR. The panel was unable to retrieve the paperwork relating to the homicide or the decision. A review of the two DHRs and their recommendations suggests that there are a number of common themes including partnership working; service provision and the need for a co-ordinated, multi-agency response; risk identification; and training and awareness. The Community Safety Partnership should use the learning from these two DHRs to inform a review of the domestic violence strategy, governance arrangements and operational delivery structures in the borough.

#### **4.3.3 More specific themes identified from this review**

##### **4.3.4 Training and disclosure.**

4.3.5 Lottie had extensive contact with a wide range of agencies during the timeframe of this review and specifically during her relationship with Bert. Even when carrying visible injuries, she was rarely asked about domestic abuse and only selectively disclosed it. It is well known that victims of domestic abuse will often choose not to disclose because it can increase the risk of further abuse and, in Lottie's case would, because the relationship with Bert was on-going, also reduce the likelihood of her having Betty returned to her care. The Kelly<sup>49</sup> model of crisis intervention highlights the importance of really understanding the victim's perspective and tailoring support accordingly.

4.3.6 Female survivors describe wanting primary health care providers to listen, show validation, empathy, and non-judgemental and confidential responses.<sup>50</sup> These skills were within the scope of all professionals, were written into most operational procedures, but there were very few instances of professionals, not just in primary care but across the full range of services, showing curiosity either directly with Lottie or by sourcing corroborating evidence from colleagues. Lottie was subject to both physical violence and coercive control.<sup>51</sup> There was a lack of awareness among professionals about coercive control and how to identify it. As a result,

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<sup>49</sup> Kelly et al, Domestic Violence Matters, Home Office, 1999.

<sup>50</sup> Mental illness and domestic homicide: a population based descriptive study. Oram et al. Psychiatric Services in Advance. July 1, 2013.

<sup>51</sup> Controlling or Coercive Behaviour in an Intimate or Family Relationship, Statutory Guidance Framework, Home Office, December 2015

some of Lottie's behaviour, such as minimising or denying abuse, was misunderstood so the risks to her safety were not properly identified.

#### 4.3.7 **Information sharing**

4.3.8 Information sharing is pivotal to safeguarding children and vulnerable adults, yet some agencies appeared to work in a silo. Most agencies involved with Lottie and Bert kept records but there were some significant gaps in the both the content and sharing of these records. Only a few agencies were aware of the relationship between Lottie and Bert and, in some cases, basic information regarding social structure, past social and health history, and risk factors wasn't gathered. Both Lottie and Bert had complex needs yet most agencies didn't seek information from other agencies, or indeed proactively share information with others already involved in their care. The education system and the school, in particular, weren't adequately involved or kept informed by other agencies despite having a central role in safeguarding Betty. Despite the level of contact and information available to agencies, there were no successful referrals to MARAC, MAPPA or adult safeguarding.

4.3.9 Cooperation between agencies was sometimes good but often lacking. On a number of occasions information was sought but not provided and it was also clear that some referrals, such as a safeguarding referral and referrals to specialist services, were made but never received. At times some agencies refused to share information because of concerns about confidentiality. At other times, information was shared inappropriately. This created significant gaps in knowledge, which impacted on understanding Lottie and Bert's history and the wider social environment, which, in turn, impacted on holistic risk assessments and appropriate service response. Lottie's family, particularly her brother, made several attempts to raise their concerns about the risks that Bert posed to Lottie, or disclose Bert's whereabouts when he was wanted by the police, with several agencies but these were not acted on. Specific issues about communication between police forces were highlighted in the review.

4.3.10 At the end of Bert's sentence he was released, despite having been recalled for non- engagement with mental health professionals and domestic abuse, without any notification to any local agency. He was also released without suitable accommodation, a GP, or sufficient medication. All of these increased the risks to Lottie.

#### 4.3.11 **Risk identification**

4.3.12 Risk assessment tools help identify the appropriate level of intervention. Despite a high level of contact with statutory agencies, a number of disclosures, and highly changeable personal circumstances, Lottie had remarkably few domestic abuse risk assessments. This was because the risk of domestic abuse to Lottie was not the focus for most agencies and was lost in the midst of her complex presentation, Bettys welfare, and Bert's established mental illness and violent behaviour. A retrospective risk assessment using CAADA DASH undertaken by the

Independent Chair indicated that Lottie's risk would in late 2014 have indicated a score of 16, well above the threshold for a MARAC referral,<sup>52</sup> irrespective of other considerations such as potential escalation and professional judgement.

4.3.13 Despite the CAADA DASH risk assessment tool being the tool agreed for use within Hillingdon<sup>53</sup> and being embedded in most agreed operational procedures, the tool was not consistently used. For example, Victim Support used this tool to risk assess Lottie in July 2014 and the IDVA then risk assessed her again, three days later, using a different tool. An analysis of DHRs undertaken by Sharp-Jeffs<sup>54</sup> shows inconsistencies in professionals' use of the Safe Lives RIC risk assessment tool. The problem with this is that practitioners across different services can be seen to 'weight' different parts of the risk assessment differently and the information then cannot be shared reliably. The paucity of risk assessment and the absence of consistent usage of the tool, meant that Lottie wasn't referred to MARAC, as she should have been, that information couldn't easily be shared between agencies, and opportunities for multi-agency safety planning and intervention were missed. Risk assessments must be comprehensive, consistent, holistic and regularly reviewed. There was no evidence that agencies recognised the changing nature of the risk that Bert was presenting to Lottie. Arrangements for sharing this information between agencies also need to be agreed otherwise other high risk cases may not be identified or escalated to the MARAC and specialist services.

#### 4.3.14 **Escalation to multi-agency interventions**

4.3.15 Most agencies working with Lottie focused on their area of responsibility. This led to a silo approach and did not reflect the complexity or reality of Lottie's life. There was also a tendency to expect Lottie to be proactive in making contact or seeking the support of other agencies. Many victims of domestic abuse end up leading chaotic lives as a result and some, like Lottie, will also be fearful, disenfranchised and lack the confidence or capability to pursue help themselves. Lottie was reported to say that 'no-one wants to help me'. The system needs to work to support people to gain help and professionals need to have clear and agreed referral pathways.

4.3.16 The referral pathway should move from general to specialist services and multi-agency interventions. It must also be clear on the most appropriate referral routes for immediate and longer term support. The referral pathway to the MARAC must be reviewed to ensure that those victims at highest risk are identified and escalated up the pathway in a timely fashion. Other than historically, in 2009, Lottie didn't reach the MARAC. Had she been risk assessed appropriately, Lottie would

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<sup>52</sup> MARAC protocol for Hillingdon Borough, April 2016.

<sup>53</sup> Domestic Violence Procedures for adults social care services and children and young people services, Hillingdon HADIA.

<sup>54</sup> Domestic Homicide Review (DHR) Case Analysis, Report for Standing Together, Nicola Sharp-Jeffs and Liz Kelly, June 2016

have met the criteria for referral on several occasions on the basis of her score, repeated incidents and also on professional judgement. Successful referral to MARAC would have also provided agencies with an opportunity to consider the risks Bert posed to the wider community and other family members. A number of missed opportunities to refer Lottie have been identified and these have been highlighted in the report.

- 4.3.17 Similarly, Lottie was not effectively referred to adult safeguarding despite it being indicated on several occasions, some of which preceded the relationship between Lottie and Bert. The London protecting multiagency safeguarding policy and procedure<sup>55</sup> used in Hillingdon, states that cases not reaching the threshold for MARAC or considered high risk will still be managed under the Safeguarding Adults process with strategy discussions taking place to develop appropriate plans to prevent escalation in circumstances and to provide appropriate support for the adult. An adult safeguarding concern is any worry about an adult who has or appears to have care and support needs, that they may be subject to, or may be at risk of, abuse and neglect and may be unable to protect themselves against this, and the presence of all three means that a referral must be made. Factors that could, at times, have supported a referral included a history of domestic abuse; a history of mental illness including depression, anxiety, suicidal or self-harm risks; threat from others; self-neglect and social withdrawal. Despite being a perpetrator of violence, at times Bert was also vulnerable and sought help from agencies. Missed opportunities to refer Lottie and Bert to adult safeguarding have also been identified in the report.
- 4.3.18 There were also missed opportunities to refer Bert to MAPPA which resulted in missed opportunities to agree an effective multi-agency risk management plan to support the effective management of Bert and minimise the risk to Lottie and to the wider public. CNWL for example include a recommendation within their Internal Investigation that, 'the Community Mental Health Team should ensure that where there is a significant forensic history including claims of a serious criminal nature for patients who come into contact with mental health services, those services should refer to the local MAPPA'. Other agencies could, similarly, have referred Bert, who would have qualified for MAPPA based on his previous relevant conviction. The panel considered that this lack of escalation resulted from a limited understanding of MAPPA's role, and the criteria and thresholds for referral.
- 4.3.19 The MAPPA guidance<sup>56</sup> stresses the need for coordination between MAPPA and MARAC to ensure the best use of resources and the most effective support for victims, and that MAPPA should take precedence over MARAC because it is a statutory set of arrangements. Since neither Lottie nor Bert were successfully

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<sup>55</sup> <http://londonadass.org.uk/wp-content/uploads/2015/02/LONDON-MULTI-AGENCY-ADULT-SAFEGUARDING-POLICY-AND-PROCEDURES.pdf>

<sup>56</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/582380/mappa-guidance-2016.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582380/mappa-guidance-2016.pdf)

referred to MARAC or MAPPA, it is impossible to assess the effectiveness of multi-agency working, but the lack of escalation is, in itself, concerning.

#### 4.3.20 **Health and domestic abuse**

4.3.21 A DHR case analysis<sup>57</sup> report notes that when responding to complex needs, agencies tend to focus on addressing mental health or substance misuse and generally miss the opportunity to identify and risk assess the potential for violence to intimate partners and family members. There undoubtedly was a focus among health professionals on medical models of diagnosis and treatment so that social issues were overlooked or not understood.

4.3.22 It has also been shown, and was a point reflected in the judges summing up of this case, that the potential for violence to partners/carers is significantly increased when serious substance misuse is present.<sup>58</sup> An analysis of DHRs<sup>59</sup> also found that mental health issues and alcoholism emerged as an area of concern, leading it to conclude that this cluster of issues should be recognised as posing a high risk and should be seen as an alert for perpetration of domestic abuse. Agencies appeared not to be aware of the risks of this combination, sometimes referred to as the toxic trio.

4.3.23 In this case, it is likely that the domestic abuse was hidden, or less visible to agencies, because of Bert's violent behaviour, mental illness and substance misuse, and Lottie's complicated life and, at times, limited engagement. A coordinated and holistic approach to recognising the increased risk posed by perpetrators like Bert and the vulnerabilities of victims like Lottie is essential and the weaknesses of silo working are evidenced in this DHR.

4.3.24 Bert was diagnosed with a dissocial personality disorder and had a recorded history of serious violence. He was well known to the police and to mental health services but there was almost no collaboration between these organisations. There is a need for mental health services and the police to share information about individuals who present a risk to their partners or members of the public in order to ensure appropriate responses. Some people with personality disorders can be particularly challenging for agencies so they require clear pathways for referrals to ensure the most effective multiagency care is provided. An antisocial

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<sup>57</sup> Sharp-Jeffs, N. and Kelly, L. (2016) Domestic Homicide Review (DHR) Case Analysis: Report for Standing Together, London: Standing Together Against Domestic Violence and London Metropolitan University

<sup>58</sup> Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs, Neville and Sanders-McDonagh, 2014

<sup>59</sup> Preventing Domestic Violence and Abuse: Common Themes Lessons Learned from West Midlands' DHRs, Neville and Sanders-McDonagh, 2014

personality disorder network, as recommended by NICE,<sup>60</sup> could be developed to evaluate the effectiveness of local provision.

4.3.25 While Bert and Lottie generally appeared to receive appropriate care and treatment for their mental health and physical health problems, despite a number of disclosures by Lottie and a number of risk indicators with Bert, there was a general lack of awareness of the risk of domestic abuse, particularly coercive control, among health professionals and little curiosity shown. There was also little evidence of information sharing between health services, even within the same organisation, and between health and other services. In addition, the potential risks arising from the relationship between Bert and Lottie, both patients of CNWL, was not identified. Implementing the NICE guidelines<sup>61</sup> on domestic violence would help address these gaps.

#### 4.3.26 **Perpetrators**

4.3.27 It is important to acknowledge that Lottie was not responsible for the abuse she was subjected to, Bert was. The agencies should have worked together to support her and keep her safe. Bert was responsible for the abuse and should have been held to account for it. Apart from his recall to prison, this wasn't done effectively. Despite a significant number of recorded incidents involving violence to Lottie, his brother and members of the public, in the nine months since his release from prison until Lottie's death, Bert wasn't successfully prosecuted for any offence.

4.3.28 Bert did on occasions disclose that he had subjected Lottie to domestic abuse. He did this on the telephone to the police and also made oblique references in his contact with health professionals. There was no evidence that professionals responded to this positively by seeking to explore this further, hold him to account, or engage him with specialist services. While the evidence base for effective interventions with perpetrators is generally limited, there is evidence that some approaches, such as the Domestic Violence Intervention Project, do reduce domestic abuse. There are no resources currently available within Hillingdon and ensuring there is access to appropriate resources/services to support perpetrators is essential and should form part of a comprehensive commissioning strategy.

## 4.4 **Recommendations:**

### 4.5 **Review Panel Multi-Agency Recommendations**

The recommendations below should be acted on through the development of a partnership owned action plan. This is in addition to the actions identified in the

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<sup>60</sup> Antisocial personality disorder: prevention and management, National Institute of Clinical Excellence (NICE) guidelines, January 2009, updated March 2013

<sup>61</sup> Domestic violence and abuse: how health services, social services and the organisations they work with can respond effectively, National Institute for Clinical Excellence (NICE), 2014

individual IMRs (**Appendix 1**). Recommendations identified in IMRs remain the responsibility of that agency, however, initial reports on progress by agencies on their IMR actions plans should be made to the SHP within six months of the Review being approved by the Partnership.

- 4.5.1 Safer Hillingdon Partnership (SHP) to conduct a rigorous borough wide review of Hillingdon's strategic overview and operational response to domestic violence. This review must address:
- a) the effectiveness of the SHP, specifically the effectiveness of the governance and strategic leadership that the partnership provides for domestic abuse;
  - b) the effectiveness of the Domestic Violence Forum and related sub-groups,
  - c) the strategic direction and priorities for Hillingdon;
  - d) the gap between the strategy and delivery of the strategic aims by all agencies.
- 4.5.2 SHP to ensure that all partner agencies conduct an internal review of their domestic violence/abuse policies and procedures in relation to how they identify, risk assess, refer and respond appropriately to victims, particularly those who don't engage and/or are subject to coercive control, and make changes as appropriate. This must include reviewing referral pathways to multi-agency forums (MARAC, MAPPA and Safeguarding) and ensuring that they are clearly identified and utilised.
- 4.5.3 SHP to review the partnership approach to perpetrators of domestic abuse and produce recommendations for change based on the learning from the two recent DHRs.
- 4.5.4 SHP to undertake a needs assessment and review of existing domestic abuse specialist support services (including the management of IDVA), and develop a comprehensive commissioning strategy that meets the needs of both victims and perpetrators and includes a focus on prevention and early intervention.
- 4.5.5 SHP to review the use of the CAADA DASH risk identification checklist in Hillingdon agencies including: the purpose of DASH completion, the adoption of DASH consistently across agencies and in front line practice, the use of DASH as an on-going risk identification tool, and the arrangements for sharing of risk information outcomes between agencies involved with the same client. A multi-agency task and finish group should be established in order to develop a multiagency protocol regarding the risk assessment of victims of domestic violence.
- 4.5.6 SHP to establish a task a finish group in order to develop a multiagency protocol on information management including creating a common information record and sharing information on victims and perpetrators of domestic violence.
- 4.5.7 SHP to review the effectiveness of the information available to the public about the appropriate action to take if they have concerns about the risk of domestic



violence against a person, to enable the police and other agencies to intervene positively.

- 4.5.8 SHP to seek assurance from partner agencies that they are compliant with the NICE guidelines on domestic violence and abuse; multi agency working, by local agencies.
- 4.5.9 SHP to review provision for perpetrators of domestic abuse released from prison and develop a plan to include the provision of suitable housing, access to primary health care, access to mental health services and prescribed medication.
- 4.5.10 SHP to ensure that the new MASH arrangement addresses the information sharing needs of schools and education services about cases of domestic abuse.
- 4.5.11 SHP to ensure that all partner agencies agree a policy on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client.
- 4.5.12 SHP to review the multiagency training strategy including:
  - (a) Front-line and professional staff awareness of the dynamics of domestic abuse, especially coercive control and non-engagement. This must include consideration, in partnership with Hillingdon CCG, of commissioning IRIS or a similar domestic violence programme designed specifically for primary health care teams including General Practice, the Out of Hours service and the Urgent Care Centre.
  - (b) Front line and professional staff's skills in safe enquiry and disclosure, and the specific challenges of working with victims of coercive control and poor engagement.
  - (c) Ensuring front-line and professional staff are aware of the heightened risks associated with domestic abuse, mental ill health, and drug and alcohol misuse.
  - (d) Audit safeguarding children's training (and take up across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.
  - (e) Audit adult safeguarding training (and up take across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.

## **4.6 Review Panel Single Agency recommendations**

### **4.6.1 Recommendation – London Borough of Hillingdon Children's Social Care**

- a) Hillingdon Children's Social Care to ensure that they assess and take appropriate steps to address the abusive behaviour of perpetrators who come within the remit of their service.
- b) Hillingdon Children's Social Care to ensure that domestic violence dynamics are actively addressed during supervision.

- c) Hillingdon Children's Social Care to introduce standards for record keeping.

For these three recommendations to be regularly reviewed in supervision, and for a dip sample audit to take place six months after changes have been made, with the results reported to the SHP.

#### 4.6.2 **Recommendations – Metropolitan Police**

- a) Metropolitan Police to audit the effectiveness of mechanisms in place to prioritise and actively pursue outstanding offenders of domestic abuse.
- b) Metropolitan Police to audit the effectiveness of arrangements for increasing the number of prosecutions using evidence based prosecutions.
- c) Metropolitan Police to dip sample compliance with the Victim's Charter to ensure that victims of domestic abuse are regularly updated on progress.

#### 4.6.3 **Recommendation – Metropolitan Police and Thames Valley Police**

- a) Metropolitan and Thames Valley Police to audit compliance with investigative expectations and supervision of allegations of domestic abuse.
- b) Metropolitan and Thames Valley Police to review the arrangements for ensuring that all relevant information is gathered before conducting arrest attempts in relation to domestic violence in another forces area. This should be subject to dip sampling to ensure compliance.

#### 4.6.4 **Recommendation – Hillingdon Hospital NHS Foundation Trust**

- a) Hillingdon Hospital to improve the arrangements for sharing safeguarding concerns between Accident and Emergency, liaison psychiatry, and all other departments within the hospital, including outpatients. Success measures should be identified and audited.

#### 4.6.5 **Recommendations – Hillingdon CCG**

- a) Hillingdon CCG to provide assurance to SHP that CNWL's action plan arising from the Internal Investigation Report has been implemented. The action plan will be monitored by the CCG using the Goodall Safeguarding meeting. An update on the action plan should be provided within six months of the DHR being approved by the Partnership. Further updates to be determined by the Partnership.
- b) Hillingdon CCG to oversee the implementation of NICE guidelines on Antisocial Personality Disorders: prevention and management, and to evaluate the effectiveness of local provision for people with personality disorders.
- c) Hillingdon CCG to share the findings and learning from this DHR with Hillingdon GP practices, Out of Hours Service and Hillingdon Urgent Care Centre.
- d) Hillingdon CCG to work with Hillingdon health service providers to ensure that all information systems enable the flagging of high risk victims of domestic abuse.

e) Hillingdon CCG to ensure that all Hillingdon GP practices, the Out of Hours Service and the Hillingdon Urgent Care Centre develop policies that ensure staff are aware of the issue of domestic violence, how to identify and assess people at risk, how to identify and assess perpetrators of domestic violence, what services are available locally and the referral pathway.

f) Hillingdon CCG to consider commissioning IRIS or a similar domestic violence programme designed specifically for primary health care teams.

#### 4.6.6 **Recommendation – London Borough of Hillingdon Housing**

a) Hillingdon Housing to review the local housing procedure and develop guidance on specific considerations when accommodating perpetrators of domestic abuse.

#### 4.6.7 **Recommendations – Hillingdon IDVA**

a) HIDVA to focus support on high risk cases and review repeat victims and audit to ensure the risk levels are being reduced.

b) HIDVA to actively manage their case load and communicate the status of cases to other agencies. This should be subject to regular audit.

c) HIDVA to ensure proactive and timely support for victims when known perpetrators are due to be released from prison. This should be overseen in supervision.

# Appendix 1: IMR recommendations

## **IMR recommendations**

Actions or recommendations identified in IMRs remain the responsibility of the agency, however, initial reports on progress by agencies on their IMR actions plans should be made to the Safer Hillingdon Partnership within six months of the Review being approved by the Partnership.

### **4.6.8 CNWL recommendations**

4.6.9 Note: these five recommendations from the thirteen included within the CNWL internal review report are highlighted because they are most relevant to the DHR.

4.6.10 Hillingdon Mental Health Services need to ensure that awareness of the risk of domestic abuse and available local resources is increased and embedded into practice. This should include greater emphasis on the risk of domestic violence during local safeguarding induction and training and should also incorporate information regarding key agencies and forums which support management of this risk.

4.6.11 The Community Mental Health Team (which now incorporates the Assessment and Brief Intervention Team) need to ensure that where it is known that patients under the care of that team are in a relationship that this is discussed in clinical reviews. Systems need to be put in place to identify and manage the potential risks when individual patients are thought to be in a potentially abusive relationship with another patient, this should include links with partner agencies.

4.6.12 The Community Mental Health Team should develop robust systems of communication with children and families social services wherever children are potentially at risk in consultation with children and families social services.

4.6.13 The Community Mental Health Team should ensure that where there is a significant forensic history, including claims of a serious criminal nature for patients who come into contact with mental health services, the services should refer to the local MAPPAs. When a patient is known to MAPPAs there should be clear evidence of liaison by mental health services with this body.

4.6.14 The Community Mental Health Teams should ensure that patient discharge communication should be sent to all relevant professionals, teams and services.

### **4.6.15 National Probation Service**

4.6.16 That an audit of the casework of the probation officer concerned takes place so that appropriate remedial action can be undertaken.

4.6.17 That checks are made on a sample of cases each month through case audit to ensure that licences are being correctly supervised and enforced.

- 4.6.18 NPS London ensures that arrangements for liaison with Children's Social Care within each of the boroughs is known and understood by all practitioners.
- 4.6.19 Where an offender is released at the end of their sentence, such that no supervision takes place post release, the appropriate partner agencies are notified of the release date and arrangements.
- 4.6.20 **Housing**
- 4.6.21 To review/update the housing and homelessness risk assessment tools, suitability checklist for legislative requirements and pathway for housing applicants who present as fleeing domestic abuse. This will inform the assessment of suitability of accommodation to best meet client needs.
- 4.6.22 To ensure that all housing staff are briefed and undertake refresher training on the current arrangements/referral pathways/protocols/policies for domestic abuse. This will be extended to incorporate the lessons learned from DHRs, when these are known/agreed.
- 4.6.23 Provide support and guidance for housing staff when assessing or case managing clients who choose to remain in borough due to family and community links i.e. use of sanctuary scheme, regular contact, liaison with other agencies involved, and ensure an on-going evaluation of risk/risk assessment is undertaken as circumstances change.
- 4.6.24 **Hillingdon Wide (from Housing IMR)**
- 4.6.25 For those clients who are at risk of domestic abuse and who choose to live 'near' to or accessible to their alleged perpetrator and/or who choose to return to live/co-habit with their alleged perpetrator review the advice, guidance and risk assessment arrangements for agencies so that risks are regularly re-assessed and mitigating action can be agreed and undertaken.
- 4.6.26 Review and update risk assessment for all known domestic abuse cases who have chosen to remain living 'near' to or accessible to their alleged perpetrator and/or who choose to return to live/co-habit with their alleged perpetrator to identify if any further mitigating action for agencies in Hillingdon needs to be taken.
- 4.6.27 **GP**
- 4.6.28 No recommendations identified.
- 4.6.29 **Care UK, Out of Hours GP Service**
- 4.6.30 Ensure that clinicians have level 3 safeguarding training and are aware of the referral processes, particularly when adults are presenting with behaviour or illness which may have a negative impact on others safety.
- 4.6.31 Develop a procedure for seamlessly sharing safeguarding concerns between organisations for a robust service.
- 4.6.32 **Hillingdon Hospital**

- 4.6.33 Training for staff to be able to deal with domestic violence and abuse.
- 4.6.34 Revise the current Trust action card for staff into a flowchart for staff as to what to do if a vulnerable adult is at risk of abuse.
- 4.6.35 Trust's safeguarding adults policy to be revised and incorporate a revised domestic violence flowchart.
- 4.6.36 Domestic violence and abuse policy to be completed.
- 4.6.37 **Hillingdon Urgent Care Centre**
- 4.6.38 Staff to be reminded of the importance of asking and documenting a social history, particularly when adults are presenting with behaviour or illness which may have a negative impact on others safety.
- 4.6.39 **School**
- 4.6.40 Improve record taking by confirming telephone conversations with an email to ensure a paper trail.
- 4.6.41 To continually make referrals where the concerns are not accepted by other agencies.
- 4.6.42 **Hestia – Floating support service**
- 4.6.43 Ensure that active case management around 'float off' is consistent and includes updating Children's Social Care when it is known that there are children involved.
- 4.6.44 **Metropolitan Police**
- 4.6.45 Hillingdon Borough SLT dip sample domestic abuse incidents (CRIS) to identify the degree of compliance in completion of Merlin reports in circumstances where children are not present, taking action to address any learning identified.
- 4.6.46 **Thames Valley Police**
- 4.6.47 The training for student officers in relation to PNC related matters should be reviewed. All officers should be reminded of the policies relating to Warning Signals and Information Flags on PNC and Niche.
- 4.6.48 The Gen 212 prisoner handover package should be revised to include a section for warning signals. Prompts should be given for officers to consider existing warning signals, check whether justification exists for additional warning signals or information flags and request as necessary.
- 4.6.49 **Hillingdon Education**
- 4.6.50 That a ICT based business performance system linking off and on roll activity be developed to flag children with poor attendance or high mobility as an early indicator of potential problems.
- 4.6.51 **IDVA**

- 4.6.52 Revise guidance on information sharing and communication between IDVA and children social care to include multi agency meetings at point of crisis for victims.
- 4.6.53 Carry out regular welfare checks on clients where there is a high risk of harm but they are failing to engage with services.
- 4.6.54 **Children's Social Care**
- 4.6.55 Ensure that clients identified as having alcohol issues are referred to specialist services at an early stage.
- 4.6.56 Misuse of drugs and alcohol should be assessed to determine whether this is a risk to children.
- 4.6.57 Genogram to be completed for all cases.
- 4.6.58 Relationships to be recorded on LCS and confidential information to be clearly flagged as such.
- 4.6.59 Assessments of carers for children deemed to be at risk to be undertaken as a matter of course.
- 4.6.60 A social history should be undertaken for parents struggling to raise their children to look at their own experience of childhood.
- 4.6.61 Decisions by managers and supervision notes should be recorded on the child's case file.
- 4.6.62 Full assessments should be carried out on the partners of any parent who lives in the same home as the child or has sole or joint care of that child in another home.
- 4.6.63 Where there are concerns about the partner of a parents then a request should be made to undertake full police and probation checks to ascertain whether they pose a risk to the child. An assessment of the dynamics of their relationship with the child/parent should be made as a matter of course.
- 4.6.64 Where a parent refuses to co-operate with mental health or drug assessments then the relevant agencies should be contacted for advice on how best to engage with the service user.
- 4.6.65 If a parent continues to decline services then the consequences should be made clear.

# Appendix 2: DHR Terms of Reference for Hillingdon Lottie

This Domestic Homicide Review is being completed to consider agency involvement with Lottie and Bert following her death in March 2015. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

## **Purpose**

1. Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Lottie and Bert during the relevant period of time: 1<sup>st</sup> June 2009– March 2015.
3. To summarise agency involvement prior to 1<sup>st</sup> June 2009.
4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
7. To commission a suitably experienced and independent person to:
  - a. chair the Domestic Homicide Review Panel
  - b. co-ordinate the review process
  - c. quality assure the approach and challenge agencies where necessary
  - d. produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.



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

### **Membership**

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

11. The following agencies are to be involved:

- a. Clinical Commissioning Groups (formerly known as Primary Care Trusts)
- b. General Practitioner for the victim and perpetrator
- c. LBH Education
- d. LBH Social Care
- e. NHS England
- f. Substance misuse services
- g. LBH Housing services
- h. Met Police
- i. Prison Service
- j. National Probation Service
- k. Victim Support (including Homicide case worker)
- l. CNWL
- m. Hestia Housing

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

13. If there are other investigations or inquests into the death, the panel will agree to either:

- a. run the review in parallel to the other investigations, or
- b. conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

### **Collating evidence**

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

15. Each agency must provide a chronology of their involvement with the Lottie and Bert during the relevant time period.

16. Each agency is to prepare an Individual Management Review (IMR), which:
  - a. sets out the facts of their involvement with Lottie and Bert
  - b. critically analyses the service they provided in line with the specific terms of reference
  - c. identifies any recommendations for practice or policy in relation to their agency
  - d. considers issues of agency activity in other boroughs and reviews the impact in this specific case.
17. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Lottie and Bert in contact with their agency.

### **Analysis of findings**

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

### **Liaison with the victim's and perpetrator's family**

19. Sensitively involve the family of Lottie in the review, following the completion of criminal proceedings. Also to explore the possibility of contact with any of the perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.
20. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
21. Coordinate with any other review process concerned with the child/ren of the victim and/or perpetrator.

### **Development of an action plan**

22. Individual agencies will take responsibility to establish clear action plans for agency implementation as a consequence of any recommendations in their IMRs. The Overview Report will set out the requirements in relation to reporting on action plan progress to the Community Safety Partnership: for agencies to report to the CSP on their action plans within six months of the Review being completed.
23. Community Safety Partnership to establish a multi-agency action plan as a consequence of the recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

### **Media handling**

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

### **Confidentiality**

26. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.
27. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.
28. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Confidential information must not be sent through any other email system. Documents can be password protected.

### **Disclosure**

29. Disclosure of facts or sensitive information may be a concern for some agencies. We manage the review safely and appropriately so that problems do not arise and by not delaying the review process we achieve outcomes in a timely fashion, which can help to safeguard others.

## Appendix 3: Members of the Panel

| Name               | Agency  |
|--------------------|---|
| Della Fallon       | Standing Together Against Domestic Violence                                 |
| Samantha Dury      | Care UK, Out of Hours GP Service  |
| Jenny Reid         | Hillingdon Clinical Commissioning Group                                     |
| Representative     | School  |
| Kim Cox            | Central and North West London NHS Foundation Trust                          |
| Erica Rolle        | London Borough of Hillingdon  |
| Dr Alison Lennox   | GP, Greenbrook, Hillingdon Centre   |
| Victoria Oji       | Hestia  |
| Anna Fernandez     | Hillingdon Hospital   |
| Tendayi Sibanda    | Hillingdon Hospital   |
| Vicki Hurst        | London Ambulance Service  |
| Dan Kennedy        | London Borough of Hillingdon Education and Housing                          |
| Nikki Cruickshank  | Children's Social Care, London Borough of Hillingdon                        |
| Lynne Adams        | Children's Social Care, London Borough of Hillingdon                        |
| Teresa McKee       | Community Safety, London Borough of Hillingdon                              |
| Angela Middleton   | NHS England   |
| Dr Jeffrey Fehler  | Consultant Psychiatrist, Central and North West London NHS Foundation Trust |
| Penny Mackenzie    | Thames Valley Police  |
| Jude Noronha       | Victim Support  |
| Janice Cawley      | Metropolitan Police Service   |
| Antony Rose        | National Probation Service  |
| Alison Braithwaite | Community Services, Central and North West London NHS Foundation Trust      |
| Clare Murray       | Metropolitan Police Service   |

## Appendix 4: Action Plan

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency   | Key milestones in enacting the recommendation  | Target Date     | Date of Completion and Outcome   |
|--|--|--|---|--|-----------------|--|
| <p><b>1. Safer Hillingdon Partnership (SHP) to conduct a rigorous borough wide review of Hillingdon's strategic overview and operational response to domestic violence. This review must address:</b></p> <p><b>a) the effectiveness of the SHP, specifically the effectiveness of the governance and strategic leadership that the partnership provides for domestic abuse.</b></p> <p><b>b) the effectiveness of the Domestic Violence Forum and related sub-groups,</b></p> <p><b>c) the strategic direction and priorities for Hillingdon,</b></p> <p><b>d) the gap between the strategy and delivery of the strategic aims by all agencies.</b></p> | Local  | <p>Governance of Domestic Abuse Steering Executive and link to the SHP to be reviewed and updated.</p> <p>SHP Annual Plan to include domestic abuse as a strategic priority.</p> <p>Current Domestic Abuse strategy to be revised and updated. This revision will include a review (and restructure if necessary) of the DV Action Forum sub-groups.</p> | London Borough of Hillingdon (LBH)<br>Community Safety Team | <p>Governance established.</p> <p>Annual Plan agreed.</p> <p>Violence Against Women and Girls (VAWG) [incorporating Domestic Abuse] Strategy supported, subject to final 'sign off'.</p> | <b>May 2018</b> | <p><b>On Track</b></p> <p>Inclusive Violence Against Women and Girls (VAWG) strategy drafted. Agreed by Safer Hillingdon Partnership (SHP) on 13 March 2018.</p> <p>Internal audit of SHP, Community Safety commenced on 12 February 2018.</p> <p>Re-focussed DA Governance and Leadership structure in place.</p> |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                                   | Key milestones in enacting the recommendation   | Target Date      | Date of Completion and Outcome   |
|---|--|--|---|---|------------------|--|
| <p><b>2. SHP to ensure that all partner agencies conduct an internal review of their domestic violence/abuse policies and procedures in relation to how they identify, risk assess, refer and respond appropriately to victims, particularly those who don't engage and/or are subject to coercive control, and make changes as appropriate.</b></p> <p><b>This must include reviewing referral pathways to multi-agency forums (MARAC, MAPPA and Safeguarding) and ensuring that they are clearly identified and utilised.</b></p> | Local  | <p>Audit risk and review procedures in all agencies, (including referral pathways to multi-agency forums such as MARAC and MAPPA) and the use of DASH within agencies.</p> <p>Audit current practice for the sharing of risk assessment outcomes between agencies involved in the same client.</p> <p>Develop a multi-agency protocol regarding the risk assessment, risk review and risk management of victims (to include specific guidance in relation to coercive control.</p> | DA Steering Executive (MARAC Steering Group)  | <p>Audit completed.</p> <p>Protocol developed, agreed and adopted.</p>  | <b>May 2018</b>  | <p><b>On Track</b></p> <p>Risk assessment is robust. Improved use of DASH model. Risk management (including risk review) is comprehensive and effective.</p> <p>This is subject to on-going training and evaluation.</p> |
| <p><b>3. SHP to review the partnership approach to perpetrators of domestic abuse and produce recommendations for change based on the learning from the two recent DHRs.</b></p>  | Local  | <p>Audit current service provision for perpetrators.</p> <p>Review available perpetrator programmes and conduct feasibility study.</p> <p>Present findings and recommendations to Domestic Abuse Executive Steering Group</p>  | DA Steering Executive (Perpetrator sub-group) | <p>Audit completed</p> <p>Review and study produced and presented to Domestic Abuse Executive Steering Group.</p> | <b>July 2018</b> | <p><b>On track</b></p> <p>Monthly meetings take place between Criminal Justice System (CJS) agencies and Hillingdon IDVA Service.</p>  |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency   | Key milestones in enacting the recommendation                                       | Target Date       | Date of Completion and Outcome  |
|---|--|--|---|---|-------------------|---|
|   |  | for consideration.   |   |   |                   | <p>At force level the Metropolitan Police has a service level agreement with the CPS for the investigation and prosecution of domestic abuse cases.</p> <p>Multi-Agency Tasking and Coordinating Group being piloted.</p> |
| <p><b>4. SHP to undertake a needs assessment and review of existing domestic abuse specialist support services (including the management of IDVA), and develop a comprehensive commissioning strategy that meets the needs of both victims and perpetrators and includes a focus on prevention and early intervention</b></p> | Local  | <p>Conduct a review of existing domestic abuse specialist support services (include the management of the Independent Domestic Violence Advocates (IDVA) and the Specialist Domestic Violence Court (SDVC).</p> <p>Undertake a needs assessment (to include consultation with victims of domestic abuse). This should also explore the need to provide opportunities for</p> | DA Steering Executive (Service Provision sub-group) | <p>Review completed.</p> <p>Needs assessment and client consultation completed.</p> | <b>April 2018</b> | <p><b>On Track</b></p> <p>A co-ordinated response to domestic abuse. Victims and survivors are able to access specialist services that meet their needs.</p> <p>Completed: mapping exercise of</p>                        |



| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                                  | Key milestones in enacting the recommendation              | Target Date                              | Date of Completion and Outcome  |
|---|--|--|--|--|--|---|
|   |  | <p>perpetrators to change their behaviour.</p> <p>Develop a comprehensive commissioning strategy, covering all areas of Domestic Abuse (DA) service provision and meets the needs of both victims and perpetrators.</p> <p>Conduct procurement of new commissioning strategy and transition from existing to new contract(s).</p>  |  | Commissioning strategy produced and procurement commenced. |  | <p>service provision on 27/28 September 2017.</p> <p>Victims/Survivors listening event took place on 25 November 2017.</p> <p>On track: Procurement process scheduled to start May 2018.</p>  |
| <p><b>5. SHP to review the use of the CAADA DASH risk identification checklist in Hillingdon agencies including: the purpose of DASH completion, the adoption of DASH consistently across agencies and in front line practice, the use of DASH as an on-going risk identification tool, and the arrangements for sharing of risk information outcomes between agencies involved with the same client.</b></p> | Local  | <p>Audit risk and review procedures in all agencies, (including referral pathways to multi-agency forums such as Multi-Agency Risk Assessment Conference (MARAC) and Multi-Agency Public Protection Arrangements (MAPP) and the use of DASH within agencies. Audit current practice for the sharing of risk assessment outcomes between agencies involved with the same client.</p> <p>Develop a multi-agency protocol</p> | DA Steering Executive (MARAC Steering Group) | <p>Audit completed.</p> <p>Protocol</p>                    | <p><b>May 2018</b></p> <p><b>May</b></p> | <p><b>Complete</b></p> <p>Risk assessment is robust. Improved use of DASH model.</p> <p>Risk management (including risk review) is comprehensive and effective.</p> <p>This is subject to</p> |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency   | Key milestones in enacting the recommendation                                | Target Date      | Date of Completion and Outcome   |
|---|--|---|---|--|------------------|--|
| A multi-agency task and finish group should be established in order to develop a multiagency protocol regarding the risk assessment of victims of domestic violence.  |  | regarding the risk assessment, risk review and risk management of victims (to include specific guidance in relation to coercive control)  |   | developed, agreed and adopted.   | <b>2018</b>      | on-going training and evaluation.  |
| 6. SHP to establish a task and finish group in order to develop a multiagency protocol on information management including creating a common information record and sharing information on victims and perpetrators of domestic violence.                       | Local  | Review current information sharing arrangements between agencies in relation to domestic abuse. The review to include how the information is managed. Update information sharing protocol in line with national and best practice.          | DA Steering Executive (MARAC Steering Group)              | Review completed<br><br>Multi-agency protocol drafted                        | <b>July 2018</b> | <b>On Track</b><br><br>Review completed<br><br>Draft protocol has been developed   |
| 7. SHP to review the effectiveness of the information available to the public about the appropriate action to take if they have concerns about the risk of domestic violence against a person, to enable the police and other agencies to intervene positively. | Local  | Conduct a review of current information available.<br><br>Develop and implement a partnership communications strategy, ranging from general awareness and zero tolerance messages, to targeted communications for victims and perpetrators. | DA Steering Executive (Prevention & Engagement sub-group) | Audit completed<br><br>Communications and Engagement strategies implemented. | <b>June 2018</b> | <b>On Track</b><br><br>Audit completed<br><br>Strategies developed.<br><br>Programme of events and information mediums being updated or developed. |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                                    | Key milestones in enacting the recommendation  | Target Date      | Date of Completion and Outcome  |
|--|--|--|--|--|------------------|---|
| <p><b>8. SHP to seek assurance from partner agencies that they are compliant with the NICE guidelines on domestic violence and abuse; multi-agency working, by local agencies.</b></p>   | Local  | <p>Hillingdon Clinical Commissioning Group (CCG) will review the implementation of NICE guidelines on domestic violence and abuse; multi agency working, by local agencies and identify any gaps in commissioned services. If there are any gaps in the service provision a scoping exercise will be conducted to identify any care pathways which may require change.</p> | Hillingdon CCG                                 | <p>Review completed</p> <p>Evaluation of the effectiveness of the local provision completed and recommendations to commissioners within NHS Hillingdon CCG made.</p> | <b>Sept 2018</b> | <p><b>On Track</b></p> <p>Report on the current position is being prepared following consultation with service providers.</p>   |
| <p><b>9. SHP to review provision for perpetrators of domestic abuse released from prison and develop a plan to include the provision of suitable housing, access to primary health care, access to mental health services and prescribed medication.</b></p> | Local  | <p>Review current arrangements for the management of prison leavers and implement a local mechanism whereby prison leavers and their needs are assessed and managed.</p>   | DA Steering Executive (Perpetrators sub group) | <p>Review of current arrangements to be updated.</p>   | <b>Dec 2018</b>  | <p><b>On Track</b></p> <p>Perpetrator Management highlighted in VAWG Strategy</p> <p>Multi-agency Tasking and Coordinating Group meeting being piloted (starts April 2018) to complement Multi-agency Public Protection</p> |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency  | Key milestones in enacting the recommendation   | Target Date            | Date of Completion and Outcome   |
|--|--|--|--|---|------------------------|--|
|  |  |  |  |   |                        | <p>Arrangements meeting.</p> <p>Perpetrator Programme arrangements being considered.</p>   |
| <p><b>10. SHP to ensure that the new MASH arrangement addresses the information sharing needs of schools and education services about cases of domestic abuse.</b></p> | <p>Local</p>                                       | <p>The effectiveness of the Multi-Agency Safeguarding Hub (MASH) arrangements including the information sharing arrangements to be reviewed via an audit led by Local Safeguarding Children's Board (LSCB) in July 2017.</p> | <p>London Borough of Hillingdon (LBH) Children's Social Care</p> | <p>Information sharing consent forms already embedded in practice. The effectiveness of information sharing linked to schools and education services to be tested out in the forthcoming audit.</p> <p>Audit completed in August 2017.</p> <p>Learning sets and actions completed in December 2017.</p> | <p><b>May 2018</b></p> | <p><b>On Track</b></p> <p>Information sharing practices are embedded across agencies including education services.</p> <p>MASH audit has taken place</p> <p>Borough is a pilot for Operation Encompass, which starts in May 2018</p> |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency   | Key milestones in enacting the recommendation  | Target Date                                   | Date of Completion and Outcome   |
|--|--|---|---|--|---|--|
| <p><b>11. SHP to ensure that all partner agencies agree a policy on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client.</b></p>   | Local  | <p>Review current practice and develop policy to address recommendation.</p> <p>Ensure that any new commissioned support service contract includes a policy on reallocation.</p>  | DA Steering Executive (Service Provision sub-group)       | <p>Review completed.</p> <p>Policy drafted - awaits approval.</p>  | <p><b>Dec 2017</b></p> <p><b>May 2018</b></p> | <p><b>On Track</b></p> <p>Policy drafted and circulated to partner agencies for review.</p>  |
| <p><b>12. SHP to review the multiagency training strategy including:</b></p> <p><b>(a) front-line and professional staff awareness of the dynamics of domestic abuse, especially coercive control and non-engagement.</b></p> <p><b>(b) This must include consideration, in partnership with Hillingdon CCG, of commissioning IRIS or a similar domestic violence programme designed specifically for primary health care teams including General Practice, the Out of Hours service and the Urgent Care Centre.</b></p> | Local  | <p>Develop and deliver a partnership training programme, which takes a trauma informed approach - to support all practitioners who have contact with domestic abuse victims, perpetrators and their wider support network.</p> <p>Training modules to include: general awareness of the dynamics of domestics abuse, especially coercive control; targeted audiences (such as primary health care teams); and specific areas, such as safe enquiry and disclosure, poor engagement, the issue of 'victim blaming' and recording practices by professionals etc.</p> | DA Steering Executive (Prevention & Engagement sub group) | <p>An Initial audit of training needs completed.</p> <p>Training programme developed and implemented.</p> <p>Training Needs Analysis to be conducted</p> | <b>July 2018</b>                              | <p><b>On Track</b></p> <p>An initial training programme for multi-agency professionals started in November 2017 pending completion of a Training Needs Analysis (TNA).</p> |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency | Key milestones in enacting the recommendation | Target Date | Date of Completion and Outcome |
|--|--|---|-------------|---|-------------|--------------------------------|
| <p><b>(c) Front line and professional staff's skills in safe enquiry and disclosure, and the specific challenges of working with victims of coercive control and poor engagement.</b></p> <p><b>(d) Ensuring front-line and professional staff are aware of the heightened risks associated with domestic abuse, mental ill health, and drug and alcohol misuse.</b></p> <p><b>(e) Audit safeguarding children's training (and take up across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.</b></p> <p><b>(f) Audit adult safeguarding training (and up take across the multi-agency partnership) to ensure that domestic violence is appropriately addressed</b></p> |  | <p>The analysis of recording practices and the findings thereof may inform the training and further development of professionals</p> <p>(see above)</p> |             |   |             |                                |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                               | Key milestones in enacting the recommendation   | Target Date            | Date of Completion and Outcome   |
|---|--|--|---|---|------------------------|--|
| <p><b>13. Children's social care to ensure that they assess and take appropriate steps to address the abusive behaviour of perpetrators who come within the remit of their service.</b></p> | <p>Local</p>                                       | <p>Review current practice regarding DA assessment work and actions for perpetrators within case work activity both at Children In Need (CIN) and Care Plan (CP) level.</p> <p>An audit of case files to assess the appropriateness of the use of 'safeguarding agreements' in Domestic Abuse Cases (David Mandel's Safe and Together Pivoting Tool is likely to be a useful aid in this process; to ensure the perpetrator is held accountable and the non-offending parent is supported to safeguard the child).</p> <p>Hillingdon Children's Social Care to agree the most effective evidence based model to embed practice that holds the perpetrator to account and supports the non-offending parent to safeguard the child (Edinburgh Safe and Together Implementation report would be a useful aid in this process).</p> | <p>LBH<br/>Children's Social<br/>Care</p> | <p>Bespoke audit completed in October 2017</p> <p>Training events to follow to address learning as appropriate.</p> | <p><b>Oct 2017</b></p> | <p><b>Complete</b></p> <p>Appropriate and timely steps taken to assess and intervene when working with abusive perpetrators.</p> <p>Follow up audit to be undertaken from July 2018.</p> |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                | Key milestones in enacting the recommendation   | Target Date         | Date of Completion and Outcome   |
|--|--|--|----------------------------|---|---------------------|--|
| <p><b>14. Hillingdon Children's Social Care to ensure that domestic violence dynamics are actively addressed during supervision.</b></p> | Local  | <p>Training on DA to be provided to all social care staff to increase awareness of the impact of coercive control on victims.</p> <p>Effective supervision training to be provided to all team managers to ensure the dynamics of DA are focused on within case supervision.</p> | LBH Children's Social Care | <p>SafeLives DASH tools to become mandatory in all cases where DA is a feature.</p> <p>Bite size training events, led by Practice Improvement Practitioners made available to all staff in social care on DA throughout Autumn 2017.</p> <p>Managers are routinely using supervision as a tool in risk assessing DA in cases where DA is a feature.</p> | <b>Feb 2018</b>     | <p><b>Complete</b></p> <p>An increased awareness and understanding of perpetrator behaviour.</p> <p>Evidence based assessments.</p> <p>Subject to on-going supervision and audit. Staff attend bi-monthly training sessions.</p> |
| <p><b>15. Hillingdon Children's Social Care to introduce standards for record keeping.</b></p>   | Local  | Review current practice in regards to record keeping, if learning is identified remedial action to be taken in a timely way.   | LBH Children's Social Care | Bespoke audit undertaken in September 2017.   | <b>October 2017</b> | <p><b>Complete</b></p> <p>Contemporaneous records in all social care files.</p>  |



| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency   | Key milestones in enacting the recommendation  | Target Date       | Date of Completion and Outcome  |
|--|--|---|---|--|-------------------|---|
|  |  |   |   |  |                   | Subject to on-going supervision and audit.  |
| <p><b>16. For these three recommendations for Hillingdon Children's Social Care to be regularly reviewed in supervision, and for a dip sample audit to take place six months after changes have been made, with the results reported to the SHP.</b></p> | Local  | A dip sample audit will be completed by Practice Improvements Practitioners to ensure compliance                          | LBH Children's Social Care                                    | Bespoke audit tools to be devised in order to review practice in line with the three recommendations above.  | <b>May 2018</b>   | <p><b>Complete</b></p> <p>Compliance reviewed and report to SHP.</p>  |
| <p><b>17. Metropolitan Police to audit the effectiveness of mechanisms in place to prioritise and actively pursue outstanding offenders of domestic abuse.</b></p>   | Local  | Existing strategies around outstanding suspects and the way in which 'man hunts' are controlled/conducted to be reviewed. | Metropolitan Police Service (MPS) Community Safety Unit (CSU) | <p>Weekly meetings held to discuss outstanding suspects and actions taken to locate held at Inspector /Chief Inspector level.</p> <p>Domestic abuse meeting held weekly with</p> | <b>April 2018</b> | <p><b>Complete</b></p> <p>Reduction in the number of outstanding suspects. This is subject to review at performance meetings.</p> |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency  | Key milestones in enacting the recommendation  | Target Date     | Date of Completion and Outcome  |
|--|--|--|--|--|-----------------|---|
|  |  |  |  | Detective Inspector (DI)/Chief Inspector (CI) / Superintendent present to discuss outstanding cases and suspects. EWMS (Emerald Warrants Management System) team created to ensure resources are in place to deal with urgent arrest requests. |                 |   |
| <b>18. Metropolitan Police to audit the effectiveness of arrangements for increasing the number of prosecutions using evidence based prosecutions.</b> | Local  | Existing strategies and use around Domestic Violence Protection Notice (DVPN) & DV Protection Orders (DVPO) and other existing legislation to be examined. Review of all victimless prosecutions to be undertaken. | Metropolitan Police Service (MPS ) [Community Safety Unit] | Increase use of Body Worn Video footage to be used to capture allegation and impact of offence on DA victim.<br><br>All DA Operation Dauntless subjects to have  | <b>April 18</b> | <b>Complete</b><br><br>All Operation Dauntless subjects now have a DVPN/DVPO on their file.<br><br>Training to all Community Safety Unit staff delivered. |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency                                     | Key milestones in enacting the recommendation   | Target Date            | Date of Completion and Outcome   |
|--|--|---|---|---|------------------------|--|
|  |  |   |   | <p>pre-prepared DVPN/DVPO files to remain on intelligence systems.</p> <p>Additional training given to all CSU officers in this and also in Clare's law.</p>  |                        |  |
| <p><b>19. Metropolitan Police to dip sample compliance with the Victim's Charter to ensure that victims of domestic abuse are regularly updated on progress.</b></p> | <p>Local</p>                                       | <p>CSU DI tasked to dip sample compliance in this area on a weekly basis.</p> | <p>Metropolitan Police Service (MPS ) (CSU)</p> | <p>Monitoring and measuring to be completed weekly around Victims Code of Practice (VCOP) and contact made with victims by investigating officers.</p> <p>Discussed at weekly offender management meeting and DA performance meeting.</p> | <p><b>April 18</b></p> | <p><b>Complete</b></p> <p>Systems in place, monitoring continues on an on-going regular basis.</p> |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                              | Key milestones in enacting the recommendation  | Target Date     | Date of Completion and Outcome  |
|---|--|--|--|--|-----------------|---|
|   |  |  |  | Procedures in place to ensure that gaps are covered in the event of the absence of Officer in the case.  |                 |   |
| <p><b>20. Metropolitan and Thames Valley Police to audit compliance with investigative expectations and supervision of allegations of domestic abuse.</b></p> | Local  | Existing strategies around supervision and investigation strategies to be reviewed (MPS) | Metropolitan Police Service (MPS ) (CSU) | <p>Ongoing supervisory rates form part of offender and DA weekly meeting.</p> <p>Detective Inspector (DI) dip samples investigation plans and reviews crimes closed under "Victim does not wish to proceed" for opportunities under DVPN legislation, Clare's Law, Un-supported prosecutions etc</p> | <b>April 18</b> | <p><b>Complete</b></p> <p>Actions will remain in place around the supervision of DA investigation.</p> <p>This standard is subject to an on-going review process.</p> |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency                              | Key milestones in enacting the recommendation  | Target Date       | Date of Completion and Outcome   |
|--|--|---|--|--|-------------------|--|
|  |  | DA Investigation Unit (DAIU) DI to carry out a review of DAIU investigations to check supervisory input and setting of investigative actions (TVP). | Thames Valley Police (TVP)               | DAIU D/I has reviewed a sample number of DAIU investigations.  |                   | Audit completed - the level of supervisory input is appropriate & robust when required. Investigation actions have been set appropriately by the Officer In the Case (OIC) initially, & the supervisor during reviews. |
| <b>21. Metropolitan and Thames Valley Police to review the arrangements for ensuring that all relevant information is gathered before conducting arrest attempts in relation to domestic violence in another forces area. This should be subject to dip sampling to ensure compliance.</b> | Local  | All arrest packages and processes to be reviewed, regardless of location of suspect (MPS)   | Metropolitan Police Service (MPS ) (CSU) | Internal processes reviewed. All arrest dockets are to have oversight from CSU team and DS and are to sit with them until allocation to QA. OIC to ensure that package contains all relevant | <b>April 2018</b> | <b>Complete</b><br><br>New policies have been adopted around this including arrest dockets, which are quality assured by a CSU Detective Sergeant.   |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                | Key milestones in enacting the recommendation   | Target Date         | Date of Completion and Outcome   |
|---|--|--|----------------------------|---|---------------------|--|
|   |  | DAIU D/I to review DAIU investigations where an out of force arrest is required or planned (TVP)   | Thames Valley Policy (TVP) | intelligence and information before request is made and this will be recorded on a locally produced and held form.<br><br>Review sample of DAIU investigations to assess level of liaison. This type of police activity is covered in current detective training for investigators. |                     | This is further complemented by a Detective Inspector (DI) dip sample.<br><br>Completed. Review has been completed and appropriate liaison has taken place with the other force(s) & sufficient information gathering has taken place. |
| <b>22. Hillingdon Hospital to improve the arrangements for sharing safeguarding concerns between Accident and Emergency, liaison psychiatry, and all other departments within the hospital, including outpatients. Success measures should be identified and audited.</b> | Local  | Information regarding adults and children with safeguarding concerns to be shared with MASH (Social Care, Central North West London (CNWL), Mental Health and ARCH, CNWL, Community Health (Health Visitors and Schools Nursing) | Hillingdon Hospital        | Weekly safeguarding meetings established.   | <b>October 2016</b> | <b>Complete</b><br><br>There is an established way to identify and share safeguarding concerns.  |

| Recommendation | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency | Key milestones in enacting the recommendation   | Target Date | Date of Completion and Outcome   |
|----------------|--|---|-------------|---|-------------|--|
|                |  | <p>Domestic abuse and safeguarding alerts are available to all staff via Patient Administration System. This includes DA flags for victims, children and perpetrators</p> <p>Complete and publish the Trust's Domestic Violence and Abuse (DVA) Policy.</p> <p>Deliver enhanced DA training to staff to enable them to identify DA and share information effectively.</p> <p>Commence 6 monthly audits on DVA record keeping and information sharing.</p> |             | <p>Flagging system implemented.</p> <p>Published in April 2016.</p> <p>DA training commenced in September 2016 and is on-going.</p> <p>DA audit commenced October 2016.</p> |             | <p>Weekly safeguarding meetings established</p> <p>Trust MARAC representatives attend the Strategic and Operational MARAC meetings</p> <p>All safeguarding concerns are referred to relevant agencies and feedback is monitored closely by safeguarding leads. This ensures that any identified risk is addressed effectively.</p> |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                                 | Key milestones in enacting the recommendation  | Target Date      | Date of Completion and Outcome   |
|---|--|--|---|--|------------------|--|
| <p><b>23. Hillingdon CCG to provide assurance to SHP that CNWL's action plan arising from the Internal Investigation Report has been implemented. The action plan will be monitored by the CCG using the Goodall Safeguarding meeting. An update on the action plan should be provided within six months of the DHR being approved by the Partnership. Further updates to be determined by the Partnership.</b></p> | Local  | <p>The Designated Safeguarding Adult Nurse or the Designated Children's Safeguarding Nurse will attend CNWL Goodall safeguarding meeting where their action plan will be monitored. If there are any exceptions or concern's these will be raised to NHS Hillingdon's Monthly Clinical Quality Committee meeting. An action will be requested for CNWL to submit the six-month action plan update to the Clinical Quality Committee prior to the submission.</p> | Hillingdon Clinic Commissioning Group (CCG) | <p>Attendance at the CNWL Goodhall Safeguarding Meetings.</p> <p>Reality checking to be undertaken against action plan.</p>  | <b>Sept 2018</b> | <p><b>Complete</b></p> <p>Action plan completed and performance presented to SHP.</p> <p>Further update to the action plan to be submitted to the SHP in September 2018.</p>                       |
| <p><b>24. Hillingdon CCG to oversee the implementation of NICE guidelines on Antisocial Personality Disorders: prevention and management, and to evaluate the effectiveness of local provision for people with personality disorders.</b></p>   | Local  | <p>Hillingdon CCG will review the implementation of National Institute of Health and Care Excellence (NICE) guidelines on Antisocial Personality Disorders: prevention and management and identify any gaps in commissioned services. If there are any gaps in the service provision a scoping exercise will be conducted to identify any care pathways which may require change.</p>  | Hillingdon CCG                              | <p>The Designated Safeguarding Adult Nurse with support from the Mental Health Commissioners will undertake a review of the NICE Guidance on Antisocial Personality Disorders: prevention,</p> | <b>Sept 2018</b> | <p><b>On Track</b></p> <p>The Nice Guidance has been introduced into Hillingdon Commissioning intentions for 2018 / 19 and will be reviewed as part of The Mental Health Transformation Board.</p> |



| Recommendation | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency | Key milestones in enacting the recommendation  | Target Date | Date of Completion and Outcome |
|----------------|--|---|-------------|--|-------------|--------------------------------|
|                |  | <p>Once a review has been undertaken an evaluation of the effectiveness of local provision for people with personality disorders will be conducted and any recommendations for commissioning or practice will be made to the NHS Hillingdon CCG commissioning team via the internal processes required.</p> |             | <p>management and identify any gaps in commissioned services.</p> <p>If gaps are identified a scoping exercise to identify changes to care pathways will be undertaken.</p> <p>The Designated Safeguarding Adult Nurse with support from the Mental Health Commissioners will undertake an evaluation of the effectiveness of the local provision / make any recommendations NHS Hillingdon CCG Commissioners.</p> |             |                                |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency           | Key milestones in enacting the recommendation   | Target Date      | Date of Completion and Outcome  |
|---|--|---|-----------------------|---|------------------|---|
| <p><b>25. Hillingdon CCG to share the findings and learning from this DHR with Hillingdon GP practices, Out of Hours Service and Hillingdon Urgent Care Centre.</b></p> | <p>Local</p>                                       | <p>The findings and learning from the Domestic Homicide Review (DHR) will be disseminated to GP practices via the GP leads meeting and a Master Class for all GP practices, where key staff from Out of Hours and the Urgent Care Centre will be invited.</p> <p>The findings and learning from the DHR will also be shared at the provider leads meeting which are led by NHS Hillingdon CCG and where the Out of Hours Service and Urgent Care Safeguarding leads attend.</p> <p>There will also be information available about the DHR learning on the GP Intranet pages.</p> <p>All future Level 2 GP training courses delivered by the NHS Hillingdon CCG Named GP for Safeguarding Vulnerable Adults and Children will incorporate the learning from the DHR in the training.</p> | <p>Hillingdon CCG</p> | <p>The GP leads meeting has taken place and the DHR findings disseminated.</p> <p>The Master Classes for GP practices included an invitation to an Out of Hours Key Lead and an Urgent Care Key Lead.</p> <p>Learning from the DHR disseminated at NHS provider Leads meetings.</p> <p>DHR Learning onto the Hillingdon CCG's intranet pages.</p> <p>All safeguarding training of level 2</p> | <p>Sept 2018</p> | <p><b>On Track</b></p> <p>Master class Training sessions for GPs took place in July and September 2018.</p> <p>DHR Recommendations discussed at GP Leads meetings.</p> <p>Bi-monthly multi-agency professionals' training open to local healthcare professionals to complement their own organisation's training and development.</p> |

| Recommendation  | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency    | Key milestones in enacting the recommendation   | Target Date     | Date of Completion and Outcome  |
|---|--|---|----------------|---|-----------------|---|
|   |  |   |                | and above delivered by the Named GP for Safeguarding Vulnerable Adults and Children will include the learning from the DHRs.  |                 |   |
| <p><b>26. Hillingdon CCG to work with Hillingdon health service providers to ensure that all information systems enable the flagging of high risk victims of domestic abuse.</b></p> <p><b>Hillingdon CCG to ensure that all Hillingdon GP practices, the Out of Hours Service and the Hillingdon Urgent Care Centre develop policies that ensure staff are aware of the issue of domestic violence, how to identify and assess people at risk, how to identify and assess perpetrators of domestic violence, what services are available locally and the referral pathway.</b></p> | Local  | <p>An audit will be undertaken to review the different systems and processes providers are using for flagging high risk victims of domestic abuse. Any gaps will be identified and Hillingdon CCG will work with NHS health services providers to address any inadequate systems or processes.</p> <p>The CCG will audit the domestic violence policies, systems and processes in place within GP Practices, Out of Hours and Urgent Care. Once the audit is completed the CCG will ensure that all of the above providers will have a Domestic Violence / Abuse Policy and information on how to</p> | Hillingdon CCG | <p>Review undertaken by the Designated Safeguarding Adult Nurse. Advice given to upgrade systems and processes.</p> <p>The audit of NHS Providers' policies will be conducted in conjunction with the development of the SHP's Violence Against Women and Girls (VAWG) strategy, which includes</p> | <b>Sept '18</b> | <p><b>On Track</b></p> <p>Audit of policies undertaken.</p> <p>Audit being conducted for GP practices.</p> <p>HCCG Designated Adult Nurse and Designated Nurse Safeguarding Children Nurse participates on 4 of the 5 subgroups and are helping to inform the</p> |

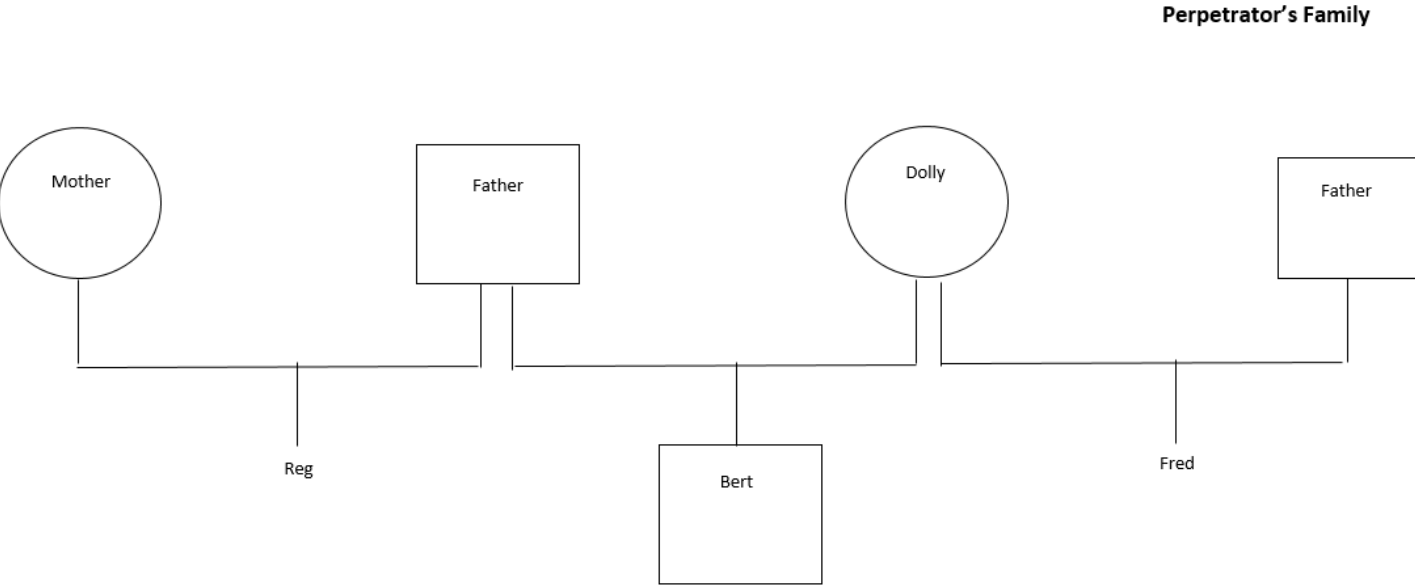
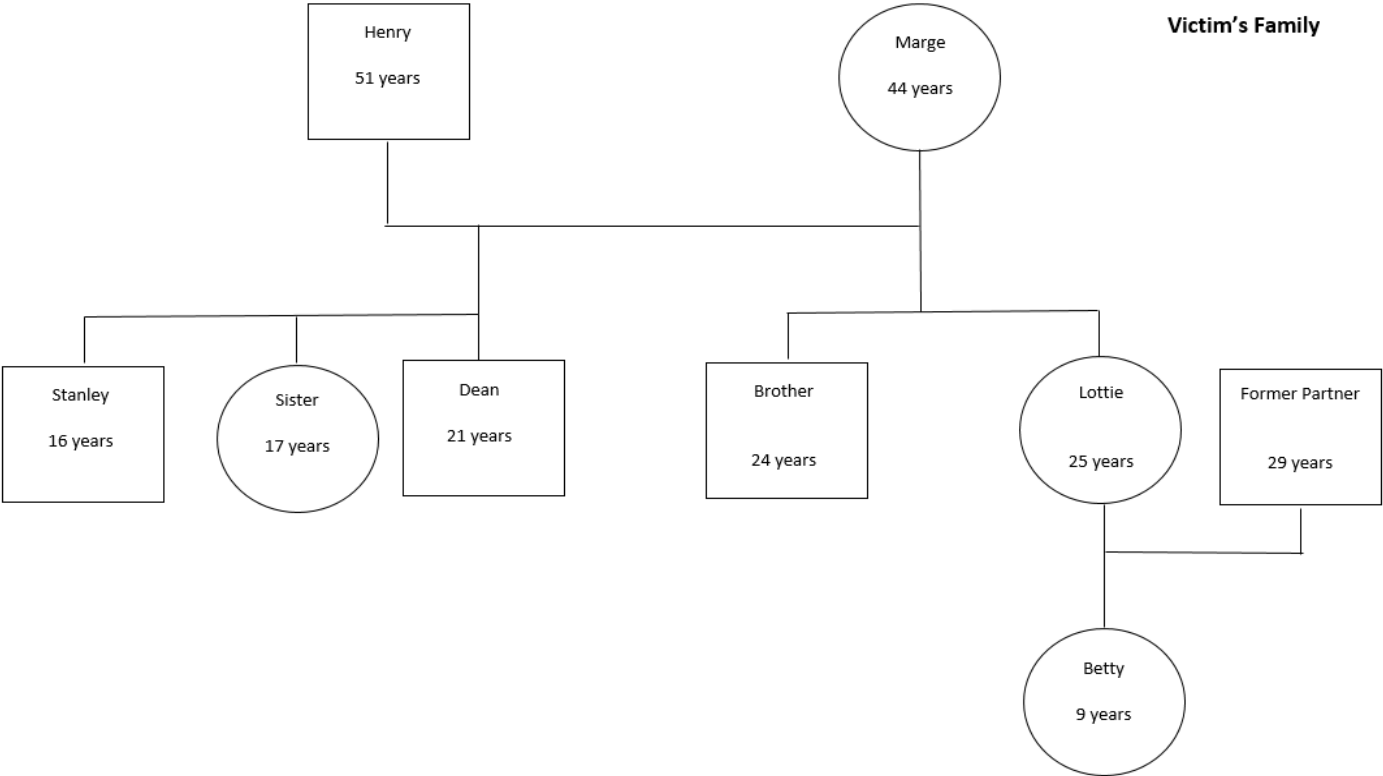
| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency          | Key milestones in enacting the recommendation   | Target Date      | Date of Completion and Outcome   |
|--|--|---|----------------------|---|------------------|--|
|  |  | identify and assess perpetrators of domestic violence, as well as know what local services and referral pathways are available.   |                      | key commitments focused on perpetrators.  |                  | Hillingdon's VAWG Strategy.  |
| <b>27. Hillingdon CCG to consider commissioning IRIS or a similar domestic violence programme designed specifically for primary health care teams.</b>                 | Local  | Hillingdon CCG will review the available systems for primary health care teams in relation to a specific domestic violence programme and make recommendations for commissioning.          | Hillingdon CCG       | NHS Hillingdon Designated Safeguarding Adult Nurse will review the current DA programmes specifically for primary health care teams in line with the prioritisation of current safeguarding work streams. | <b>July 2018</b> | <b>On Track</b><br><br>The IRIS system and its benefits have been presented and discussed at The Strategic Children's Transformation Group and the local Quality Clinical Risk & Safety Group.<br><br>Business Case being developed. |
| <b>28. Hillingdon Housing to review the local housing procedure and develop guidance on specific considerations when accommodating perpetrators of domestic abuse.</b> | Local  | Carry out a review of the current service provision and provide guidance notes to staff on the additional considerations to be taken when housing client's who are fleeing domestic abuse | LBH Housing Services | Review to be carried out on procedures. Updated procedures developed and disseminated.  | <b>July 2018</b> | <b>On Track</b><br><br>New Procedures are being prepared   |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take  | Lead Agency  | Key milestones in enacting the recommendation  | Target Date       | Date of Completion and Outcome   |
|--|--|---|--|--|-------------------|--|
| <p><b>29. HIDVA to focus support on high risk cases and review repeat victims and audit to ensure the risk levels are being reduced.</b></p>               | Local  | <p>Conduct comparison of high risk clients over the last three years.</p> <p>Audit IDVA s compliance with the internal process with regards to repeat referrals.</p> <p>IDVA service to conduct a review of outcomes for clients to measure the effectiveness of the intervention.</p>                                  | Hillingdon Independent Domestic Violence Advocacy Service (HIDVAS) | Audit was completed to review numbers and compliance with internal established processes. Review conducted to measure the effectiveness of intervention. | <b>Jan 2018</b>   | <p><b>Complete</b></p> <p>Policy Decision: HIDVA Service will deal with medium and high risk cases to accord with a policy of prevention &amp; early intervention.</p> <p>Thresholds for the service are clear and understood.</p> |
| <p><b>30. HIDVA to actively manage their case load and communicate the status of cases to other agencies. This should be subject to regular audit.</b></p> | Local  | <p>Proactive caseload management and capacity monitoring to take place in each HIDVA supervision session.</p> <p>Monthly audits of all open cases to take place by HIDVA manager in order to help prioritise tasks.</p> <p>Information sharing with agencies involved to be considered in each supervision session.</p> | HIDVAS   | Monthly supervisions with a six monthly review of common themes highlighted to the DA Steering Executive   | <b>April 2018</b> | <p><b>Complete</b></p> <p>Audit of the HIDVA Service commenced on 24.1.18. Current service delivery has been reviewed alongside the review of the MARAC Operational Group.</p> <p>Status Reports of the HIDVA Service</p>          |

| Recommendation   | Scope of recommendation<br>e.g. local/<br>regional | Action to take   | Lead Agency                      | Key milestones in enacting the recommendation   | Target Date       | Date of Completion and Outcome  |
|--|--|--|----------------------------------|---|-------------------|---|
|  |  |  |                                  |   |                   | to be provided to governance meetings e.g. DA Steering Executive, MARAC Steering Group and Supervision meetings.  |
| <p><b>31. HIDVA to ensure proactive and timely support for victims when known perpetrators are due to be released from prison. This should be overseen in supervision.</b></p> | Local  | <p>HIDVA to request a Prisoner Intelligence Notification System (PINS ) release from the MARAC coordinator if a perpetrator is in prison and respond appropriately by:</p> <p>Contacting the victim and relevant agency within 24 hours of receiving the release information.</p> <p>Timely review of the support plan once there is a significant change in circumstances and status regarding the perpetrator</p> <p>Monthly supervision to include reviews of support plans in place for individual victims</p> | Hillingdon IDVA Service (HIDVAS) | <p>Liaison with MARAC to establish process.</p> <p>Training for all IDVAS on expected process in relation to PINS.</p> <p>Develop and implement a revised operational framework.</p> <p>Audit of cases where a PINS has been enacted to measure</p> | <b>April 2018</b> | <p><b>Complete</b></p> <p>The HIDVA Service is co-located with the local police. A police SPOC leads on prisons releases through PINS / complemented by excellent joint working.</p> <p>Prison Releases are an agenda item at the MARAC Operational Group too.</p> <p>Individual Safety and Support Plans</p> |

| Recommendation | Scope of recommendation<br>e.g. local/<br>regional | Action to take | Lead Agency | Key milestones in enacting the recommendation                            | Target Date | Date of Completion and Outcome   |
|----------------|--|----------------|-------------|--|-------------|--|
|                |  |                |             | <p>compliance and impact.</p> <p>Ongoing audit of HIDVA supervision.</p> |             | <p>are reviewed with the victim / survivor prior to the perpetrator's release from prison.</p> |

# Appendix 5: Genogram





## Appendix 6: Glossary of Terms

| Glossary of terms |  |
|-------------------|--|
| A and E           | Accident and Emergency department (NHS)            |
| AAFDA             | Advocacy after Fatal Domestic Abuse                |
| ABH               | Actual Bodily Harm                                 |
| ABT               | Assessment and Brief Therapy Team                  |
| ADASTRA           | IT system used in Hillingdon Urgent Care Centre    |
| ADD               | Attention Deficit Disorder                         |
| ADHD              | Attention Deficit and Hyperactivity Disorder       |
| AMHP              | Approved Mental Health Professional                |
| ASB               | Anti-Social Behaviour                              |
| ASBO              | Anti-Social Behaviour Order                        |
| ASC               | Adult Social Care                                  |
| AUDIT             | Alcohol Use Disorders Identification Test          |
| B&B               | Bed and Breakfast Accommodation                    |
| BME               | Black Minority Ethnic                              |
| CAIT              | Child Abuse Investigation Team                     |
| CAT               | Cognitive Analytical Therapy                       |
| CBT               | Cognitive Behavioural Therapy                      |
| CCG               | Clinical Commissioning Group                       |
| CMHT              | Community Mental Health Team                       |
| CNS               | Clinical Nurse Specialist                          |
| CNWL              | Central and North West London NHS Foundation Trust |
| CPN               | Community Psychiatric Nurse                        |
| CPS               | Crown Prosecution Service                          |

|                 |  |
|-----------------|--|
| CSP             | Community Safety Partnership   |
| CRHT            | Crisis Resolution Home Treatment Team – part of NHS Mental Health Service through which admission to inpatient services are usually accessed |
| CRIS            | Crime Reporting Information System – Metropolitan Police Service   |
| CS              | Children’s Services (Children’s Social Services)   |
| CSP             | Community Safety Partnership   |
| CSU             | Community Safety Unit  |
| DA              | Domestic Abuse   |
| DASH            | Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model                                      |
| Depot Injection | Special preparation of medicine given by injection that is slowly released over a number of weeks  |
| DHR             | Domestic Homicide Review   |
| DPS             | Directorate of Professional Standards, Metropolitan Police Service   |
| DV              | Domestic Violence  |
| ED              | Emergency Department (NHS)   |
| EIS             | Early Intervention Service   |
| FLO             | Family Liaison Officer   |
| FME             | Forensic Medical Examiner  |
| GP              | General Practitioner   |
| HAGAM           | Hillingdon Action for Addiction Management   |
| HDAS            | Hillingdon Drug and Alcohol Service  |
| HDC             | Home Detention Curfew  |
| HIDVA           | Hillingdon Independent Domestic Violence Advocacy Service  |
| HSCA            | Health and Social Care Act 2008  |
| HTT             | Home Treatment Team  |
| ICPC            | Initial Child Protection Case Conference   |

|        |   |
|--------|---|
| IDVA   | Independent Domestic Violence Advisor   |
| IMR    | Individual Management Review  |
| IMRs   | Individual Management Reviews   |
| IO     | Investigating Officer   |
| ICPC   | Initial Child Protection Case Conference  |
| IPCC   | Independent Police Complaints Commission  |
| IRIS   | Identification and Referral to Improve Safety   |
| ISVA   | Independent Sexual Violence Advisor   |
| LA     | Local Authority   |
| LAS    | London Ambulance Service  |
| LCJB   | Local Criminal Justice Board  |
| LFB    | London Fire Brigade   |
| MAPPA  | -Multi Agency Public Protection Arrangements or <b>MAPPA</b> is the process through which the police, probation and prison services work together with other agencies to assess and manage violent and sexual offenders in order to protect the public from harm. |
| MARAC  | Multi-Agency Risk Assessment Conferences -A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm.   |
| MASH   | Multi-Agency Safeguarding Hub- aims to improve the safeguarding response for children and vulnerable adults through better information sharing and safeguarding responses.  |
| Merlin | Database for Children coming to notice of police and missing persons  |
| MHA    | Mental Health Act 1983  |
| MIT    | Major Investigation Team  |
| MPS    | Metropolitan Police Service   |
| NEET   | Young people aged 16-24 not in education, employment or training  |
| NHS    | National Health Service   |

|       |  |
|-------|--|
| NICE  | National Institute for Clinical Excellence   |
| NOMS  | National Offender Management System  |
| NPCC  | National Police Chiefs Council (Formally ACPO)   |
| NSPCC | National Society for the Prevention of Cruelty to Children   |
| OAsys | Offender Assessment System – used by National Probation and Prison Service   |
| OIC   | Officer in the Case  |
| PACE  | Police and Criminal Evidence Act 1984  |
| PALS  | Patient Advisory and Liaison Service   |
| PNC   | Police National Computer   |
| PNC   | Police National Computer   |
| PND   | Police National Database   |
| PND   | Police National Database   |
| PPE   | Personal Protective Equipment  |
| RCPC  | Review Child Protection Conference   |
| SARC  | Sexual Assault Referral Centre   |
| SC&O  | Specialist Crime and Operations (MPS)  |
| SHP   | Safer Hillingdon Partnership   |
| SIO   | Senior Investigating Officer   |
| SOIT  | Sexual Offences Investigative Techniques (MPS terminology for Specially Trained Officer – see below)                                     |
|       | Police officers providing help and support to victims of serious sexual violence, through the investigation and criminal justice process |
| SPA   | Single Point of Access   |
| STADV | Standing Together Against Domestic Violence  |
| SUI   | Serious Untoward Incident (NHS)  |
| TAC   | Team Around the Child – group of staff supporting children   |
| TDC   | Trainee Detective Constable  |

|      |  |
|------|--|
| UAL  | CNWL's Out-of-Hours Urgent Advice Line                                 |
| UCC  | Urgent Care Centre (can be GP led and may be linked to Hospital A & E) |
| UKBA | United Kingdom Border Agency   |
| YOS  | Youth Offending Service  |
| YOT  | Youth Offending Teams  |
| Ypva | Young People's Violence Advisor  |
| 124D | Domestic Abuse Form  |
|      | Critical Incident Review Team – Metropolitan Police Service            |
|      | Crisis Intervention Assessment Team                                    |
|      | Criminal Intelligence System – Metropolitan Police Service             |
|      | Early Evidence Kit   |
|      | Missing Persons  |
|      | Victim, Informant, Witness   |

# Appendix 7: Home Office Quality Assurance Panel's letter



Home Office

Public Protection Unit  
2 Marsham Street  
London  
SW1P 4DF

T: 020 7035 4848  
[www.gov.uk/homeoffice](http://www.gov.uk/homeoffice)

Ms Fran Beasley  
Chief Executive London Borough of Hillingdon  
Civic Centre High Street  
Uxbridge  
UB8 1UW 26

January 2018

Dear Ms Beasley,

Thank you for submitting the Domestic Homicide Review (DHR) report for Hillingdon (Lottie) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 13 December 2017.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a well written review which demonstrates a good understanding of the dynamics of domestic abuse and which has identified a good set of recommendations. The Panel also commended the breadth and expertise of the review panel.

There were, however, some aspects of the report which the Panel felt may benefit from further analysis, or be revised, which you will wish to consider:

- It may assist a reader if the terms of reference were in the main report and not an annex;
- The executive summary contains insufficient information to get a sense of the relationship and the basis of the recommendations;
- The Panel noted that the overview report is a long document and suggested that it may be helpful to make it more concise and focused;
- Consideration could be given to including a recommendation around the analysis and findings in relation to inadequate recording practices;

- You may wish to consider whether a recommendation is required in relation to the victim being asked to sign a safeguarding agreement;
- The Panel felt that the recommendation around all local agencies being aware of referral pathways also has national resonance;
- Notwithstanding the considerable number of panel members involved, the Panel felt the review may have found it helpful to also include specialists in mental health and those working with women with complex needs given the circumstances of the case;
- The action plan will require updating before publication;
- Please proof read the full report as there are a considerable number of typing errors.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at [DHREnquiries@homeoffice.gsi.gov.uk](mailto:DHREnquiries@homeoffice.gsi.gov.uk) and provide us with the URL to the report when it is published. The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the Mayor's Office for Policing and Crime for information.

Yours sincerely

**Hannah Buckley**

Acting Chair of the Home Office DHR Quality Assurance Panel