



SAFER LEWISHAM PARTNERSHIP DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

**Report into the death of Kate
July 2018**

Independent Chair and Author of Report: James Rowlands
Associate Standing Together Against Domestic Abuse
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“No words can truly describe the amount of love we have for Kate. She really was a beautiful kind-hearted soul that filled our home with love. Her energy and affection were the light in our life. She was such a generous giver that never failed to put a smile on anyone’s face. She was the bravest and we are so very proud her. It’s truly a blessing to be a part of her life. Her love and memories created are forever treasured. We love you dearly our precious angel.”

Yara, Mother of Kate

“Kate was a beautiful loving child who was taken from her family before she could even start living her life; before she achieved her dreams, goals and aspirations. Dreams of travelling the world and aiding in any way to the less fortunate and people who were truly in need. Not only in need of positions and financial help. But people in need of attention, friendships and happiness.

For her to have this mentality at such a young tender age, was an achievement in itself. Which I was more than proud of.

Her aspirations were to become a beauty stylist. Making people look beautiful and feel comfortable was her role at her workplace. Her plan was to be able to do that on a bigger scale through social media. Hence why she was preparing to complete a course in hair extension to further broaden her ability and opportunities. At 17 she was already working 5 days a week in a beauty and hair salon. Working minimum wage because of her age. Yet she decided to persevere and strived to achieve her goals whether [or not] that came with sacrifices.

Like working a weekend for a low income. She was happy to give it all up to succeed in her goals and aspiration. I am saddened she was not able pursue those goals, I am saddened she was not able to live a full live, I am saddened she was alone in her last moments. Her smile will be missed because she had the ability to walk into almost any room and simply liven it up with smiles, joy and laughter.

That why she was loved and will be missed by her family, friends and acquaintance. She was not only a sister but a best friend to us all. Some we love, live and long for. Our lives have been turned upside down without her radiant presence, happiness and silliness around. We will always remember your smile and constant jokes some funny and some very funny. You will be sorely missed by all who love you. Forever in our heart.

My Love, My All, My Joy.”

Written by Kate’s brothers and sisters

Executive Summary

1.1 The Review Process

- 1.1.1 This summary outlines the process undertaken by the Safer Lewisham Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Kate¹, a resident of the London Borough of Lewisham (hereafter ‘Lewisham’).
- 1.1.2 On a day in July 2018, Kate went to the address of her ex-boyfriend Xavier,² which was in the London Borough of Southwark (hereafter ‘Southwark’). An argument ensued in the lobby and, when Xavier tried to grab Kate, they both fell to the ground. Kate fell onto her bag, which contained a knife that she had been carrying. The knife penetrated Kate’s chest and she suffered a fatal injury. Xavier was subsequently charged with manslaughter and, having pleaded guilty, was sentenced to 2 years and 3 months imprisonment.³
- 1.1.3 In the months prior to the homicide, Kate had been in contact with the Metropolitan Police Service (MPS). As a result, an investigation was also undertaken by the Independent Office for Police Conduct (IOPC).⁴
- 1.1.4 Undertaking this DHR has been challenging because of the involvement of multiple local authority areas. This is because Kate and her family moved on a number of occasions, living in Northern England, the Midlands and London. This is discussed in the methodology below, but in summary, the DHR has focused on agency contact/involvement with Kate and Xavier from the 1st January 2015 to the date of the homicide. This timeframe was chosen because it includes substantive contact by agencies with Kate, and also included the period in which Kate and Xavier knew each other. Additionally, the DHR has considered contact prior to these dates where appropriate.
- 1.1.5 The following pseudonyms have been used in this DHR to protect the identities of the victim, other parties, those of their family members and the perpetrator:⁵

Name	Relationship
Kate	-
Xavier	Ex-boyfriend and perpetrator
Yara	Mother
Mason	Father
Child A	Sibling (under 18)

¹ Not her real name.

² Not his real name.

³ The sentence length reflected the circumstances of the case as outlined above, as well as Xavier’s guilty plea.

⁴ The Independent Office for Police Conduct (IOPC) oversees the police complaints system in England and Wales. For more information, go to: <https://www.policeconduct.gov.uk/who-we-are>.

⁵ At her family’s request, the pseudonym ‘Kate’ was used to refer to the victim. Other pseudonyms were chosen by the chair

Name	Relationship
Child B	Sibling (under 18)
Ezra	Brother (over 18)
Eliana	Friend
Lucas	Former boyfriend

- 1.1.6 Given Xavier's relatively short sentence, he was released during the course of the DHR. Reflecting this, as well as the preference of Kate's family, the chair and the Review Panel have recommended that only the Executive Summary is published.
- 1.1.7 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Safer Lewisham Partnership – commissioned this DHR. Having received notification from the MPS at the end of July 2018, a decision was made to conduct a DHR by in the same month. Subsequently, the Home Office was notified of the decision in writing in September 2018.

Standing Together Against Domestic Abuse (Standing Together) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in October 2018. The completed report was handed to the Safer Lewisham Partnership in November 2020. In December 2020, it was tabled at a meeting of the Safer Lewisham Partnership and signed off, in part because Lewisham Council had been ordered to disclose the DHR as part of the resumed coroner's inquest.⁶ Thereafter, it was before being submitted to the Home Office Quality Assurance Panel in January 2021. In June 2021, the completed report was considered by the Home Office Quality Assurance Panel. In August 2021, the Safer Lewisham Partnership received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the Executive Summary (as noted in 1.1.6, the Review Panel has recommended that the Overview Report is not published).⁷

1.2 Contributors to the Review

- 1.2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. As Kate was under the age of 18 at the point of the homicide, consideration was given to whether a Child Safeguarding Practice Review should be conducted. Following consultation with the national Child Safeguarding Practice Review Panel,⁸ the

⁶ The death of Kate was referred to the HM Coroner, and an inquest was opened and suspended at Southwark Coroner's Court in July 2018. The inquest was resumed from August 2020. As part of this process, the coroner ordered Lewisham Council to disclose the DHR.

⁷ While the Review Panel welcomed the feedback from the Home Office Quality Assurance Panel, it disagreed with several the areas suggested for final development. Two changes were agreed. The name of Kate's school was anonymised, and the report was ammended to clarify that the terminations of pregnancy occurred after Kate was over the age of 16.

⁸ The Child Safeguarding Practice Review Panel is an independent panel commissioning reviews of serious child safeguarding cases. It confirmed on the 20th September 2018 that it did not feel the case met the criteria for a national review but welcomed the decision to commission a local review to identify learning. For more information, go to: <https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel>.

DHR will consider any associated learning that will improve safeguarding practice in relation to children. In respect of this, the DHR will have reference to the principles set out in Working Together to Safeguard Children 2018 for Child Safeguarding Practice Reviews.⁹

- 1.2.2 The Review Panel comprised of agencies from Lewisham, as Kate was living in that borough at the time of the homicide. Agencies were contacted as soon as possible after the DHR was established to inform them of the Review, their participation and the need to secure their records.
- 1.2.3 However, it became apparent that Kate and her family had only lived in Lewisham for a short period of time before the homicide and consequently had no contact with agencies in that borough.
- 1.2.4 It was established that Kate's family had moved extensively, living in Northern England, the Midlands and London (as well as another area where at least some of the family had been in a refuge). Overall, at least 12 addresses were identified during the DHR, alongside potential residence in 11 local authority areas. However, the family moved to the London Borough of Merton (hereafter 'Merton') in 2010/2011, then later to the London Borough of Bromley (hereafter 'Bromley') and finally, the London Borough of Lewisham (hereafter 'Lewisham'). The Review Panel agreed to focus on these three boroughs.¹⁰
- 1.2.5 Agencies from these three London boroughs were contacted for information and involved in this DHR. This was coordinated through the local CSP and/or Children's Services, who were subsequently invited to sit on the Review Panel. Additionally, the Review Panel also included a representative from the London Borough of Southwark (hereafter 'Southwark'), where Xavier resided at the time of Kate's death.
- 1.2.6 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. Given the involvement of a number of boroughs, this was a complex and time-consuming. The chair would like to acknowledge the work of the DHR Team at Standing Together who facilitated this process.
- 1.2.7 The approach adopted was to undertake a scoping exercise in each borough and, where agencies had substantive contact, to request either a Short Report or Individual Management Reviews (IMRs). Five agencies had limited contact and submitted a Summary of Engagement; Seven agencies submitted Short Reports as they had short term involvement; and 12 agencies were asked to submit Individual Management Reviews (IMRs).¹¹ A narrative chronology was also prepared.

⁹ For more information, go to:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard_Children.pdf.

¹⁰ The Review Panel considered approaching these other local authority areas to try to map the experiences of Kate and her family over these years, in order to understand any service offers, outcomes, as well as the impact of these moves. However, it was agreed that this was both disproportionate and not practicable, and that it would be a better use of resources to focus on more recent contact.

¹¹ Additionally, AAFDA and VSHS participated in a reflective exercise relating to family support as part of this DHR. As part of that process both agencies also submitted IMRs and a Chronology. See 1.2.9.

Pan London

Agency	Contribution
MPS	IMR and Chronology
Victim Support	Summary of Engagement
London Community Rehabilitation Company (CRC)	IMR and Chronology
London Ambulance Service (LAS)	Summary of Engagement
British Pregnancy Advisory Service (BPAS) ¹²	IMR and Chronology

Lewisham

Agency	Contribution
The Athena Service, provided by Refuge ¹³	Summary of Engagement

Bromley

Agency	Contribution
Bromley Council Children's Social Care	IMR and Chronology
Greenbrook Healthcare ¹⁴	Short Report
Bromley Healthcare ¹⁵	Short Report

Merton

Agency	Contribution
Catch 22 ¹⁶	IMR and Chronology

¹² An independent healthcare charity which advocates and cares for women and couples who decide to end a pregnancy. For more information, go to: <https://www.bpas.org>.

¹³ Provides confidential, non-judgmental support to those living in the London Borough of Lewisham who are experiencing gender-based violence. It opened its doors in April 2015 and provides outreach programmes, independent advocacy, group support, refuge accommodation and a specialist service for young women. For more information, go to: <https://www.refuge.org.uk/our-work/our-services/one-stop-shop-services/athena/>.

¹⁴ Provides primary care services in Urgent Care Centres, Walk-in Centres and GP practices. For more information, go to: http://www.greenbrook.nhs.uk/About_Us.

¹⁵ Provides community health care services in Bromley, Bexley, Croydon, Greenwich and Lewisham. For more information, go to: <https://www.bromleyhealthcare.org.uk/about/>.

¹⁶ A specialist service integrating substance misuse treatment, detached youth work and C-Card Scheme including access to sexual health information and advice. Works with young people aged 11 to 24-years-old in Merton. For more information, go to: <https://www.catch-22.org.uk/services/merton-young-peoples-risk-and-resilience/>.

Agency	Contribution
Figges Marsh Surgery (General Practice (General Practice (GP) of Kate)	IMR and Chronology
Kate's Secondary School ¹⁷	IMR and Chronology
London Borough of Merton Housing Service	IMR and Chronology
Merton Council Children's Social Care	IMR and Chronology
Merton Council Education Welfare Service	Short Report
Merton Council Family and Adolescent Service	IMR and Chronology
South West London & St George's Mental Health NHS Trust (SWLStG) ¹⁸	IMR and Chronology
St Georges University Hospital NHS Foundation Trust ¹⁹	Short Report
Central London Community Healthcare NHS Trust (CLCH) ²⁰	IMR and Chronology

Southwark

Agency	Contribution
Concordia Parkside Medical Practice (GP of Xavier)	Summary of Engagement
Edith Cavell Practice (GP of Xavier)	Summary of Engagement
Guy's and St Thomas' NHS Foundation Trust ²¹	Short Report
Kings College Hospital NHS Foundation Trust (KCH) ²²	Short Report

¹⁷ Not named to protect Kate's anonymity.

¹⁸ Provides mental health services across south west London. For more information, go to: <https://www.swlstg.nhs.uk/about-the-trust>.

¹⁹ Provides acute hospital services, as well as a variety of specialist care and a full range of community services in southwest London. For more information, go to: <https://www.stgeorges.nhs.uk/about/>.

²⁰ Provides community health services across eleven London boroughs and Hertfordshire, including school nursing and sexual health services in Merton. For more information, go to: <https://clch.nhs.uk/about-us>.

²¹ Provides a full range of full range of health services for residents of Lambeth, Southwark and Lewisham. For more information, go to: <https://www.guysandstthomas.nhs.uk/about-us/about-us.aspx>.

²² Provides a wide range of specialist acute and elective inpatient and outpatient services across a number of hospital and community sites throughout the South East, including Princess Royal University Hospital, Orpington Hospital, Beckenham Beacon, and Queen Mary's Hospital, Sidcup. For more information, go to: <https://www.kch.nhs.uk/>.

Agency	Contribution
Metropolitan Thames Valley Housing ²³	Short Report

- 1.2.8 In addition, the IOPC shared a copy of its independent investigation report with the chair and provided a verbal update to a panel meeting in December 2019.
- 1.2.9 Kate’s family also contributed to the DHR, with both her mother (Yara) and brother (Ezra) being interviewed. (A friend of Kate’s Eliana was also interviewed). Kate’s mother received a copy of the draft report and had the opportunity to provide feedback. The family also provided Pen Portraits and these have been included at the start of this report.
- 1.2.10 As part of the process of family involvement, the family received support from AAFDA²⁴ and the Victim Support Homicide Service (VSHS)²⁵.
- 1.2.11 Unusually, both AAFDA and the VSHS were invited to provide IMRs in this case. This is because, during the course of the DHR, both were involved in family support and the chair and the Review Panel identified some challenges with having both providing parallel and, at times, overlapping support. As a result, the chair approached AAFDA and VSHS and invited them to engage in a reflective exercise, similar to the IMR process undertaken by the other agencies that had contact in this case. The intention was to identify any learning about the support they offered around the DHR process and joint working.
- 1.2.12 The Review Panel is grateful that both agencies were willing to take part in this reflective exercise which, while unusual, was in the spirit of the statutory guidance: that is, as a learning exercise concerned with accountability rather than blame.
- 1.2.13 In inviting AAFDA and VSHS to take part in this reflective exercise, there was a shared commitment to try and co-produce the findings. However, each agency was made aware at the point of invitation that the final decision rested with the chair and the Review Panel and that, should there be any disagreement, this would be noted. Neither AAFDA or VSHS was entirely satisfied with the final text that was produced and which is summarised here, arguing respectively that more or less information and analysis should be included. Regrettably, VSHS asked for its disagreement to be recorded as it felt that the reflective exercise was disproportionate.
- 1.2.14 In summary, it appears that initially there was an effective working relationship between AAFDA and VSHS in the management of family support. Unfortunately, it appears that over time joint working between the AAFDA advocate and the VSHS caseworker involved in the case broke down. An early point of concern was the meeting in June 2019, when there was confusion about the support to be

²³ Metropolitan Thames Valley provides housing at different levels of affordability for people living in London, the South East, East Midlands and East of England. For more information, go to: <https://www.mtvh.co.uk>.

²⁴ AAFDA provides specialist and expert advocacy and peer support to those left behind after domestic homicide. For more information, go to: <https://aafda.org.uk>.

²⁵ VSHS supports families bereaved by homicide. For more information, go to: <https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service>.

offered by VSHS and inter-agency working with AAFDA. After November 2019, although both AAFDA and VSHS continued to work with Yara, it appears that their respective service offers became almost entirely disconnected.

- 1.2.15 Reflecting these issues, and other matters identified during the production of their IMRs, both agencies have identified learning. In summary,
- AAFDA identified that it would have been helpful to agree on roles and responsibilities at the outset with both the VSHS caseworker (or any other partner agency) and the family. AAFDA additionally noted that the use of case management recording could have been improved (including when using WhatsApp and Messaging services) and identified that there should always be explicit consideration as to the use of interpreters; and
 - VSHS identified learning in relation to consistent recording (relating to the recording of already established facts, and also management decisions). VSHS also noted the need to work together more effectively with AAFDA advocates, as well as the importance of establishing contact and then having ongoing communication with DHR chairs.
- 1.2.16 In response to this learning, both AAFVA and VSHS made single agency recommendations which are included in 1.9 below.
- 1.2.17 The Review Panel noted that, in addition to the case-specific learning identified by AAFDA and VSHS, there is also a broader context to this case. This includes both AAFDA and VSHS’s potential future joint working relationship, the importance of ensuring that family support is available, and clarity about how those involved with families should work together (including chairs and review panels). The Review Panel has therefore made three recommendations, which are included in 1.10 below.
- 1.2.18 *Independence and Quality of IMRs:* The Short Reports and IMRs were written by authors independent of case management or delivery of the service concerned. Most of the Short Reports and IMRs received were comprehensive and enabled the panel to analyse the contact with Kate and/or Xavier and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Agency	Role	Agency
Aneesa Kaprie ²⁶	Head of Service for Safeguarding East and Care Proceedings	Bromley Council

²⁶ Replaced Lydia Bennett from March 2020. Was succeeded by Stuart Hill in October 2020

Agency	Role	Agency
Bill Turner	Head of Safeguarding Children & Adults	St Georges University Hospital NHS Foundation Trust
Charlene Noel	Violence Against Women and Girls (VAWG) Strategy and Programme Manager	Lewisham Council
Charlotte Dick	Named Adult Safeguarding Lead	Bromley Healthcare
Dr Karen Worthington	Named GP for Child Safeguarding	NHS Merton Clinical Commissioning Group (CCG) ²⁷
Emma Norman	Assistant Director	Catch 22
Frankie Campbell	Named Nurse for Safeguarding Children	SWLStG
Gary Connors	Community Safety Lead	Lewisham Council
Heather Payne	Head of Adult Safeguarding	KCH
John Walsh ²⁸	Head of Service: QAPD & Principal Social Worker	Merton Children's Services
Joy Lynch	Interim Service Manager, Quality Assurance Child Protection	Southwark Council
Keith Shipman	Education Inclusion Manager	Merton Council
Julia Dwyer	Senior Operations Manager, Eastern European Advocacy Service	Refuge (provides the 'Athena Service' in borough)
██████████	Designated Safeguarding Lead	Kate's Secondary School
Dr Maqsood Ahmed	Practice Partner and Safeguarding Lead	Figges Marsh Surgery
Maureen Gabriel	Designated Nurse Safeguarding Children	NHS Lewisham CCG
Maria Ellery	Lead Nurse Safeguarding	BPAS

²⁷ The safeguarding lead at Figges Marsh Surgery, Dr M Ahmed (also a practice partner), attended one of the earlier panel meetings to represent the practice.

²⁸ Replaced Caroline Muller from June 2019.

²⁹ Not named to protect Kate's anonymity.

Agency	Role	Agency
Mick Brimms	Business Manager	Lewisham Safeguarding Children Partnership (LSCP)
Nathan Glew ³⁰	Head of Quality Improvement, Lewisham	Lewisham Council Children's Social Care
Rob Vale	Head of Trading Standards & Community Safety	Bromley Council
Roberta Evans	Head of Adolescent and Family Service Interim Head of 14+ and Care Leavers	Merton Youth Offending Service (YOS)
Russell Pearson	Review Officer, Specialist Crime Review Group (SCRG)	MPS
Sarah Bell	Service Manager	Catch 22
Sarah Ham	Clinical Nurse Specialist Emergency Department Liaison, Safeguarding Children and Young People	St Georges University Hospital NHS Foundation Trust
Trish Stewart	Associate for Safeguarding	CLCH

1.3.2 The Review Panel is grateful for the participation of the following, who did not have any contact but provided their expertise, as a critical friend and Review Panel member respectively:

- Dr Carlene Firmin,³¹ who developed and led the contextual safeguarding and peer-on-peer abuse research programmes at the University of Bedfordshire.³² Dr Firmin acted as a critical friend, providing comment and feedback on the draft report; and
- Additionally, Refuge, which provides the 'Athena Service' in borough, nominated a Review Panel representative who managed their Eastern European Advocacy Service.³³

1.3.3 *Independence and expertise:* Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

³⁰ Left Lewisham Council before the DHR was concluded.

³¹ For more information, go to: <https://www.beds.ac.uk/iasr/staff/carlene-firmin/>.

³² Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships. For more information, go to: <https://contextualsafeguarding.org.uk>.

³³ For more information, go to: <https://www.refuge.org.uk/our-work/our-services/culturally-specific-services/>.

- 1.3.4 The Review Panel met a total of five times, with a first meeting being held on the 18th March 2019. To help manage the cross-borough process, it was agreed that this first meeting would be attended by a core group of Review Panel members, representing each borough's CSP and/or Children Services, as well the MPS. At the meeting, it was agreed which of these agencies would be submitting IMRs and how to undertake the scoping exercise.
- 1.3.5 Thereafter, based on scoping return, the wider Review Panel membership was convened and invited to subsequent meetings along with the core group. Unfortunately, a planned meeting on the 10th July 2019 was cancelled because there were delays in both the submission of some IMRs and scoping information. This meeting was re-scheduled to the 24th October 2019. There were further meetings on the 6th December 2019, the 30th March 2020 and the 6th July 2020. Additionally, Review Panel members were invited to a briefing session in October 2020 to discuss returns from AAFDA and VSHS (this process, and the learning and recommendations arising, are described in 1.9). Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment and sign off on a final draft by email during August 2020.
- 1.3.1 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.4 Chair of the DHR and Author of the Overview Report

- 1.4.1 The chair and author of the review is James Rowlands, an Associate DHR Chair with Standing Together. James has received DHR Chair's training from Standing Together. He has chaired and authored nine previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.
- 1.4.2 Standing Together is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides. Standing Together has been involved in the Domestic Homicide Review process from its inception, chairing over 80 reviews.
- 1.4.3 *Independence:* James has no other current connection with the local area, the other boroughs participating, or any of the agencies involved.

1.5 Terms of Reference for the Review

- 1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1st January 2015 to the date of the homicide of Kate. The Review Panel decided to consider the information relating to contact before 2015 where relevant but agreed it would not be proportionate

or practicable to include this earlier contact within the scope of the DHR. Consequently, where there was agency involvement with any subject prior to these dates, agencies were asked to summarise this, and review any issues pertinent to the DHR.

1.5.2 *Key Lines of Inquiry:* The Review Panel considered both the ‘generic issues’ as set out in statutory guidance and identified and considered the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies;
- The co-operation between different agencies involved with Kate and/or Xavier [and wider family];
- The opportunity for agencies to identify and assess domestic abuse risk;
- Agency responses to any identification of domestic abuse issues;
- Organisations’ access to specialist domestic abuse agencies;
- The policies, procedures and training available to the agencies involved on domestic abuse issues;
- Specific consideration to the following issues: Being a young carer;³⁴ Being a care leaver;³⁵ Youth Crime and Gangs.³⁶ [In this context the Review Panel has considered in particular Child Sexual Exploitation (CSE)³⁷ and Child Criminal Exploitation (CCE)³⁸]; and
- Any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

³⁴ Someone is a young carer if they are under 18 and help to look after a relative with a disability, illness, mental health condition, or drug or alcohol problem

³⁵ Any adult who spent time in care as a child (i.e. under the age of 18). This could include time in residential care (mainly children's homes), or other arrangements outside the immediate or extended family.

³⁶ The word ‘gang’ means different things in different contexts, with distinctions made between peer groups, street gangs and organised criminal gangs. A recent report by the Children’s Commissioner considered this issue. For more information, go to: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/02/CCO-Gangs.pdf>.

³⁷ Defined as: “... a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology”. For more information, go to: <https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners>.

³⁸ Defined as: “Child Criminal Exploitation is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology”. For more information, go to: <https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines>.

1.6 Summary of Chronology

Kate

- 1.6.1 Prior to the timeframe under review, Kate experienced considerable instability in childhood, moving repeatedly. This was because of abuse by her father (Mason) to her mother (Yara). Kate and her family moved to London around 2008/209 before settling in Merton. In 2012 Kate was reported to be the victim of a serious sexual assault. Although these experiences are outside of the timeframe for the DHR, the cumulative trauma provides an important context to her subsequent risks, needs and interactions with services.
- 1.6.2 From 2015, the timeframe under review, Kate had contact with services in Merton through to the end of 2016. This contact was extensive, involving a range of different agencies, from social care, education and health. This contact had been triggered by concerns about Kate's poor school attendance; that she was often returning home late, after midnight and sometimes not returning at all; substance misuse; and physical health issues. Other issues included her experience of actual or potential violence and abuse, both in her own relationships and from peers, as well as Kate's sexual health.
- 1.6.3 The result was professional concern about Kate's school attendance, sexual health and domestic abuse, drug misuse, gangs, and CSE, as well as CCE. Professionals were also concerned about whether Kate's parents were able to protect her because, at times, she appeared to be beyond parental control.
- 1.6.4 As a result, a range of 1-2-1 interventions offered by statutory and non-statutory services, some of which were linked directly to statutory requirements (including a Child Protection (CP) plan, as well as Referral Orders, or managed through different multi-agency fora. These interventions included mentoring, motivational work and some group work. They addressed relationships, violence and abuse, substance misuse, safety planning, as well as other health issues. They also focused on Kate's aspirations for the future, including her training.
- 1.6.5 Taken together, these interventions appear to have been successful. Kate talked positively about her interactions with professionals in this time. In a great part, this also reflects Kate's determination to make changes in her own life, including both addressing relationships that were unhealthy, but also pursuing her aspirations to obtain qualifications and work in the beauty industry.
- 1.6.6 However, it is also clear that there were a number of issues that affected agency responses. There were multiple professionals involved, as well as different multi-agency fora in which information was shared and/or multi-agency actions were coordinated. These did not always overlap, reflecting the difficulty of coordinating across these fora, as well as the fact that different forums focused on different issues, broadly whether Kate was considered at risk (e.g. of CSE or CCE) or as an offender (e.g. in terms of youth justice). Importantly, domestic violence and abuse was not considered explicitly. For Kate, this was because professionals were more focused on other issues. Yet the broader context was also not recognised, including identifying and responding appropriately to reports of domestic violence and abuse in the family home (from her father towards her mother). In

one case, this led to SWLStG inappropriately asking her mother (Yara) to translate for her father (Mason).

- 1.6.7 While there were good professional relationships with Kate, in some cases there were examples of language that focused on Kate's "*lifestyle choices*", which risked victim blame. Moreover, there was often a focus on Yara's responsibility as a parent to keep Kate safe, despite many of the risks arising outside the family home.
- 1.6.8 In its discussions of these issues, the Review Panel noted that CSE and CCE (and the wider contextual safeguarding agenda) were relatively recent developments for some social workers at the time. In the intervening years, policy and practice have developed considerably. Nonetheless, a key element of learning from this period of time has been the importance of contextual safeguarding so that professionals consider risk and harm holistically. Taking a contextual safeguarding approach includes considering whether there are concerns around coercion and control, sexual health, violence (mostly related to offending), peer groups (as well as other presenting needs and contexts of harm).
- 1.6.9 After September 2016, agencies became aware that Kate and her family were moving to Bromley. At the time, Kate was still on a CP plan. However, a dispute between Merton and Bromley meant that a care transfer conference was not held. Instead, Merton Children's Social Care made the decision to step-down Kate (and her two siblings, who were also on a CP plan) to a Child in Need (CIN) plan. This plan was not robust. Then in December, Merton Children's Social care referred the case to Bromley Multi Agency Safeguarding Hub (MASH) along with copies of the CIN plan, case chronology and the recent assessment. The case was then closed to Merton. When Bromley MASH screened the case, the focus was on Kate's siblings. As they were doing well at school and no concerns were identified, it was decided that the family would be signposted to the Early Help service (although this did not in fact lead to any contact from the Early Help service. If this signposting had led to an approach by Early Help, any support offer would also have required consent from the family). As a result of this focus on her siblings, Kate became lost in the screening process and her needs were not actively considered. This is particularly significant because it meant Kate was not supported in her move from one borough to another. Despite the progress Kate had made, and some support provided by professionals from Merton, the result was that the risks and needs she had faced in Merton were not reviewed.
- 1.6.10 In January 2017, Kate and Xavier met in person for the first time (they appear to have first met via social media in November 2016). Little is known about their relationship, although it appears that they broke up on at least four or five occasions. During 2017 and 2018, Kate would seek support from a range of different providers around her sexual health, including termination of pregnancy. This contact has highlighted the importance of sexual health/termination services considering vulnerability when working with under 18s.
- 1.6.11 Other broader health learning has also been identified by Kate's GP, the Figges Marsh Surgery. Kate had intermittent contact with the surgery, including in relation to health problems linked to sexual activity. Some of these contacts were when she was under the age of consent and there should have been an explicit assessment of Kate's competence, both in terms of her maturity to make her

own decisions and specifically in relation to contraception and sexual health. Additionally, the surgery was also aware that Kate had accessed sexual health/termination services when she was over the age of consent but did not explore this with her.

- 1.6.12 In 2018, Kate had contact with the MPS on five occasions, all linked to reports of violence and abuse by Xavier. These incidents varied, and Kate shared different amounts of information with police officers. However, the extent and severity of violence and abuse is evident, with Kate disclosing a range of different behaviours by Xavier ranging from assault, to knives, verbal abuse and threats, while Kate also expressed her own fears and that the abuse was getting worse and more frequent. In its response to these five incidents, a parallel IOPC investigation has highlighted how there were missed opportunities by the MPS to conduct and link risk assessments across incidents (i.e. they were seen in isolation), as well as identifying issues with communication with Kate. Meanwhile, Kate's family and friends have suggested that her age (and perhaps her race and ethnicity) affected how she was perceived. In light of these issues, the Review Panel has considered the outcome of risk assessments undertaken by police officers. It is of the view that in some of these incidents the risk assessment should have been higher, reflecting what was known at the time, in particular Kate's age. Additionally, the Review Panel has noted that there were opportunities to trigger a multi-agency response, specifically by making a Multi Agency Risk Assessment Conference (MARAC) referral, on the basis of 'Visible High Risk',³⁹ 'Professional Judgement'⁴⁰ or Escalation⁴¹. However, any such consideration was impeded by both problems with the assessment of risk by the police officers and referral pathways locally (specifically, the threshold for 'potential escalation' referrals).
- 1.6.13 One of these contacts (in February 2018) triggered a referral to the Bromley MASH by both the MPS and LAS, however no action was taken. In part, this was because of a focus on the actions Kate was seen to be taking, but critically this decision failed to consider her experiences in Merton, despite this information having previously been shared. Like the learning from agencies interactions with Kate in Merton, for Bromley this has identified the importance of a contextual safeguarding approach.

Xavier

- 1.6.14 A feature of this DHR is the relative absence of information on Xavier. He was known as a child to Lambeth Council Children's Social Care and, as a young person and an adult, Xavier was also

³⁹ Kate was not assessed as 'high risk' in any of these contacts. However, the Review Panel felt that at least two of the incidents in 2018 could have been assessed as high risk (based on Kate's disclosures, her age and what was known about the incident) and could therefore have been referred to MARAC.

⁴⁰ The Review Panel felt that police officers could have considered making a referral on professional judgement. It would have been reasonable for police officers to have considered making a referral on professional judgement, particularly in the later incidents when a more complete picture was available.

⁴¹ The Review Panel felt police officers could have considered making a referral on the basis of 'Potential Escalation', although considering whether this threshold had been met would have been complicated by the location of the incidents which occurred in Bromley, Lewisham and Southwark. However, the Review Panel noted that, even if police officers had considered a referral on the basis of potential escalation, in Lewisham, the threshold for is set at 4 police *crimes* in the past 12 months. This is in contrast to the national guidance which is set at 'three domestic abuse events'. Of the reports to the MPS in 2018 all were classified as incidents, with only one being crimed. As a result, technically Kate would not have met the Lewisham MARAC threshold for escalation.

known to services, including for his association with gangs, possible drug use or dealing, and violence within his family home as well as in public (in 2012 and 2013 there were the first reports where Xavier was named as the assailant in sexual assaults).

- 1.6.15 However, the only substantive involvement with Xavier was by the CRC after he was released following a sentence for Possession with Intent to Supply Controlled Drugs of Class A (heroin and cocaine) in 2015. Xavier was released on licence conditions in September 2016, when he was assessed as low risk of harm. His licence expired in December 2017. In its interactions with Xavier, while there was evidence of good work being completed around his health needs and issues like employment/training/education and benefits, the CRC could have been more professionally curious about his circumstances. In particular, there was limited exploration of his familial and intimate relationships.
- 1.6.16 The MPS also had contact with Xavier in 2018, as a result of the reports by Kate about his behaviour. Broadly speaking, the opportunities to intervene with Xavier were limited because the response to Kate's disclosures was insufficient, as discussed above. A more robust response may have led to a recognition of the risk posed by Xavier, which as a minimum may have triggered a referral to MARAC. This could have provided an opportunity to build a picture of what was known about his behaviour but also to identify what interventions may have been possible to either hold him accountable or better protect Kate.

Analysis

- 1.6.17 This DHR was triggered by the homicide of Kate. Although the manner of Kate's homicide may have been unusual (in that she died after falling on a knife she had been carrying in her bag), Xavier was convicted of manslaughter.
- 1.6.18 A DHR is an opportunity to take a broad perspective of the circumstances leading to a homicide, looking beyond the incident itself. Tragically, it will never be possible to know the full extent of Kate's experiences. However, considering the government definition of domestic violence and abuse, information provided by agencies, and the recollections of those who knew her personally or professionally, it is evident that Kate was the victim of domestic violence and abuse by Xavier. This included:
- *Physical abuse*: Kate reported a number of assaults by Xavier, both at her family home and in public spaces. She, or others, also reported that knives were used or brandished. After separating from Xavier, an escalation in Xavier's behaviour was reported by Kate, who told police officers at various points that his behaviour was getting worse;
 - *Coercion, threats and intimidation*: Xavier is also reported to have made threats to Kate and her family, and Kate told police officers that she was afraid of what he might do. There are also reports that Xavier may have been stalking Kate, including waiting outside her house. Kate described Xavier's behaviour as "*harassing*". She said, for example, that after they separated,

he continued to contact her (including via social media)⁴². Family and friends described different behaviours, including Xavier continuously ringing her phone and on at least one occasion, paying someone to watch her. Kate herself described Xavier as controlling;

- *Emotional abuse and isolation*: There are reports that Kate was isolated by Xavier. For example, he did this practically by stealing her phone. When he had her phone, Xavier is also reported to have used this to send derogatory messages to her friends and family. The impact of the abuse also affected Kate, with Eliana describing how she changed during the relationship;
- *Sexual abuse*: No information has been shared with the Review Panel that would allow it to rule sexual abuse in or out. However, Xavier is reported to have been sexually jealous of Kate, including monitoring who she was with. There is also at least one occasion when Xavier is reported to have shared personal photos without her consent;
- *Children and pregnancy*: Although Kate did not have children; she is reported to have been pregnant on a number of occasions. She sought help from a number of different health providers in relation to either contraception or termination of pregnancy, of which two occurred during the time in which she knew Xavier. No information has been shared with the Review Panel that would allow it to determine how Kate felt about her pregnancies, or conversely the feelings and behaviours of Xavier; and
- *Economic abuse*: During the relationship, Yara said that Kate was “*supporting him*” financially. After the end of their relationship, Kate told police officers that Xavier’s behaviour, including coming to her workplace and being abusive, had caused her to lose her job. As noted above, Xavier is reported to have taken Kate’s property and, on at least one occasion he is also reported to have destroyed her bank card.

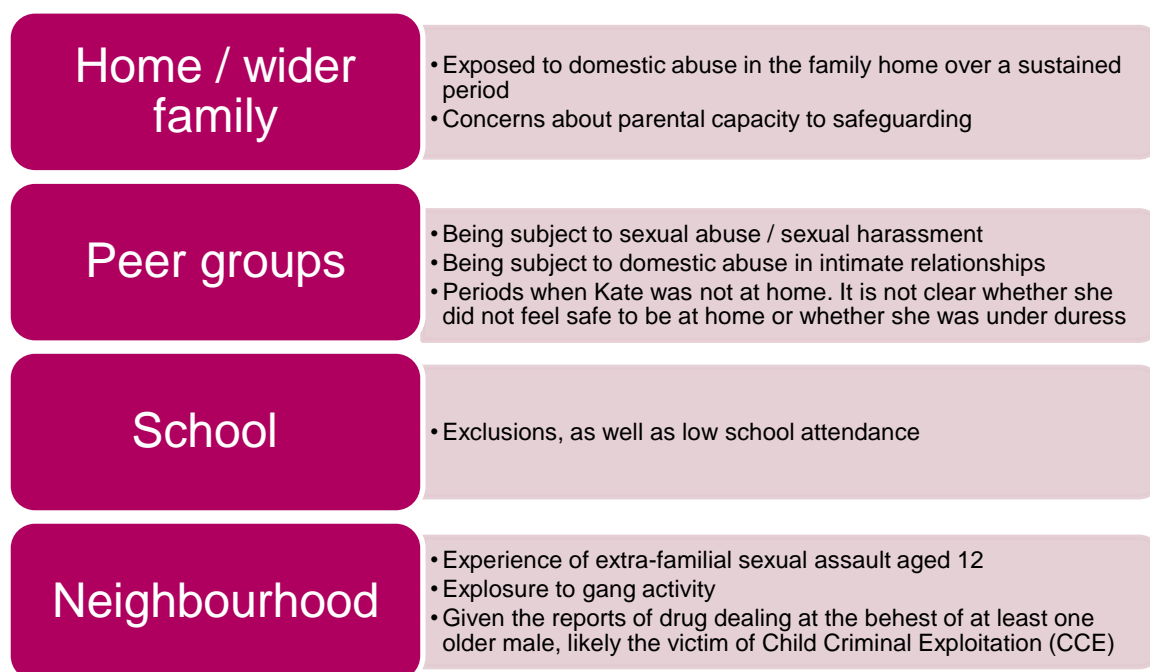
1.6.19 It is also of note that all the incidents of abuse that Kate reported to the MPS occurred after she had separated from Xavier. This does not mean that the Review Panel is of the view that Xavier’s behaviour suddenly and inextricably began. Rather, the information available to the Review Panel indicates that Xavier’s behaviour was coercively controlling during the relationship (but was not reported at the time, although Kate told family and friends), it then escalated after their separation.

1.6.20 The impact on Kate was significant, and she was clearly (and understandably) scared of Xavier. Tragically, it is not possible to ask Kate why she took a knife to her last meeting with Xavier, a meeting which appears to have been arranged to retrieve a phone that Xavier had taken. However, it is reasonable to assume that she did so because she wanted to be able to protect herself. Her multiple encounters with Xavier in the months beforehand, where he had been violent and abusive, are surely relevant to her decision to carry a knife.

⁴² The use of where online platforms is used to perpetrate domestic abuse and is described as ‘tech abuse’. For more information, go to: <https://safelives.org.uk/tech-vs-abuse>.

- 1.6.21 All of these types of abuse, as well as a victim’s fear, are included in the DASH RIC as examples of ‘high risk’ factors.⁴³
- 1.6.22 In this DHR, the Review Panel has been influenced by an approach known as a Contextual Case Review methodology. Contextual Case Review has been used to better understand the ‘peer-on-peer’ abuse that occurs between young people in either their friendship or intimate relationship.⁴⁴ A key concern about the responses to young people’s experience of violence has been that professionals do not always take extrafamilial risk (i.e. wider social context beyond the family) into account.⁴⁵
- 1.6.23 From a contextual safeguarding perspective, Kate was clearly vulnerable for much of the time period covered by this DHR, including when she was known to agencies. The risks she faced are summarised below in *Figure 1*. Additionally, while it is outside of the timeframe for this DHR, is also relevant to consider her extensive experience of domestic violence and abuse in the family home, as well as her experience of sexual assault (in 2012).

Figure 1: Contextual summary of the risks to Kate



⁴³ For more information on the DASH RIC, go to: <http://www.safelives.org.uk/node/516>.

⁴⁴ Firmin, C., Curtis, G., Fritz, D., Olatain, P., Latchford, L., Lloyd, J. and Larasi, I. (2016) *Towards a Contextual Response to Peer-on-peer Abuse: Research and Resources from MsUnderstood Local Site Work 2013 -2016*. Luton: University of Bedfordshire.

⁴⁵ Firmin, C. (2017). Contextualizing case reviews: A methodology for developing systemic safeguarding practices. *Child & Family Social Work* 23(1):45–52.

- 1.6.24 Given these contextual factors, it is reasonable to suggest that, to assess and intervene successfully, agencies would have needed to have identified and responded to these different issues.
- 1.6.25 In making this observation, the Review Panel felt it important to note that, in drawing attention to the experiences and circumstances that made Kate vulnerable, it is important to recognise that these do not constitute a complete picture of Kate's life. For example, her family and friends have described her as warm and full of character. They have also described her goals and ambitions, which she was also fulfilling: from 2016 onwards, she had undertaken vocational training and secured employment in an industry that she was passionate about.

1.7 Conclusions and key issues arising from this DHR

- 1.7.1 Kate was a daughter, sister and friend. The accounts from family and friends shared as part of this DHR speak to Kate as a charismatic and ambitious young woman. She had experienced trauma, in the home as a child and as a young person outside it, and in her relationships. At times, her experiences meant that Kate had struggled. However, she had worked hard to overcome these challenges and her family sought to support her as she did so (in particular her mother), as did several professionals. Ultimately, Kate's perseverance paid off. She had completed training, and then secured work, in an industry she was passionate about and was in the process of entering adulthood and building a life.
- 1.7.2 Yet, tragically, Kate's life was cut short and Xavier has been convicted of her manslaughter. The Review Panel extends its sympathy to the family and friends of Kate for their loss.
- 1.7.3 The circumstances of Kate's death are unusual: she died during an argument with Xavier outside his home, after falling on a knife she had been carrying in her bag. Yet, the unusual circumstances should not distract from Xavier's responsibility. At the end of Xavier's trial, the Judge themselves noted that Xavier had played a part in the build-up to the confrontation, suggesting that Kate had brought a knife because she had expected it to be so serious. That fear reflects the reality of Xavier's broader behaviour towards Kate: all the evidence shared with the Review Panel points to the violent and abusive behaviour he perpetrated.
- 1.7.4 The Review Panel has tried to explore Kate's lived experiences and consider the issues she faced to try and understand the circumstances of the homicide and identity relevant learning. This has been challenging for several reasons. First, during the DHR, the chair shared their reflection that this was one of the most distressing and challenging cases they had reviewed, not least because the death of someone so young is particularly hard to bear. Many on the Review Panel agreed. Second, the number of boroughs and agencies who had some involvement means the DHR has been complex. As a result, the Review Panel has had to make decisions about what issues to focus on and, where it has decided not to explore a particular line of enquiry, has sought to be clear why.
- 1.7.5 There has been significant learning identified during this DHR, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships across the London boroughs

involved, to further develop their response to domestic violence and abuse. In this endeavour, the Review Panel has been aided to a great extent by help from family members and extends its thanks to all those who have participated in this DHR. The learning is summarised below.

1.8 Lessons to be learnt

- 1.8.1 The learning in this DHR has been extensive. Individually, many of the agencies involved in this DHR have made recommendations to address learning they have identified. These reflect a range of issues, from professional curiosity to decision making and developing robust action plans, to record-keeping.
- 1.8.2 More broadly, this DHR has identified learning across three areas. First, and perhaps most importantly, the importance of contextual safeguarding. Broadly put, contextual safeguarding emphasises an approach to young people's experience of harm that includes recognising the significance of multiple, sometimes overlapping relationships, including at home and in the family; in peer groups; schools; and neighbourhoods. To address the risks and needs arising as a result, and to avoid victim blame, agencies need to engage in different ways, in particular in terms of assessment and intervention. This DHR has highlighted how multi-agency and professional practice in Merton at times varied, in some cases evidencing good practice and strong professional relationships with Kate. Ultimately, these interventions were positive and helped Kate make changes in her own life. Yet at times, there were barriers to this, often arising from the ways that different multi-agency fora interacted, or because domestic violence and abuse was obscured by a focus on other issues like CSE or CCE. In contrast, while Merton had extensive context, agencies in Bromley had almost no contact. In particular, at the MASH an awareness of Kate's previous experiences did not inform decision making. The key recommendation made by the Review Panel in response is for the Safeguarding Children Partnership in Bromley, Lewisham and Merton to be assured of the robustness of response to all forms of extra-familial harm young people experience.
- 1.8.3 Second, cross border working. For various reasons, Merton and Bromley Children's Social Care did not work together effectively to manage the move of Kate and her family to Bromley. This meant that there was both insufficient attention to the support that Kate (and her family) may have needed as part of this move and also, critically, affected the later decisions made in the Bromley MASH as noted in the previous paragraph. In considering this issue, the Review Panel received assurances about changes in practice in each borough which should mean that something similar would not happen again but has nonetheless made recommendations to address learning on a regional basis.
- 1.8.4 Third, responses to domestic violence and abuse. As noted above, in Merton domestic violence and abuse was obscured by a focus on other issues like CSE or CCE, both for Kate and also her family. In the MPS' contact with Kate, the Review Panel has interrogated how risk was assessed. In part, this reflects the learning from the IOPC investigation about how the incidents were seen in isolation. It is also a response to the Review Panel's view of the assessed risk. In several contacts, the Review Panel is of the view that risk was greater than that which was assessed. The Review Panel has made recommendations about this, as well as reflecting on broader issues that arose as a result in terms of

the pathway to multi-agency responses via the MARAC. A further area of learning in terms of domestic violence and abuse is the information provided to victim/survivors. In particular, the Review Panel has recommended to the MPS that police officers have the training and resources to provide appropriate and targeted advice on specialist domestic abuse support services. Finally, the Review Panel considered the partnership response to domestic violence and abuse in adolescent relationships. While work is ongoing in Bromley, Merton and Lewisham, it has recommended that each borough review their response, not least to ensure there is sufficient specialist provision to support this client group. In making this recommendation, the Review Panel has been clear that any actions taken need to reflect the links to the broader contextual safeguarding agenda to avoid either creating or re-enforcing silos between different types of harm.

- 1.8.5 As a final reflection, learning has been identified around the provision of support to family members as part of the DHR process. This has included recognising the importance of inter-agency working between advocacy services, as well as clarity around the support offer (not least for family members, but also chairs).
- 1.8.6 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively, in this case in Lewisham but also other boroughs. The Review Panel hopes that this DHR informs local processes, systems and partnership working, with this underpinned by a recognition that collectively it is possible to make the future safer.

1.9 Single Agency Recommendations – family advocacy agencies

AAFDA

- 1.9.1 Improve case management logging.
- 1.9.2 To reach an agreement with partner agencies over roles and responsibilities when working with a client and for this to be documented and regularly reviewed.
- 1.9.3 To clarify roles and responsibilities with clients.
- 1.9.4 Routine offer of translation/interpreter services to clients. The offer should be repeated.
- 1.9.5 Make better use of the available settings on WhatsApp and Messaging services.

VSHS

- 1.9.6 All those involved with the DHR process; chair, panel and advocates will support the advocacy choice of the client and work together to facilitate this.

- 1.9.7 Communication between advocates and the chair to be improved.
- 1.9.8 Communication between advocates where there is more than one advocate to be improved.
- 1.9.9 VSHS case management notes:
 - Case workers to ensure notes are recorded in the case management system even when this is a repeat of an already established fact.
 - Management to ensure all case discussions and decisions are recorded within the electronic case records and complaints log if appropriate.

All other agencies

Bromley Healthcare

- 1.9.10 It is recommended that clinicians ensure the patient is seen alone when accompanied. It has been reiterated to all clinical staff that this must be documented in the notes in light of this incident.

Bromley Council Children's Social Care

- 1.9.11 To support best practice, the processes for managing cross-borough case transfer requests to remain within the MASH Team ensuring clear management oversight and appropriate threshold application informed by a review of all the information available.

CLCH

- 1.9.12 7-minute briefing developed to highlight learning from this DHR.
- 1.9.13 Domestic abuse champion programme to be developed across CLCH services.
- 1.9.14 Awareness of ACEs /trauma-informed care to be incorporated into domestic abuse training.
- 1.9.15 Awareness of contextual safeguarding to be included in safeguarding training.

Figges Marsh Surgery

- 1.9.16 Raise awareness amongst primary health care team that vulnerable young people should be booked a follow up appointment if there are concerns, as a way of safety netting, as if they don't come back a DNA process will be followed.
- 1.9.17 More systematic recording of assessment under Fraser competencies – consider the introduction of a template to record this information.
- 1.9.18 Recording of details of person attending with a child/young person. Offer for them to also be seen alone and document outcome as this may provide an opportunity for disclosure.
- 1.9.19 Maintain professional curiosity and to try to 'look behind' presenting behaviours.

- 1.9.20 For primary care to continue to try to work professional to professional with local partners such as social care and education in the care of children and young people.

London CRC

- 1.9.21 Sharing the lessons learnt from this DHR across the London CRC.
- 1.9.22 Continuation of Public Protection Boards to develop practice and policy, including in regard to domestic abuse and safeguarding.
- 1.9.23 Continued training including in regard to domestic abuse and safeguarding.
- 1.9.24 Emphasis on end-of-sentence review of sentence plan, including the provision of post-sentence support and consideration of information sharing with partner agencies where appropriate.

Merton Council Children's Social Care

- 1.9.25 Ensure all case transfer conferences are held in the local authority where the child or young person is living and that the relevant members of the network have been included.
- 1.9.26 Step down plans need to be SMART and to have a contingency.
- 1.9.27 Where contextual safeguarding issues have been a concern there needs to be consideration of how this will be monitored in the new authority and that there is information sharing with the Multi-Agency Sexual Exploitation (MASE) as well as the relevant social work team.

Merton Council Adolescent and Family Service

- 1.9.28 Merton now has a combined panel for CSE, CCE and Serious Youth Violence (MARVE). It is recommended that Merton review the MARVE Protocol and Panel Terms of Reference to ensure that it is clear that cases involving domestic violence (whether the young person or their parents) are also considered for a MARAC referral and consultation.

Metropolitan Thames Valley Housing

- 1.9.29 Review information sharing agreements so that channel of communications are open and there are no barriers to sensitive information being shared.
- 1.9.30 Review which member of staff attends what meetings.
- 1.9.31 How we store information from these meetings to take into account staff turnover and changes.

MPS

- 1.9.32 All MPS boroughs will create a Criminal Intelligence (CRIMINT) entry listing the details of all subjects and offenders considered by the borough MARAC for each meeting.

SWLStG Trust

- 1.9.33 SWLStG requires a Domestic Abuse Policy.
- 1.9.34 A business case for a domestic abuse Trust lead should be formulated.

- 1.9.35 Enhanced training in domestic abuse should be rolled out across the Trust.
- 1.9.36 Trust-wide Domestic Abuse Conference should take place on 10th December 2019 to raise awareness of the issue.
- 1.9.37 Staff should only use family members as interpreters in an emergency or crisis situation, where other options are not available.

1.10 Multi Agency Recommendations:

- 1.10.1 **Recommendation 1:** AAFDA and VSHS to develop a Memorandum of Understanding on joint working.
- 1.10.2 **Recommendation 2:** The Home Office to ensure that the guidance concerning support for families during the DHR process is updated and facilitates the centrality of family involvement by setting out key principles and expected working practices (including joint working between advocacy services, the role of chairs and review panels, as well as commissioning arrangements).
- 1.10.3 **Recommendation 3:** The Home Office and Ministry of Justice to evaluate what works in terms of family involvement in the DHR process (from commissioning and commencement of DHRs, to the provision and commissioning of specialist and expert advocacy support for families, as well as the role and practice of chairs and review panels).
- 1.10.4 **Recommendation 4:** The Safer Lewisham Partnership to satisfy itself that Child A and B (and Kate's family) are offered support in relation to the publication of the DHR.
- 1.10.5 **Recommendation 5:** The Safer Lewisham Partnership should produce and publish a learning summary, as well as facilitate a range of disseminating events to share the learning from this DHR.
- 1.10.6 **Recommendation 6:** The London Children's Social Care Practice Leaders Group is asked to respond to concerns that there are delays in carrying out notifications of moves across boroughs and in the transfers of cases. In particular, to give a view on whether there are adequate escalation processes in place and whether they are used.
- 1.10.7 **Recommendation 7:** The Editorial Board of the London Child Protection Procedures to consider whether the wording of the Procedures in relation to the movement of children subject to Child Protection Plans is adequate, and once agreed or amended, to remind safeguarding professionals of the requirements in the Procedures.
- 1.10.8 **Recommendation 8:** The MPS to consider the learning from this case, reflecting both the IOPC findings and the above reflections by the Review Panel, and review current policy and practice in relation to risk assessment relating to young people experiencing domestic violence and abuse.
- 1.10.9 **Recommendation 9:** The MPS to ensure that police officers are aware of the different referral routes to MARAC.

- 1.10.10 **Recommendation 10:** The Safer Lewisham Partnership to review the current threshold for making referrals to the local MARAC on the basis of escalation.
- 1.10.11 **Recommendation 11:** The MPS to ensure that police officers have the training and resources to provide appropriate advice on specialist domestic abuse support services.
- 1.10.12 **Recommendation 12:** The Safer Lewisham Partnership, as well as the CSPs in Bromley and Merton, to respectively review their understanding of need, strategy and actions plans in response to domestic abuse in adolescent relationships and ensure there is sufficient specialist provision to support this client group.
- 1.10.13 **Recommendation 13:** The Safeguarding Children Partnerships in Bromley, Lewisham and Merton respectively to seek assurance as to the robustness of:
- Social care response to all forms of extra-familial harm young people experience (including domestic violence and abuse), including how consideration of peers, places and schools is integrated into assessments; and
 - The join up between social care and youth justice responses (including multi agency meetings) so that there is a shared objective and coordinated interventions around safety and safeguarding in relation to young people in these different arenas.
- 1.10.14 **Recommendation 14:** Lewisham Council Children’s Social Care to work with Merton and Bromley to identify the best way to work with regional partners to develop a Multi-Agency Sexual Exploitation (MASCE) / Multiagency, Vulnerability and Exploitation Panel (MARVE) / Contextual Safeguarding Single Point of Contact (SPOC) network.