# SAFER LEWISHAM PARTNERSHIP DOMESTIC HOMICIDE REVIEW

**Overview Report into the Death of Donna Williamson**
**August 2016**

**Independent Chair and Author of Report: Althea Cribb**
**Associate, Standing Together Against Domestic Violence**
**Completion (sent to SLP): March 2018**

# Contents

# 1. Executive Summary

1.1.1. This summary outlines the process undertaken by Lewisham Domestic Homicide Review (DHR) Panel in reviewing the homicide of Donna Williamson who was a resident in their area.

1.1.2. The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members: Donna Williamson and YZ.

1.1.3. Criminal proceedings were completed in February 2017 and the perpetrator was found guilty of murder; he received a life sentence with a minimum term of 20 years.

1.1.4. The process began with an initial discussion by the Safer Lewisham Partnership in August 2016 when the decision to hold a DHR was agreed. All agencies that potentially had contact with Donna Williamson or YZ prior to the point of death were contacted and asked to confirm whether they had involvement with them.

# 2. Preface

## 2.1. Introduction

2.1.1. Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

2.1.2. This DHR (Review) examines agency responses and support given to Donna Williamson, a resident of Lewisham, prior to her murder at her home in August 2016.

2.1.3. Donna Williamson was stabbed by YZ in her own home. He was convicted after trial in early 2017, and he received a life sentenced with a minimum term of 20 years.

2.1.4. This Review will consider agencies contact/involvement with Donna Williamson and YZ from 1 January 2008 to the date of the homicide, alongside information from any of their family or friends who agree to participate in the Review.

2.1.5. The Review aims to examine Donna Williamson and YZ's past to identify any relevant background or trail of abuse before the homicide. This may include whether support was accessed within the community and whether there were any barriers to Donna Williamson accessing support. By taking a holistic approach the Review seeks to identify appropriate solutions to make the future safer for other women in situations such as Donna Williamson's.

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

2.1.7. In identifying learning and how this can be acted upon as part of this Review process, the independent chair and Review Panel have been mindful of the fact that this is the seventh Domestic Homicide Review in Lewisham.

2.1.8. This Review process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

2.1.9. The Review Panel expresses its sympathy to the family and friends of Donna Williamson for their loss and thanks them for their contributions and support for this process.

## 2.2. Timescales

2.2.1. The Safer Lewisham Partnership, in accordance with the March 2013 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, commissioned this Review. The Home Office were notified of the decision in writing in August 2016.

2.2.2. Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this Review in August 2016. The completed report was handed to the Safer Lewisham Partnership in March 2018.

2.2.3. Home Office guidance states that DHRs should be completed within six months of the initial decision to establish one; this was not achieved. The first meeting was delayed to ensure that all panel representatives could attend, including the independent chair, Standing Together DHR Team and the Safer Lewisham Partnership lead identifying all the agencies that needed to attend. A long timeframe was given for agencies across two local authorities to complete their IMRs to ensure that these were all submitted prior to the Review Panel meetings to discuss them; due to the number of these and length of some of them, four meetings were held to allow time for review and analysis. Completion of the Review was extended to ensure that Donna Williamson's family had the time to read the draft report and comment on it.

## 2.3. Confidentiality

2.3.1. The findings of this Review are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel.

2.3.2. This Review has been suitably anonymised in accordance with the 2016 guidance. The specific date of death has been removed and only the independent chair and Review Panel members are named.

2.3.3. The family expressed to the independent chair that they wished the Review to be published with Donna Williamson's real name. The independent chair outlined that the Review process was established and proceeded on the basis of the final publication being anonymised. Having proceeded on this basis, it was not a decision for the independent

chair or Review Panel to make but that the family could make a representation to the Home Office if they wished.

2.3.4. As a result, the victim is referred to as Donna Williamson and the perpetrator as YZ in the Overview Report and Executive Summary.

## 2.4. Equality and Diversity

2.4.1. The independent chair and the Review Panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the Review process, as well as considering what additional vulnerabilities or issues Donna Williamson and YZ may have experienced.

2.4.2. At the first meeting, the Review Panel agreed that the following protected characteristics and additional vulnerabilities were relevant in relation to what was known about Donna Williamson at that time: her physical impairment / health issues; her mental health issues; her problematic alcohol use; and the impact of the fact that she had experienced domestic abuse from YZ for many years.

2.4.3. That Donna Williamson was female, and experienced abuse from (and was killed by) her male partner, was also agreed as an important factor in the Review. Research shows that the majority of domestic abuse victims[1], and domestic homicide victims, are female; and that the majority of perpetrators of both domestic abuse and domestic homicide are male[2]. The Review Panel considered this factor alongside the fact that Donna Williamson had at times been identified by agencies as a perpetrator of domestic abuse against YZ, and that she had been convicted of assaulting him. The Review Panel agreed this was a key line of inquiry.

2.4.4. The panel additionally discussed the protected characteristics and additional vulnerabilities in relation to what was known about YZ, and these were: problematic alcohol use; his role as a carer for a member of his family; his mental health issues; and his experiences of violence from Donna Williamson.

## 2.5. Terms of Reference

2.5.1. The full Terms of Reference are included at Appendix 1. This Review aims to identify the learning from DWs and YZ's case, and for action to be taken in response to that learning:

[1] Walby, S. & Allen, J. (2004) 'Domestic violence, sexual assault and stalking: Findings from the British Crime Survey' Home Office Research Study 276, particularly p25: "*Women constituted 89 per cent of all those who suffered four or more incidents.*"

[2] "*In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over*". Home Office (2016) "*Key Findings from Analysis of Domestic Homicide Reviews*" p.3
"*Analysis of a STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent of victims and men ninety-seven per cent of perpetrators*". Sharp-Jeffs, N. and Kelly, L. (2016) *Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* p.69

with a view to preventing homicide and ensuring that individuals and families are better supported.

2.5.2. The Review Panel comprised agencies from Lewisham, as Donna Williamson was resident in that area at the time of the homicide. Agencies were contacted as soon as possible after the Review was established to inform them of the Review, their participation and the need to secure their records.

2.5.3. As information was provided during the initial stages of the Review, it was established that YZ lived in Greenwich, and both he and Donna Williamson had contact with agencies in that borough. Therefore, agencies were contacted for information and involved in the Review as required.

2.5.4. At the first meeting, the Review Panel shared brief information about agency contact with Donna Williamson and YZ, and as a result, established that the time period to be reviewed would be from 1 January 2008 to the date of the homicide. This would cover the time that Donna Williamson and YZ were in a relationship, and in addition their substantive contact with agencies.

2.5.5. *Key Lines of Inquiry:* The Review Panel considered the issues set out in the 2013 Guidance and identified and considered the following case specific issues (please also see the Equality and Diversity section above, 1.4):

(a) Drug and alcohol use (Donna Williamson and YZ)
(b) Mental health issues (Donna Williamson and YZ)
(c) Physical health issues and impairment (Donna Williamson)
(d) Clients who engage and disengage from services (Donna Williamson and YZ)
(e) Situations in which a victim of domestic abuse (Donna Williamson) is also identified as a perpetrator
(f) Responses to victims of domestic abuse (Donna Williamson) identified as high risk, including but not limited to the Multi-Agency Risk Assessment Conference (MARAC) process. (These terms are explained in Appendix 4.)

2.5.6. The independent chair and Review Panel agreed that the presence of the following agencies on the panel would ensure that relevant expertise was in place to fully address the above issues:

(a) CGL (Aspire, Greenwich and New Direction, Lewisham) *community drug and alcohol agencies*
(b) South London and Maudsley NHS Foundation Trust *mental health trust*
(c) Together for Mental Wellbeing *charity for people with mental health issues*
(d) Refuge and Housing for Women *specialist domestic abuse services*

## 2.6. Methodology

2.6.1. Throughout the report the terms 'domestic abuse', 'domestic violence' and 'domestic abuse/violence' are used interchangeably. The report uses the cross-government definition of domestic violence and abuse as issued in March 2013. It is included here to assist the reader to understand that domestic abuse/violence is not only physical violence but a wide range of abusive and controlling behaviours. The new definition states that domestic violence and abuse is:

"*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*

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

*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*" [3]

2.6.2. This Review has followed the 2013 and 2016 statutory guidance for Domestic Homicide Reviews issued following the implementation of Section 9 of the *Domestic Violence Crime and Victims Act 2004*. This Review was initiated before the refreshed 2016 Guidance was issued but the independent chair and Review Panel have been mindful of the 2016 Guidance.

2.6.3. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Donna Williamson and/or YZ. Twenty-three agencies submitted IMRs and chronologies, and four agencies provided information or chronologies only due to the brevity of their involvement. The chronologies were combined into one document.

2.6.4. *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. In a small number of cases this was not possible due to the very small size of the staff in an agency, and has been addressed in this Overview Report. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Donna Williamson and/or YZ, and to produce the learning for the

[3] This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf

Review. Where necessary further questions were sent to agencies and responses were received; either in the form of an addendum to their IMR or a re-written IMR.

2.6.5. Some agencies submitted IMRs without addressing the Terms of Reference and with minimal or no analysis. As a result, the independent chair compiled questions and responses from the Review Panel and these were shared with the agencies. Responses were received enabling the Review to adequately address the learning.

2.6.6. Thirteen IMRs made recommendations of their own, and in panel meetings agencies evidenced that action had already been taken on these. Where necessary, IMRs identified changes in practice and policies over time. The IMRs and panel discussions of them have also informed the recommendations in this Overview Report.

2.6.7. *Documents Reviewed:* In addition to the twenty-seven IMRs or information provided, documents reviewed during the Review process have included the Judge's sentencing remarks and research relevant to the case. The six previous DHRs completed in Lewisham were also reviewed to ensure that the recommendations in this Review take account of the cumulative learning and many actions taken in Lewisham.

2.6.8. *Interviews Undertaken:* In addition to contact with the family and friends (see below), the independent chair of the Review undertook two interviews in the course of the Review. These were with the current and former Detective Inspectors with responsibility for the Perpetrator Intervention Team (PIT) based in the Metropolitan Police Service Community Safety Team in Greenwich.

## 2.7. Contributors to the Review

2.7.1. The following agencies and their contributions to this Review are:

| **Agency** | **Contribution** |
|---|---|
| CGL Aspire (Greenwich) | IMR and Chronology |
| CGL New Direction (Lewisham) | IMR and Chronology |
| Crown Prosecution Service | Information provided |
| Donna Williamson's General Practice | IMR and Chronology |
| Her Centre | IMR and Chronology |
| Housing for Women | IMR and Chronology |
| YZ's General Practice | IMR and Chronology |
| Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital; Woolwich and University Hospital Lewisham) | IMR and Chronology |
| London Ambulance Service NHS Trust | IMR and Chronology |
| London Borough of Lewisham Adult Social Care | IMR and Chronology |

| | |
|---|---|
| London Borough of Lewisham Crime Enforcement and Regulation Service | IMR and Chronology |
| London Borough of Lewisham Single Homeless Intervention and Prevention Service (SHIP) | IMR and Chronology |
| London Borough of Lewisham Multi-Agency Risk Assessment Conference | IMR and Chronology |
| London Fire Brigade | Information provided |
| Metropolitan Police Service | IMR and Chronology |
| National Centre for Domestic Violence | IMR and Chronology |
| National Probation Service | IMR and Chronology |
| Oxleas NHS Foundation Trust | IMR and Chronology |
| Princess Royal University Hospital | Information provided |
| Refuge | IMR and Chronology |
| Royal Borough of Greenwich Adult Social Care | IMR and Chronology |
| Royal Borough of Greenwich Housing Options and Support Service | IMR and Chronology |
| Royal Borough of Greenwich Multi-Agency Risk Assessment Conference | IMR and Chronology |
| South London and Maudsley NHS Foundation Trust | IMR and Chronology |
| Thames Reach | Information provided |
| Together for Mental Wellbeing | IMR and Chronology |
| Victim Support | IMR and Chronology |

## 2.8. The Review Panel

2.8.1. The Review Panel Members were:

| Panel Member | Job Title | Organisation |
|---|---|---|
| Wayne Butcher | Service Manager | CGL Aspire (Greenwich) |
| Ed Shorter | Service Manager | CGL New Direction (Lewisham) |
| Julie Sargent | Service Manager | Her Centre |
| Judith Banjoko | Services Manager | Housing for Women |
| Teresa Sealy | Named Clinician Safeguarding Consultant Physician, University Hospital Lewisham | Lewisham and Greenwich NHS Trust |
| Julie Carpenter<br>Philip Powell | Safeguarding Specialist – Adults<br>Stakeholder Engagement Manager | London Ambulance Service NHS Trust |

| | | |
|---|---|---|
| Adeolu Solarin | Violence Against Women and Girls Lead | London Borough of Lewisham |
| Aileen Buckton | Director of Community Services | London Borough of Lewisham |
| Brian Scouler | Service Manager Safeguarding Quality Assurance Service, Adult Social Care | London Borough of Lewisham |
| Gary Connors | Service Manager, Crime Enforcement and Regulation | London Borough of Lewisham |
| Geeta Subramaniam-Mooney | Head of Public Protection and Safety | London Borough of Lewisham |
| John Barker | Service Manager, Single Homeless Intervention and Prevention Service (SHIP) | London Borough of Lewisham |
| Janice Cawley | DS, Specialist Crime Review Group | Metropolitan Police Service |
| Martin Stables | DCI, Lewisham | Metropolitan Police Service |
| Clare Capito | Deputy Regional Maternity Lead for London and NHS England London Representative | NHS England |
| Graham Hewett | Associate Director for Quality and Adult Safeguarding | NHS Lewisham CCG |
| Adam Kerr | Head of Croydon, Merton, Sutton | National Probation Service |
| Harold Bright | Central AMHP Team | Oxleas NHS Foundation Trust |
| Denise Brown | Senior Operations Manager | Refuge |
| Annette Hines | Community Safety Officer (VAWG and Hate Crime) | Royal Borough of Greenwich |
| Peter Davis | Head of Safeguarding, Greenwich Adult Social Services | Royal Borough of Greenwich |
| Lucy Stubbings | Head of Patient Safety | South London and Maudsley NHS Foundation Trust |
| Anabel Cando | Project Manager | Together for Mental Wellbeing |
| Joanna Davidson | Senior Services Delivery Manager | Victim Support |

2.8.2. *Independence and expertise*: Agency representatives were appropriate in relation to their independence from the case, their level of expertise in relation to domestic abuse and the additional issues identified (see 1.4).

2.8.3. The Review Panel met seven times, with the first meeting of the Review Panel in October 2016. There were subsequent meetings in February, March, April, May, July and October 2017. There was an additional Panel meeting in November 2017 with Donna Williamson's family.

2.8.4. The Independent Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

## 2.9. Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

2.9.1. The Independent Chair of the Review and the Review Panel acknowledged the important role Donna Williamson's and YZ's families and friends could play in the Review. From the outset, the Review Panel decided that it was important to take steps to involve family, friends and neighbours.

2.9.2. Following discussions with Panel, including the police Family Liaison Officer and Senior Investigating Officer, consideration was given to approach:

(a) The family of Donna Williamson.

(b) The family of YZ (see 1.10).

(c) Friends of Donna Williamson who had been in contact with police during the investigation into Donna Williamson's homicide.

(d) A former neighbour of Donna Williamson who had contacted London Borough of Lewisham about Donna Williamson in the past.

2.9.3. The rationale for this list was based on those people with whom agencies had previously, or were still, in contact, and as a result were able to pass on letters from the independent chair.

2.9.4. Introductory letters were passed on as early as possible to all those listed in 1.9.2. In some cases, the letters did not invite participation until following the completion of the criminal trial. All letters were sent on by police so that the individual's details remained confidential and were not shared with the independent chair or Review Panel. Subsequent letters were sent following the completion of the trial.

2.9.5. All letters outlined the DHR process, and emphasised that involvement in the process was voluntary, and could happen at a time and in a way that was best for them. They detailed

that involvement could happen in a number of ways including a face to face meeting or telephone or skype conversation with the independent chair, email or through making a statement to the Review. Included with the letters was information (or a leaflet) about Advocacy After Fatal Domestic Abuse (AAFDA) support and the appropriate Home Office DHR leaflet.

2.9.6. With the letters and contact with Donna Williamson's family, the independent chair was mindful of the ongoing criminal investigation and the Independent Police Complaints Commission (IPCC) investigation (see 1.11 below) so as to ensure the family were not overwhelmed with contacts from different places, and understood that the processes were separate.

2.9.7. Donna Williamson's family contacted the independent chair as they wished to contribute to the Review through a face to face meeting. Prior to this meeting the Terms of Reference were shared with the family.

2.9.8. The independent chair met with Donna Williamson's mother, aunt and two brothers at an early stage in the Review process. They were asked for any comments on the Terms of Reference, and whether they had any specific questions or areas they wanted the Review to address. Their comments, feedback and questions have been included in this Overview Report and the independent chair and Review Panel have been mindful of their concerns throughout the Review.

2.9.9. The family of Donna Williamson were supported initially by the police Family Liaison Officer and by a solicitor the family had engaged. Subsequently they have been supported by a specialist advocate from AAFDA.

2.9.10. The family wished to read the draft Overview Report, and this was arranged with the support of the AAFDA advocate. A copy of the report was given to the AAFDA Advocate, who read the report and then gave it to the family with an introduction. The report was then left with the family for two weeks for them to read it. The independent chair then met with the family, their solicitor, and the AAFDA Advocate, to hear their feedback and questions, and this has been added to the Overview Report. They also reviewed a later draft of the Overview Report, and the draft Executive Summary

2.9.11. The family chose to meet with the Review Panel. They selected certain agencies from the agencies on the Review Panel and prepared a list of questions for those agencies. The meeting was held at the end of November 2017. Agencies expressed their condolences to the family, answered the questions put by the family, including provided updates on actions taken since the Review had started to improve practice and responses.

2.9.12. The family requested that the Safer Lewisham Partnership update them on the progress of the Overview Report recommendations. This recommendation (1) is made.

2.9.13. After receiving no response, the independent chair wrote again to Donna Williamson's friends and to her former neighbour to find out if they wished to be part of the Review. No response was received with the exception of an email received from a friend of Donna Williamson's. The independent chair attempted contact with this friend on a number of occasions to seek consent to use the information provided and to ask further questions, but was unsuccessful.

2.9.14. Donna Williamson's landlord was written to through the London Borough of Lewisham Single Homeless Intervention and Prevention Service (SHIP), as they were the service who had the contact details. The letter contained all of the information as set out above (see 1.9.5). No response was received.

## 2.10. Involvement of YZ and his Family

2.10.1. YZ was written to in prison following the completion of the criminal trial. This contact was facilitated by the National Probation Service (NPS) panel member.

2.10.2. YZ was sent a letter from the independent chair via the prison governor with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. This was followed by a phone call to the prison to ensure YZ had received the letter.

2.10.3. YZ returned the signed consent form and stated that he wished to be interviewed for the Review. The independent chair attempted to arrange a meeting on a number of occasions but was unable to agree a date; the Review then came to an end without this interview having taken place.

2.10.4. YZ's family were written to as set out above (see 1.9). No response was received, and the independent chair worked with a member of the Review Panel whose agency had previously had contact with the family to explore other means of passing on information about the Review and an invitation to participate (while keeping the family's details confidential to that service). Unfortunately, this agency was no longer in contact with the family and was not able to pass a letter on.

## 2.11. Parallel Reviews

2.11.1. *Criminal trial:* At the start of the Review process, the criminal investigation was ongoing. The Senior Investigating Officer attended the first Review Panel meeting to provide an update on the progress of the investigation, and to ensure that the Review Panel were aware of disclosure issues (see Terms of Reference, Appendix 1) and any witnesses to ensure that contact was appropriately timed (see 1.9 above). The trial was completed prior to the sharing of IMRs and chronologies.

2.11.2. *Independent Office for Police Conduct*[4]: The independent chair and Review Panel were informed at the start of the Review process that an IOPC investigation had been established. The independent chair made contact as early as possible with the investigation lead, to understand the scope of the investigation and to ensure that contact with the family could be managed in a way that minimised any distress to them.

2.11.3. The scope of the IOPC investigation was to "*Investigate Metropolitan Police Service contact with Donna Williamson and YZ on [the date of the homicide] and to specifically examine: the information available to Police regarding Donna Williamson and YZ; and the information assessed and shared during the PNC*[5] *check of YZ.*"

2.11.4. The independent chair stayed in regular contact with the investigation lead to ensure that the two processes could inform each other as appropriate. The overview of the findings was shared with the independent chair and the Review Panel. Actions were taken by the IOPC and MPS in response to those findings. Publication will be considered following the completion of the coroner's inquest.

2.11.5. *Coroner:* While the DHR was in progress, the Coroner's Office (Inner South London Coroner's Court) informed the chair that an inquest had not been held, due to the outcome of the criminal trial. Following representations from the family, the Coroner's Office held a pre-inquest hearing in March 2018 at which a decision was made to hold a full inquest. This would be scheduled later in 2018.

## 2.12. Chair of the Review and Author of Overview Report

2.12.1. The Independent Chair and Author of the Review is Althea Cribb, an independent consultant on domestic abuse and DHR Chair. Althea is an Associate DHR Chair with STADV and received DHR Chair's training from STADV. Althea has chaired and authored twelve reviews. Althea has ten years of experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse.

2.12.2. STADV 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.

2.12.3. STADV has been involved in the DHR process from its inception, chairing over 50 reviews.

[4] https://policeconduct.gov.uk

[5] Police National Computer

2.12.4. *Independence:* Althea Cribb has no connection with the Safer Lewisham Partnership or the Greenwich Community Safety Partnership, nor any of the agencies involved in this case.

## 2.13. Dissemination

2.13.1. Prior to publication, the following reviewed the Overview Report, Executive Summary and Action Plan:

- Donna Williamson's family
- Review Panel
- Safer Lewisham Partnership
- Standing Together Against Domestic Violence DHR Team

2.13.2. The above list will also receive confirmation of the publication of the DHR, with details of where to access it, or a printed copy.

2.13.3. Each agency involved in the Review is responsible for disseminating the report and the learning internally to staff.

2.13.4. In addition, the details of the published report will be sent to:

- Greenwich Community Safety Partnership
- Lewisham Safeguarding Adults Board
- Lewisham Safeguarding Children's Board
- Greenwich Safeguarding Adults Board
- Greenwich Safeguarding Children's Board

# 3. Background Information

| The principle people referred to in this report | | | | | | |
|---|---|---|---|---|---|---|
| **Referred to in report as** | **Relationship to Donna Williamson** | **Age at time of Donna Williamson death** | **Ethnic Origin** | **Faith** | **Immigration Status** | **Disability** |
| Donna Williamson | Victim | 44 | White British | None known | British citizen | Hip replacement |
| YZ | Perpetrator of homicide Partner / Ex-Partner of Donna Williamson | 37 | White British | None known | British citizen | None known |

## 3.1. The Homicide

3.1.1. On the evening of the homicide, Donna Williamson rang police from her home alleging that someone was kicking the door to her home. She believed it to be her ex-partner YZ. Donna Williamson called again around five minutes later to cancel police assistance, stating that it had been her cousin. Police attended and spoke with Donna Williamson who again said that it was a cousin who had been at the door. The premises were checked and nothing suspicious was found.

3.1.2. Donna Williamson phoned police again two hours later that night, stating that she was being beaten up. There was a loud disturbance heard in the background and a male (believed to be YZ) shouting words to the effect of "*you're dead*". The line remained open with the call handler typing that they could hear Donna Williamson struggling to breathe. A neighbour was recorded as calling shortly after Donna Williamson's call, reporting that a male was beating up a female at Donna Williamson's address.

3.1.3. Officers attended Donna Williamson's address and found her unconscious and not breathing. YZ was at the scene and was arrested for attempted murder. London Ambulance Service (LAS) attended, and police officers then paramedics attempted to resuscitate Donna Williamson. Donna Williamson had sustained two stab wounds to her chest and her life was pronounced extinct shortly after the paramedics' arrival, following which YZ was charged with her murder.

3.1.4. It is of note to this Review, and is the subject of the IPCC investigation (see 1.11) that between Donna Williamson's two calls to police that night, police received a call from a restaurant in Lewisham reporting a disturbance. When Police attended, they identified YZ as one of the males involved and requested intelligence checks on the PNC. The PNC operator did not highlight the bail conditions that were then in force which prohibited YZ from being in the London Borough of Lewisham, following his arrest and bail for assault

against Donna Williamson. YZ was allowed to leave the scene with no further action. Police identified the link between these events shortly after Donna Williamson's murder.

3.1.5. *Post Mortem*: The post mortem examination of Donna Williamson concluded that the cause of death was "*stab wounds to the chest*". Toxicology confirmed the presence of alcohol and other substances were detected but these findings had no bearing on the fatality of the inflicted injuries.

3.1.6. *Criminal trial outcome*: YZ was charged with Donna Williamson's murder. He was convicted after trial in early 2017, and he received a life sentence with a minimum term of 20 years.

3.1.7. *Judge sentencing summary*: The Judge highlighted the aggravating factors influencing the minimum term in this case:

- "*the use of a particularly nasty kitchen knife*"
- that YZ was "*on bail at the time of the offence in relation to an allegation of assault against the same victim*" and was in "*multiple breach of your bail at the time*"
- that YZ had a previous conviction for common assault against Donna Williamson
- that Donna Williamson was trying to call police for help when YZ killed her
- that Donna Williamson was "*particularly vulnerable; she was of limited mobility and she was also, like yourself, very drunk*"

3.1.8. The Judge further remarked on the fact that YZ made "*two strikes to the chest with that knife together with … 'horrible words'. In my judgement there is plainly intent to kill rather than a lesser intention to do really serious harm.*"

3.1.9. The Judge stated that, had YZ felt truly remorseful, he would have entered a guilty plea.

## 3.2. Background Information Relating to Donna Williamson

3.2.1. *Introduction to* Donna Williamson*:* Donna Williamson was aged 44 when she died. She lived alone in private rented accommodation in the London Borough of Lewisham, close to the border with the Royal Borough of Greenwich. She was not employed; she had previously worked in a café as a waitress. One agency worker who had worked with Donna Williamson described her as "*intelligent, articulate and someone who had a sense of humour*".

3.2.2. Donna Williamson*'s background and relationships:* Donna Williamson had left school at 16 to find work, and then moved out of her parent's home to live with her boyfriend. He died two years later, and Donna Williamson moved into a bedsit on her own. Donna Williamson's next relationship involved a pregnancy that resulted in her giving birth to a stillborn baby. The relationship ended and Donna Williamson became depressed, and moved back to her parents' home. Donna Williamson did not have another intimate relationship for many years. Her family said to police that when Donna Williamson's next

relationship started, she began to drink alcohol to excess; it had not previously been a feature of her life in any significant way. That relationship ended in approximately 2009.

3.2.3. Donna Williamson*'s physical health:* In 2007 (aged 35) Donna Williamson spent seven months in hospital (Lewisham and Greenwich NHS Trust) to undergo a hip replacement. This was the result of a left neck of femur fracture following a fall, which was initially treated with a cannulated screw but this subsequently failed and she had a total hip replacement. During her stay in hospital Donna Williamson underwent alcohol detox. She underwent further surgery on this at the end of 2007 due to infection.

3.2.4. *Contact with Police:* Donna Williamson had contact with the police on multiple occasions before 2010, often in relation to alcohol and also in relation to complaints from her neighbours. She was evicted from her property in 2005, following which she moved from Greenwich to Lewisham.

3.2.5. *Synopsis of* Donna Williamson*'s relationship with YZ:* It is believed that Donna Williamson and YZ's relationship began in late 2009/early 2010. They first came to the attention of police in 2010, and records from then suggest the relationship was in its early stages. Donna Williamson's family and friends did not know YZ well; Donna Williamson's family reported to police during the homicide investigation that they felt YZ treated Donna Williamson badly, and controlled her.

## 3.3. Background Information Relating to YZ

3.3.1. *Introduction to YZ:* YZ was aged 37 at the time of Donna Williamson's death. He lived in the Royal Borough of Greenwich with a family member for whom he was a carer. No information was provided to the Review to indicate that YZ was in work, or if he had worked previously, what that was.

3.3.2. *YZ's prior contact with police:* Police records show, between 2001 and 2004, three domestic incidents involving him and the family member he cared for, one of which involved violence from YZ to the family member. During this time YZ was in contact with police twice in relation to his then female partner(s) (it is not known if these were the same partners, or different ones). On one occasion a partner reported harassment and previous violence from YZ but did not provide a statement; on another YZ smashed a window at his ex-partner's house. YZ was also recorded to have been reported to police for being abusive to an unknown female while he was working.

# 4. Overview and Chronology

## 4.1. Information from Donna Williamson's Family

4.1.1. The independent chair met with Donna Williamson's mother (D), two brothers (E and F) and aunt (G). In addition to explaining the Review process to them, and answering questions they had about it, the chair asked a number of questions about Donna Williamson, her life and her relationship with YZ. Where they asked questions, where possible the chair committed to following these up as part of the Review.

4.1.2. During the meeting, and in the report of the meeting sent to the family, they requested that YZ be referred to as X. This has been respected in this part of the report, as it presents their thoughts and feelings.

**About Donna Williamson**

4.1.3. D said that Donna Williamson was not a "*complete saint – but who is?*" Before X she liked to only drink socially. When Donna Williamson got in a relationship with X, D said that's when the drinking became worse. Donna Williamson's first boyfriend had been killed in an accident and D told the independent chair that it "*shattered*" Donna Williamson. Donna Williamson fell pregnant with her next boyfriend but the baby was stillborn and this also "*shattered*" her. She left that relationship (non-abusive) and then started to get her life back on track.

4.1.4. They described Donna Williamson as bubbly, witty and funny. E said Donna Williamson was generous and would do anything for anyone, but she could be gullible and always thought the best of people. She was never malicious. She would do things first and not think about the consequences until afterwards.

4.1.5. E said that she was not who she was painted as in the last six years of her life when with X. D said before X Donna Williamson was only a social drinker. Donna Williamson was vulnerable after losing her baby and first boyfriend. It affected Donna Williamson for a long time and she did not seek professional help. F said Donna Williamson used alcohol to forget at that time. X made her drinking worse and they'd often drink locally or with a circle of friends who drank too.

**Donna Williamson and X**

4.1.6. Donna Williamson may have had a couple of drinks but was not dependent on it until X. D said X had been violent in previous relationships and Donna Williamson had come home with parts of her hair missing from her head, she had marks from where X set his dog on her and constant bruises in hidden places. D told the chair that she had tried to get Donna Williamson off alcohol and drugs, but G said that X controlled and isolated Donna Williamson so her family did not truly know the extent of the abuse.

4.1.7. D said that when Donna Williamson was drinking lots she started to become abusive to family members, she would not see them as much when she was with X and that in the last 3-4 years Donna Williamson became very fragile, partly due to a hip replacement. G said that Donna Williamson was petrified of X, that Donna Williamson used to put a lot of effort into her appearance but stopped wearing fashionable clothes and that the Donna Williamson they knew disappeared. D stated that X wanted Donna Williamson all to himself.

4.1.8. F said that Donna Williamson used to defend X's behaviour and that if X saw any of her brothers he would run. X lived five minutes from the family home and Donna Williamson lived half an hour away. E and F said that often Donna Williamson stayed with her mum and dad, she would dry out then return to X. The drink took over her and turned her nasty, her attitude changed once she was with X. G said Donna Williamson was always a worker, but that the alcohol took over and she lost her job at a local café because of it.

4.1.9. E stated that Donna Williamson had not always been the person she presented as at the end. She was bright, but kindness was her downfall. E said that when she couldn't give any more X took everything from her, her dignity and her body. After Donna Williamson had died a family member informed the family that Donna Williamson had confided in them that she had been raped (perpetrator unknown), although the family have no evidence.

4.1.10. D said that she believed sexual violence was going on and other forms of violence such as X kicking Donna Williamson on her bad leg. X would often take Donna Williamson's phones so that she could not be contacted. Donna Williamson changed all her family's names in the phones to disguise them from X, otherwise he would delete the numbers.

4.1.11. D said that Donna Williamson was on a tag and that sometimes it seemed that X would try to get her to home late in order to get in trouble.

**Donna Williamson seeking help**

4.1.12. D said a month before the incident Donna Williamson had said she was going into rehab and hospital to stop the drinking. D told her that if she did she could return back home to her and her father. E said Donna Williamson would often say things but then not do them and that his mum and dad used to offer Donna Williamson help.

4.1.13. D told the chair that Donna Williamson used to call her house "*rehab*" and that X did not like her visiting them. D said Donna Williamson knew she was safe from X at their house as X never visited due to D banning him the first time he visited. G mentioned that X used to take Donna Williamson's money straight away once she had been paid.

4.1.14. D said she felt the family had done all they could. Donna Williamson would stay with her parents to clean herself up, they would not let her go out on her own in case she met X or bought drink so they would accompany her. D said Donna Williamson had always taken care of her body, for example having 3 baths a day; she cared about her appearance. D

said there was nothing to prevent what happened, the only thing that could have done it would have been if her family physically tied her up. D said Donna Williamson had her own will and that she would only reflect on what had happened once it was too late.

**Donna Williamson and contact with agencies**

4.1.15. F said that Donna Williamson never told the police the truth due to being embarrassed about her drinking problems and she didn't discuss it with the family. F said Donna Williamson always took pride in her appearance but in the last few years since being with X she didn't and this would have embarrassed her.

4.1.16. D said that she didn't know whether Donna Williamson had reached out to any agencies.

4.1.17. The chair read out the list of agencies involved in the DHR, and the family were surprised at the number. G stated that due to domestic abuse agencies being involved it seemed that Donna Williamson was trying to get help.

**What the family wanted from the DHR**

4.1.18. E stated that his main question to agencies was around "*What information was known, when was it known, who knew and what could have been done to repair it?*" E stated that the family did not want others to go through the same situation they are in; they want to prevent further cases like Donna Williamson's from happening.

4.1.19. D told the chair about police contact with X and questioned why no checks had been done on X's bail conditions and why he was not arrested for crimes/breaches committed in the month before the incident. D stated she was shocked that the police had done nothing with either Donna Williamson or X when they broke their bail conditions. D informed the chair that there seemed to be some confusion with the police as often Donna Williamson was escorted to D's house although she did not live there.

4.1.20. The family wanted the DHR to address the following directly:

- Police powers for gaining information.
- Bail conditions and what happens when breached.
- G asked why Donna Williamson was never given a panic button for her flat.
- Gain information from Crown Prosecution Service (CPS) and Courts if not enough information gained from the police IMR.
- What happened with the police and court cases and bail.

**Feedback on the Overview Report**

4.1.21. The independent chair met with Donna Williamson's family after they had read the Overview Report. D, E, G were present along with the AAFDA Advocate and the family's solicitor.

4.1.22. The family gave the following feedback:

- They would like an apology in the Report: primarily from the police, but also from other agencies.

- They felt the contact with Donna Williamson was "*repetitive*", and questioned if Donna Williamson's murder was "*what they were waiting for*" to do anything. What preventative work was done with Donna Williamson that could have stopped X from killing her?
- Agencies "*wrote things down but did nothing*". It seemed as though the agencies were acting through "*self-interest – what are they set up to do?*"
- Agencies and practitioners did not "*put things together*" about Donna Williamson, her life and her relationship with X.
- "*More leadership [was needed] from police*" in managing Donna Williamson's situation.
- X "*controlled her brain. He was in her brain.*"
- X "*stripped her of her dignity*".

4.1.23. The family's feedback mainly concerned the police response. They had many questions about bail, particularly why X was on bail for many months and arrested repeatedly but kept being re-bailed on the same conditions.

4.1.24. They were particularly concerned over:

- The arrest of X in early August 2016 for breach of bail, following which he was released again on bail. What information did the CPS / Court have? Does the response to X's bail conditions reflect a wider attitude in the police to bail, and what can be done about it? The specific question about bail is answered in the Overview Report (see 3.7.89); a recommendation (2) is made in relation to the second question (see 4.2.5 onwards).
- The actions of the police officer(s) in Lewisham who were informally supporting Donna Williamson but weren't sharing this information through the police or MARAC: did this increase Donna Williamson's risk or vulnerability? The Panel discussed this, and the independent chair was able to interview the police officer concerned, and this has been incorporated into the Overview Report (see 3.8).

4.1.25. The family would like the Overview Report to be published using Donna Williamson's real name, not a pseudonym.

4.1.26. Specific requests for changes to the Overview Report:

- Include a list of 'missed opportunities' at the start of the Report.
- Share the completed Action Plan with the family along with the final Overview Report and Executive Summary (prior to submission to the Home Office).
- Update the family on the progress of the Action Plan every six months (or at intervals to be agreed with the family once the DHR is complete).

4.1.27. They also asked the following specific questions of the Review:

- Why did Donna Williamson not get a panic button in her home?

- When Donna Williamson called police on the day she died, the officers who were on route remembered her and this is why they chose to attend even though she cancelled the call. Could or should they have had the history provided to them, so that any officer, even if they didn't remember Donna Williamson, could have made that decision?
- In relation to the police's actions on the day X killed Donna Williamson: did the officers attending Donna Williamson 's address, and those who stopped X on the street have, or ought to have had, access to local policing records, as these would have contained relevant information about Donna Williamson and X?

## 4.2. Information from YZ and his Family

4.2.1. No information was provided to the Review from YZ's family, and the independent chair was unable to arrange an interview with YZ himself.

## 4.3. Information Known to Agencies Involved

4.3.1. The following agencies had contact, or were involved in some way, with Donna Williamson and/or YZ during the Terms of Reference timeframe of 1 January 2008 to the date of Donna Williamson's death.

4.3.2. The large number of agencies who had contact or involvement with Donna Williamson and YZ, separately or as a couple, is notable in itself. This is explored in Section 5.

| **Agency Involvement With:**<br>(A description of each agency is in Appendix 3) | **Donna Williamson** | **YZ** | **Both** |
|---|---|---|---|
| CGL Aspire (Greenwich) | N | Y | |
| CGL New Direction (Lewisham) | Y | N | |
| Crown Prosecution Service | Y | Y | Y |
| Donna Williamson's General Practice (GP) | Y | Y | Y |
| Greenwich Multi-Agency Risk Assessment Conference | Y | Y | Y |
| Her Centre | Y | Y | Y |
| Housing for Women | Y | N | |
| YZ's General Practice (GP) | N | Y | |
| Lewisham and Greenwich NHS Trust | Y | Y | Y |
| Lewisham Multi-Agency Risk Assessment Conference | Y | Y | Y |
| London Ambulance Service NHS Trust (LAS) | Y | Y | Y |
| London Borough of Lewisham Adult Social Care | Y | Y | Y |

| | | | |
|---|---|---|---|
| London Borough of Lewisham Crime Enforcement and Regulation Service | Y | N | |
| London Borough of Lewisham Single Homeless Intervention and Prevention Service (SHIP) | Y | N | |
| London Fire Brigade | Y | N | |
| Metropolitan Police Service | Y | Y | Y |
| National Centre for Domestic Violence | Y | N | |
| National Probation Service | Y | N | |
| Oxleas NHS Foundation Trust | Y | Y | Y |
| Princess Royal University Hospital | Y | N | |
| Refuge (Independent Domestic Violence Advocacy Service) | Y | N | |
| Royal Borough of Greenwich Adult Social Care | Y | Y | Y |
| Royal Borough of Greenwich Housing Options and Support Service | Y | Y | Y |
| South London and Maudsley NHS Foundation Trust | Y | N | |
| Thames Reach | Y | N | |
| Together for Mental Wellbeing | Y | N | |
| Victim Support | Y | N | |
| Total | 25 | 14 | 12 |

4.3.3. The Terms of Reference covers the period 1 January 2008 to the date that YZ killed Donna Williamson.

4.3.4. As a result of the significant amount of information provided to this Review, the independent chair and Review Panel discussed the best way to set this out in the Overview Report. The chair and Review Panel agreed that there was no 'ideal' way to do this, but that the focus of the Report was to identify learning. It was agreed that a chronology covering 1 January 2016 to the date she died was able to highlight the themes of the case and the learning to be acted upon, and that a full chronology covering the whole period of the Terms of Reference would be too long and too much information to be a readable report.

4.3.5. On reading the first draft of the Report, Donna Williamson's family told the independent chair that they were happy with the layout, but that they wanted more detail on certain areas. Specifically, they requested a list be added of all the missed opportunities (see 5.1.6).

4.3.6. Donna Williamson and YZ's contact with agencies from 2008 to 2011 is outlined in sections 3.4 and 3.5 below. During that time Donna Williamson was in contact with seven of the agencies listed above (Metropolitan Police Service, London Ambulance Service, her General Practice, Lewisham and Greenwich NHS Trust and Princess Royal University Hospital, South London and Maudsley NHS Foundation Trust and London Fire Brigade). YZ was in contact with seven (Metropolitan Police Service, London Ambulance Service, Donna Williamson's General Practice, Lewisham and Greenwich NHS Trust and Princess Royal University Hospital, Oxleas NHS Foundation Trust and Royal Borough of Greenwich Adult Social Care).

4.3.7. The chronology of agency involvement with Donna Williamson and YZ from 1 January 2012 to the date of Donna Williamson's homicide contains over 800 entries with all of the agencies above including: direct (or attempted) contact with Donna Williamson or YZ; appointments with one of them, or appointments they did not attend; contact between agencies; multi-agency meetings/discussions; and referrals to other services. The independent chair and Review Panel therefore agreed that it would not be helpful or accessible to present every contact. The facts from 1 January 2012 to 31 December 2015 are set out for each agency individually (see 3.6).

4.3.8. The final period of the timeframe (1 January 2016 to Donna Williamson's murder) is presented chronologically (see 3.7).

## 4.4. Chronology: 1 January 2008 to 31 December 2009

4.4.1. Donna Williamson was aged 36 in 2008. She attended hospital (Lewisham and Greenwich NHS Trust) approximately ten times and was an inpatient for three months for further surgery following the hip replacement which took place at the end of 2007. She was referred for assessment for a package of care on discharge; there are no records to indicate why this was not proceeded with. She was in contact with her General Practice (GP) and LAS regarding post-operative hip pain and with regard to her mental health. These included three requests to her GP for prescriptions of diazepam[6], and three calls to LAS having taken an overdose or feeling suicidal. Following one of these calls, Donna Williamson was referred to the psychiatric liaison service. She was assessed and reported feeling "*intense loneliness*" when alone, and a recent relationship breakdown due to her drinking. Donna Williamson's risk of further self-harm were assessed as low, and coping mechanisms were discussed. Donna Williamson declined referral to alcohol services; she was given a leaflet about local services and was discharged. In 2008 Donna Williamson

[6] Used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms.

was convicted of criminal damage (having smashed a taxi car's window) and sentenced to a 15-month Conditional Discharge.

4.4.2. YZ was aged 29 in 2008. In that year he had three appointments with his GP with regard to physical health. He was referred by his GP to Oxleas NHS Foundation Trust for chronic depression. He was seen three times during which his alcohol use was addressed and then discharged as he had reduced his alcohol intake and reported feeling better.

4.4.3. In 2009, aged 37, Donna Williamson was again in contact with LAS and her GP, and also with South London and Maudsley NHS Foundation Trust (SLaM). Most contacts with these agencies concerned her mental health and alcohol use, with the exception of a call to LAS in which she alleged she had been physically assaulted and raped by "*a male*" (police were also in attendance). LAS records show that "*the police provided information that Donna Williamson makes false allegations to get a quicker response*". No police action was taken in relation to the allegations. Donna Williamson attended her GP in relation to her mental health once (in early 2009 it was recorded that her recurrent depression was "*resolved*") and once for support with her drinking. The GP referred her to SLaM and she was seen by that service five times to be treated for her alcohol use with medication (this service is now provided by CGL). In the assessment Donna Williamson reported having split up with her boyfriend after 10 years (the notes referred to a "*selfish*" boyfriend); was unemployed; lived alone; had left home at 16 and had a boyfriend at that time who was killed in an accident; had a stillborn baby with next boyfriend; following which she went to Spain where she was raped. She was offered counselling for these issues but declined. Donna Williamson completed the course of alcohol treatment and was discharged to her GP with the expectation she would continue to collect her prescription from them; there are no records that she did that. During her last appointment Donna Williamson referred to having "*upset her boyfriend*" because she had been drinking again. During this time Donna Williamson had attended her GP and referred to "*a new person*" (i.e. intimate relationship). Later in the year Donna Williamson attended her GP three times with regard to a sexually transmitted infection for which she was treated. She also had contact with police when a male recorded as being her ex-boyfriend called and alleged Donna Williamson had assaulted him; he did not pursue the allegation and no action was taken by police.

4.4.4. YZ was aged 30 in 2009. In that year he had four appointments with his GP with regard to anxiety and depression. At the appointment in September 2009 he referred to having split from his girlfriend. Through all the appointments the GP recorded offering support and medication. In this year YZ was verbally warned by police for shouting aggressively on a bus.

## 4.5. Chronology: 1 January 2010 to 31 December 2011

4.5.1. In 2010, aged 38, Donna Williamson's only agency contact was one appointment with her GP (in which she reported she was drinking excessively), and nine calls to police either by or in relation to her.

4.5.2. The first two, in April, were from a member of YZ's family in which they asked for police assistance in removing Donna Williamson from their property (YZ was not mentioned). In retrospect these were the first calls linking Donna Williamson to YZ's address, but this link was not known at the time and these were not treated as domestic incidents.

4.5.3. Five further calls were made in June, August and November in which Donna Williamson was recorded as a victim of domestic abuse from YZ.

4.5.4. In the first (June), Donna Williamson alleged YZ had "*ransacked*" her flat (at the same time a neighbour called to say that Donna Williamson had had a break in and the bath was overflowing). Donna Williamson stated YZ had threatened to do it and he had keys. Police reported that the flat had been "*turned upside down but in a very careful and methodical way i.e. furniture and TV turned round to face the wall, mirrors turned round and a chest of drawers turned upside down.*" Donna Williamson was recorded as stating that YZ had been violent in the past; she was also recorded as being drunk. The officers recorded their belief that Donna Williamson "*may have been making false claims against YZ*".

4.5.5. Donna Williamson called the next day giving a different name (with YZ's surname) and repeated the allegations of the day before, as well as the belief that YZ was knocking on her door. No offences were recorded.

4.5.6. The same day, a friend of Donna Williamson's called police reporting that YZ had threatened to "*cut her [*Donna Williamson*'s] fingernails and fingers off*", and that YZ had been following Donna Williamson to work. Donna Williamson did not make an allegation of a crime to police and no further action was taken.

4.5.7. In August Donna Williamson alleged YZ had kicked and punched her in the area of her hip replacement but subsequently did not wish to pursue the allegation; YZ was charged with common assault but no evidence was offered in court.

4.5.8. In November YZ was given a simple caution[7] for criminal damage against Donna Williamson's property. During the call officers recorded Donna Williamson's history of the relationship and abuse from YZ, and recorded listening to verbal abuse from YZ to Donna Williamson during a phone call he made to her.

[7] Home Office guidance (provided in the MPS IMR) states a simple caution can be used for "*low-level offending*" but should not be considered if the suspect has previously received a caution.

4.5.9. In these incidents, a DASH Risk Checklist was recorded as being completed with Donna Williamson (records did not state whether information was provided about domestic abuse services). Donna Williamson was identified as standard risk twice, and medium risk once. (See Appendix 4 for explanations of the Checklist and risk levels.)

4.5.10. In 2010, aged 31, YZ only had contact with his GP, with three appointments concerning anxiety and depression. In the appointment in September the GP recorded that YZ was under "*stress*" because he was "*on bail [for] alleged assault on ex*". The GP treated YZ's anxiety and depression with medication and support.

4.5.11. In 2011 police were called six times in relation to Donna Williamson (aged 39) and YZ (aged 32): one verbal argument (no offences; flagged as domestic incident); a neighbour calling that YZ was attacking Donna Williamson (no statements able to be taken; flagged as domestic incident); Donna Williamson was cautioned for criminal damage against YZ's family member's property where YZ also lived (LAS were also called to this incident as Donna Williamson had put her hand through a glass window, she was not taken to hospital); this was not flagged as a domestic incident as the damage was to the property of YZ's family member. Donna Williamson called twice trying to retrieve her dog from YZ's house (Donna Williamson was told to call her Safer Neighbourhood Team not 999, these were not flagged as domestic incidents).

4.5.12. Of the three incidents flagged as domestic abuse, in one the DASH risk identification was completed with YZ (standard risk) and in two it was completed with Donna Williamson (one standard risk and one medium risk). Donna Williamson twice declined to be referred to support services and on one occasion it was recorded that a pack of information about domestic abuse services was sent, but it does not record to whom: the DASH had been completed with YZ so it may have been sent to him.

4.5.13. In 2011 Donna Williamson also called LAS due to pain down her leg; she also mentioned an argument with her partner; she was taken to hospital (Lewisham and Greenwich NHS Trust) and there are no further records. Donna Williamson attended her GP once for depression. She (and YZ) was also recorded as present by Greenwich Adult Social Care when they carried out an assessment with a member of YZ's family.

4.5.14. In 2011 a relative of YZ's alleged to police that YZ was stealing money from the family member he cared for. YZ was arrested but no further action was taken as the alleged victim did not wish to pursue any allegation. A safeguarding alert was sent to Royal Borough of Greenwich Adult Social Care who continued to provide a package of care for the family member. YZ contacted the Oxleas Urgent Advice Line saying he was going to commit suicide. LAS were called and YZ brought to hospital (Lewisham and Greenwich NHS Trust), where he was assessed by Oxleas during which he disclosed an argument with his girlfriend Donna Williamson who had "*broken a window during a row*" (see 3.5.11), and also

that he felt "*very anxious and nervous to leave the house as he thinks someone is going to break in, so he sleeps in the lounge with 2 knives for self-defence*". LAS sent a safeguarding alert to Greenwich Adult Social Care who contacted YZ and advised him to speak to his GP; it was recorded that YZ was "*stressed with caring responsibilities … suicidal because of this and problems with* Donna Williamson". YZ continued to be in contact with Oxleas following the hospital assessment: he received two home visits from the Home Treatment Team and attended a psychological assessment appointment. He was then discharged from the Home Treatment Team to the Day Treatment Team. He did not attend three appointments with them following which he was planned to be discharged to his GP. The Nurse Practitioner followed up on this and made a further appointment for YZ which he did not attend and he was discharged.

## 4.6. Chronology from 1 January 2012 to 31 December 2015

4.6.1. Donna Williamson and YZ's contact with agencies intensified from 2012, and in every month from January 2012 to Donna Williamson's death, one or both of them was involved with at least one agency and usually more than that (all but four of those agencies listed in the table above). 'Involved with' means they were in direct contact with an agency, or an agency was trying to contact them, or they attended or missed an appointment, or there were discussions between agencies about one or both of them.

4.6.2. The most consistent level of involvement for both Donna Williamson and YZ during these four years was with police. Donna Williamson also maintained regular contact with her GP.

4.6.3. The number of (non-police) agencies YZ was involved with remained steady at three agencies in each year, but with large gaps between contacts: 2012 (GP, LAS and Royal Borough of Greenwich Adult Social Care), 2013 (GP, CGL Aspire and Greenwich Adult Social Care), 2014 (GP, Lewisham and Greenwich NHS Trust and CGL Aspire) and 2015 (GP, CGL Aspire and Greenwich Adult Social Care).

4.6.4. Donna Williamson's level of involvement with other (i.e. not police nor GP) agencies varied. In 2012 she was involved with eight agencies; this declined in 2013 (five) and 2014 (three), and increased in 2015 (seven).

4.6.5. In addition to this, Donna Williamson and YZ as a couple were discussed by the Multi-Agency Risk Assessment Conferences (MARAC) in Lewisham and Greenwich.

4.6.6. Four referrals were made to the Lewisham MARAC for Donna Williamson. The police referred in June 2012 and December 2014, and the Independent Domestic Violence Adviser (IDVA) Service at Refuge referred her twice, in August and October 2012 (see 3.6.95).

4.6.7. The police referred YZ to the Greenwich MARAC three times: June 2012, March 2013 and June 2015 (see 3.6.102).

4.6.8. The table below sets out the overlaps of contact. Excluded from the table (to make it readable) is the one-off contact Donna Williamson had with Fire Brigade (June 2012).

| | | Police | LAS | IDVA | ABGP | Lewisham Adult Social Care | Hospital | YZ GP | Probation | SLaM | CGLNew Direction Donna Williamson | CGLAspire YZ | Thames Reach | Victim Support | Housing for Women | Greenwich Housing | Greenwich Adult Social Care (YZ) | Her Centre | Lewisham MARAC | Greenwich MARAC | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2012 | Jan | | | | | | | | | | | | | | | | | | | | 1 |
| | Feb | | | | | | | | | | | | | | | | | | | | 2 |
| | Mar | | | | | | | | | | | | | | | | | | | | 1 |
| | Apr | | | | | | | | | | | | | | | | | | | | 1 |
| | May | | | | | | | | | | | | | | | | | | | | 2 |
| | Jun | | | | | | | | | | | | | | | | | | | | 5 |
| | Jul | | | | | | | | | | | | | | | | | | | | 7 |
| | Aug | | | | | | | | | | | | | | | | | | | | 7 |
| | Sep | | | | | | | | | | | | | | | | | | | | 8 |
| | Oct | | | | | | | | | | | | | | | | | | | | 11 |
| | Nov | | | | | | | | | | | | | | | | | | | | 5 |
| | Dec | | | | | | | | | | | | | | | | | | | | 5 |
| 2013 | Jan | | | | | | | | | | | | | | | | | | | | 2 |
| | Feb | | | | | | | | | | | | | | | | | | | | 3 |
| | Mar | | | | | | | | | | | | | | | | | | | | 4 |
| | Apr | | | | | | | | | | | | | | | | | | | | 5 |
| | May | | | | | | | | | | | | | | | | | | | | 4 |
| | Jun | | | | | | | | | | | | | | | | | | | | 3 |
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**Metropolitan Police Service**

4.7.1. The majority of records for police in this time period relates to Donna Williamson and YZ as a couple, and this is set out from paragraph 3.6.13 below. Appendix 3 contains a table listing every domestic incident police responded to concerning Donna Williamson and YZ.

4.7.2. In addition, Donna Williamson was in contact with police 33 times in relation to various issues including her dog, theft, being drunk/disorderly in public places, reporting concerns for friends and having drug users in her house. Twice a friend of Donna Williamson's called to report they were concerned for her. In March 2015 when Donna Williamson was sentenced to a community order for assaulting YZ, she called police at least six times over issues with her monitoring tag (see probation, below).

4.7.3. In summer 2012 Donna Williamson called police to report "*her belongings were piled on top of her cooker and it was switched on*". She was advised to call London Fire Brigade and leave the address. Donna Williamson called the Fire Brigade and they dealt with the fire. The incident was recorded as cooking left unattended on the hob with an underlying fact that the occupants appeared to be under the influence of alcohol. The message log stated the police were requested to attend this incident due to a domestic issue. Later that day a neighbour of Donna Williamson's called police to report a number of incidents that day and issues with Donna Williamson's dog. They also stated they were "*concerned the couple would harm each other as [the neighbour] had seen him strangle* Donna Williamson *earlier*". No crime report was completed on this.

4.7.4. YZ had 21 additional contacts with police: three related to concerns for the family member he cared for; and four unrelated incidents. Police recorded 15 incidents in which YZ breached bail following arrest for the assault on Donna Williamson in September 2012 (see 3.6.24).

4.7.5. From February 2012 to December 2015, police were contacted on 61 occasions with regard to Donna Williamson and YZ together. Calls were made by Donna Williamson (36), YZ (11), YZ's family (3), Donna Williamson's neighbours (3), a friend (1), a member of the public (1) and other agencies (6). There were six periods of a month or more without contact (on two occasions this was four months); at other times there were up to six contacts a month.

4.7.6. There were additionally four calls to police with regard to YZ and the family member he cared for, including one allegation of YZ assaulting that family member; and four occasions involving this family member and Donna Williamson, two in which she alleged abuse by them and two in which they alleged abuse by her.

4.7.7. 31 of the 61 calls related to allegations that YZ had physically assaulted or otherwise abused Donna Williamson. The allegations included (having made some of these allegations during 999 calls, Donna Williamson then denied them when officers attended):

- physical assault including that he had punched her in the face, "*beaten her up*", pulled her hair out, stubbed a cigarette out on her face, "*badly beaten*" her, had set the dog on her (leading to bites on the breast area), "*slapped her*", punched her in the face giving her two black eyes, assault leading to very swollen eye and cut on her forehead, punched in head and body, kicked and hit her on her hip which had been replaced
- verbal abuse
- YZ "*throwing things around*", smashing her window, "*smashing her house up*", breaking her microwave, her table
- stealing from her
- threats to kill
- threats to cut her fingers / fingernails off
- threatening her with a knife
- accusing her of affairs / infidelity

4.7.8. Two of these led to criminal justice outcomes. In June 2012 YZ called police stating they needed to attend immediately or he was going to kill his girlfriend; shortly after Donna Williamson called alleging that YZ had smashed a bottle over her head. Police arrested YZ and he was given a simple caution for assault. In September 2012 a member of the public called police to report Donna Williamson had entered their shop having been beaten badly by her partner and bitten by a dog. YZ was charged with grievous bodily harm and convicted after trial (in January 2014) of common assault and sentenced to two months imprisonment (which he was deemed to have already served due to periods in custody following the initial arrest and breaches of bail). With the exception of these two incidents, no further action was taken, either because Donna Williamson did not give a statement and there was no additional evidence, or because no crimes were detected once police attended the scene.

4.7.9. Eleven of the calls involved allegations that Donna Williamson had physically assaulted or otherwise abused YZ. The allegations included:

- physical assault including hitting/punching him, Donna Williamson had "*stabbed*" him (YZ was recorded as having a small cut mark on his chest), Donna Williamson hit him in face with a mobile phone charger
- "*smashing his house up*"
- contacting him excessively
- verbal abuse

4.7.10. One of these led to a criminal justice outcome: in March 2015 Donna Williamson was arrested for hitting YZ in the face with a mobile phone charger. She pleaded guilty and was sentenced to a 12-month community order. With the exception of this incident, no further

action was taken, either because YZ did not give a statement and there was no additional evidence, or because no crimes were detected once police attended the scene.

4.7.11. On four occasions "*arguing*", "*fighting*" or "*incidents*" between Donna Williamson and YZ were recorded. There were two incidents in which YZ called police because Donna Williamson was self-harming in his presence.

4.7.12. Police officers completed the DASH Risk Checklist with Donna Williamson on 25 occasions; with four of these, Donna Williamson refused to answer the questions (and in one she was recorded as being too intoxicated to do so). She was identified as Standard Risk 17 times, and medium risk 5 times, and the outcome was unknown in three instances. The DASH Risk Checklist was completed with YZ 13 times (with four of these, YZ refused to answer the questions), and identified as standard risk every time with the exception of March 2015, when YZ was identified as high risk, despite refusing to answer any questions; this was downgraded to standard once Donna Williamson had been arrested (the incident for which she received a community order). There were six incidents in which a DASH Risk Checklist should have been done and was not: five in which Donna Williamson or another person alleged abuse from YZ, and one in which YZ alleged abuse from Donna Williamson. (The DASH Risk Checklist and the risk levels are explained in Appendix 4.)

4.7.13. Police officers referred Donna Williamson to the Independent Domestic Violence Advocacy (IDVA) service in Lewisham four times: in June 2012, November 2013, December 2014 and November 2015. In November 2013 they also referred Donna Williamson to Lewisham Adult Social Care. Officers also referred Donna Williamson to the Greenwich Housing for Women service twice: once in September 2012 (when they made contact with Donna Williamson) and once in February 2015 (when they advised the officer to refer Donna Williamson to the Lewisham IDVA service instead). Police officers referred Donna Williamson to the Lewisham MARAC three times: July 2012, December 2014 and May 2015.

4.7.14. Of the 61 incidents, 17 were not flagged as domestic violence. In some cases this was because Donna Williamson's allegation that YZ was responsible for an alleged incident could not be checked. Those not flagged also included:

- June 2012: A neighbour of Donna Williamson called police reporting a number of incidents at the block of flats that day, including involving Donna Williamson's dog; the neighbour stated they were concerned the couple would harm each other because they "*had seen him [YZ] strangle Donna Williamson earlier*". No crime report was created and no action was taken.
- June 2012: A different neighbour called with concerns over Donna Williamson as she was "*in an abusive relationship*" and they could "*hear her crying and screaming … on*

*a regular basis*". Donna Williamson's welfare was checked and she was recorded as safe and well.

- August 2012: A male called police sounding distressed then hung up; a later call came from LAS after YZ had called them stating his family member was trying to strangle Donna Williamson. On attendance a verbal argument only was reported.
- May 2014 Donna Williamson called as YZ had "*kicked her out the house*" and YZ could be heard in the background being abusive to Donna Williamson. No crime report was created; police attended and recorded it as a dispute over ownership of the dog.

4.7.15. YZ was on bail from October 2012 (following arrest in September for assault against Donna Williamson) until January 2014 when the trial took place. This bail carried conditions including for YZ not to contact Donna Williamson.

4.7.16. On fifteen occasions YZ was recorded as breaching his bail conditions (or recorded as being involved in incidents that breached the condition not to contact Donna Williamson): on five occasions police attended incidents; and five were notifications from SERCO that YZ had breached his tag. He was arrested four times and warned once. Each time he was arrested, he was re-released on bail with the same conditions.

| Date | Event | Outcome |
|---|---|---|
| 23 February 2013 | YZ called police stating he had bail conditions not to be with Donna Williamson but she had turned up at his address, he had let her in and she had assaulted him. Action taken against Donna Williamson in relation to this. | No action taken with YZ in relation to bail. |
| 10 March 2013 | SERCO tag breach notification received | No record of action taken |
| 7 May 2013 | YZ called police stating Donna Williamson had turned up at his address and they had started drinking; Donna Williamson had picked up a knife and tried to self-harm by cutting her hand, YZ had taken the knife from her and they continued to argue until police arrived. Donna Williamson was noted to be breaching bail (from the incident on 23 February 2013) and was arrested (and taken to hospital for her hand to be checked). | No action taken in relation to YZ's bail. |
| 10 May 2013 | Police called as Donna Williamson was outside YZ's address banging on the door and swearing. Police attended and spoke to YZ who stated Donna Williamson had turned up and started banging the door. Whilst officers were talking to YZ, his family member was abusive and aggressive to officers, YZ wasn't able to leave the address to give a statement due to being on a curfew and his family member's behaviour made it impossible to get details in the house. Both parties had been drinking. | No action taken in relation to YZ's bail. |
| 11 May 2013 | SERCO tag breach notification received | No record of action taken |

| Date | Event | Outcome |
|---|---|---|
| 11 May 2013 | SERCO tag breach notification received | No record of action taken |
| 12 May 2013 | SERCO tag breach notification received | YZ arrested for breach of tag conditions and appeared at court 13-May-2013; released with minor clarifications to bail conditions. |
| 13 June 2013 | YZ called police to his home stating that his girlfriend Donna Williamson was getting aggressive and had cut herself on the wrists using a plastic glass that she broke and he wanted her to leave. On police arrival Donna Williamson was sitting outside the house and said YZ had bail conditions not to see her. When asked why she was there in that case she stated she loved him. Donna Williamson left following police attendance. | No action taken in relation to YZ's bail. |
| 18 June 2013 | Police called to YZ's home, he told police he wanted Donna Williamson removed from the premises. Donna Williamson came out of the property and spoke to police, saying she had spent most of the day with him drinking. | Police Multi Agency Team Officer (MAT) explored the potential for YZ to be arrest for breach of bail. CSU supervisor directed he be warned on that occasion. |
| 2 July 2013 | SERCO tag breach notification received | No record of action taken |
| 5 July 2013 | SERCO tag breach notification received | YZ arrested for breach of bail conditions; subsequently released from court on bail |
| 6-11 July 2013 | SERCO tag breach notification received (6) | In custody following arrest on 05-July |
| 18 July 2013 | Relative of YZ called police to report that the previous day Donna Williamson had attended YZ's home with some beers and was still there. YZ attended Greenwich police station as his family member had allowed Donna Williamson to enter and he wanted to avoid any breaches of bail and for police to remove her. Police attended YZ's home, Donna Williamson was advised to leave. | YZ was advised to call police if she returned to the address. |
| 19 August 2013 | SERCO tag breach notification received | No record of action taken |
| 22 October 2013 | YZ's family member called police as wanted Donna Williamson to leave his house. They cleared the line then called back saying Donna Williamson was hitting them, sounds of a disturbance could be heard. Police attended and spoke to both parties. It was apparent they were both very drunk and both refused to give statements or complete DASH questions. | Checks revealed that YZ had bail conditions not to allow Donna Williamson to enter the premises and she admitted having been living there for 3 weeks so he was arrested. Outcome unknown. |

| Date | Event | Outcome |
|---|---|---|
| 9 November 2013 | YZ called police for help in stopping Donna Williamson contacting him; she had called his house and left a message that she still loved him; he admitted texting her back despite bail conditions not to contact her | YZ arrested for breach of bail. Outcome unknown. |
| 10 November 2013 | SERCO tag breach notification received | In custody awaiting court appearance following arrest for breach of bail conditions previous day. |

4.7.17. *Other police contact with YZ*: The police IMR outlines the contact that YZ had with the Greenwich PIT. This team is staffed by police officers with the aim of providing "*proactive and disruptive policing to target the top 15 domestic abuse perpetrators in Greenwich in terms of both risk and frequency of re-offending.*" (Their role is explained in section 4, see 4.2.17).

4.7.18. The team worked with YZ from August 2015 to May 2016; the log for this time of contact / attempted contact contains 86 entries. The focus was on assisting YZ to engage with CGL Aspire, through regular telephone calls and face to face visits, and taking him to appointments. Officers also discussed with YZ his contact with Donna Williamson and there were records of the officers visiting Donna Williamson's address on several occasions.

4.7.19. YZ's case was closed in May 2016 as he had refused to engage with the team and other agencies. At that stage YZ was recorded as rarely being found at his home, spending most of his time at Donna Williamson's.

**Independent Domestic Violence Advocacy Service, Refuge**

4.7.20. The IDVA Service in Lewisham is delivered by Refuge through the Athena Service. This service only had contact with Donna Williamson.

4.7.21. Donna Williamson was first referred to the IDVA service by police in June 2012. From then to January 2013, the IDVA was in frequent contact with Donna Williamson, at times daily at always at least weekly. 135 records were made, of which: 34 involved direct contact with Donna Williamson; 40 involved attempted (but unsuccessful) contact with Donna Williamson and 59 were records of contact with other agencies.

4.7.22. Donna Williamson was supported by the same IDVA throughout this time, and was provided support in relation to managing her safety at home (for example ensuring doors and windows were locked, calling police in emergencies) and with friends, accessing housing support through Thames Reach, referral to counselling and debt advice, interaction with CGL New Direction and updates from court. (In September 2012 Donna Williamson was referred to Housing for Women and was in contact with them briefly, see 3.6.60.)

4.7.23. At the end of this time, in January 2013, the IDVA had a contact with Donna Williamson which was cut short as Donna Williamson was unable to talk at that time. That IDVA then left the service, and the new IDVA contacted Donna Williamson two weeks after that short contact. The new IDVA managed one further contact with Donna Williamson, and was unsuccessful in contacting her 14 times: attempts were at times frequent (every day) and at other times very spaced out, for example by up to four weeks, with no reasons recorded. In July 2013 Donna Williamson's case was closed.

4.7.24. The IDVA service received referrals for Donna Williamson from police in November 2013 and March 2014, on both occasions Donna Williamson was contacted and declined the service. Following the second of these, in April 2014, there was a record that Donna Williamson had called the service and said that she wanted support; there are no further records relating to this.

4.7.25. Donna Williamson was referred to the IDVA service twice more: in December 2014 through the MARAC (see next paragraph for details) and in November 2015 by the police when contact could not be established by the IDVA service.

4.7.26. In December 2014 the IDVA made contact with Donna Williamson. The IDVA was concerned about Donna Williamson and made a referral to Lewisham Adult Social Care (see 3.6.51). This referral included the information that Donna Williamson said she was going to kill herself; that she had been drinking heavily and neglecting herself; she did not want emergency services called but she wanted to be "*sectioned*" and passed the phone to a male friend. The IDVA asked for the phone to be given back to Donna Williamson, who said she was going to go home and all she wanted was for someone to change her locks and for the police to put a 'treat all calls as urgent' tag on her address. Donna Williamson got angry when the IDVA said she was concerned for her due to her threats to kill herself, and hung up. The IDVA was unable to contact Donna Williamson again and closed the case after making a referral to the Sanctuary Scheme for Donna Williamson's change of locks at the end of December 2014 (the outcome of this referral is not recorded). The IDVA also referred to Lewisham Adult Social Care at that time, and expressed their concerns for Donna Williamson to them following the MARAC meeting in January 2015. Adult Social Care had asked police to carry out a welfare check, during which Donna Williamson was reported to be fine, and the IDVA was notified (see 3.6.55).

4.7.27. Donna Williamson came back into the service in 2016 (see below).

**Donna Williamson's General Practice**

4.7.28. Donna Williamson was registered with the same General Practice (GP) for most of her life, and usually saw the same doctor when she attended. This service also had two contacts with YZ.

4.7.29. During 2012-2015 Donna Williamson had a face to face appointment, or spoke on the telephone, with her GP 39 times. The longest she went without contact was September to November 2014 (three months). She reported physical health issues on 17 occasions, including: vomiting; ear pain; hip pain; pain in chest; allergies; indigestion; dry skin/eczema/rash.

4.7.30. Donna Williamson discussed her mental health with her GP during eleven appointments or telephone calls, and was repeatedly prescribed medication for this including citalopram, diazepam and paroxetine. Donna Williamson also discussed her alcohol use four times. The GP attempted to manage prescriptions to Donna Williamson for diazepam, as they were concerned she could become addicted; there was also concerns shared from the pharmacy that Donna Williamson was selling her prescriptions.

4.7.31. Donna Williamson disclosed domestic abuse from YZ to her GP on seven occasions. This included three appointments that followed the injuries she sustained in the assault by YZ in September 2012 (see 3.6.16).

4.7.32. There were two notable appointments in this time.

4.7.33. In May 2014 Donna Williamson attended an appointment and disclosed having had a still born baby in 1996 that she had been with her partner for 5 years and now wanted a baby; it was noted that this was brought up at the end of the consultation and there was no further discussion.

4.7.34. In April 2015 Donna Williamson came to the GP "*very stressed, anxious, tearful, saying that she is crying out for help, wanted to be sectioned, tagged by police, patient pushing pram about thinking she has baby*". Reception staff spoke to Donna Williamson's doctor who advised them to tell Donna Williamson to go to the hospital as quickly as possible. Reception staff telephoned Donna Williamson's "*partner*" who came to the GP to pick her up by cab and was recorded as taking her to hospital. (The hospital has no record of Donna Williamson attending that day.)

4.7.35. YZ had two contacts with this GP: one in July 2011 relating to a physical health issue and one in February 2012 requesting help for anxiety and drinking, in which it was recorded he was started on medication for anxiety. In that appointment he also referred to the allegation made against him of stealing from his family member.

**YZ's General Practice**

4.7.36. This General Practice (GP) only had contact with YZ.

4.7.37. During 2012 to 2015, YZ attended his GP eleven times (and missed three appointments); the majority of these were between August and December 2013. YZ discussed his physical health (8), alcohol use (5) and mental health (4). He was prescribed medication for depression and/or anxiety, and was referred to CGL Aspire for his alcohol use. YZ referred to a "*woman he is not allowed contact with*" (September 2013) and his girlfriend who "*has a*

*restraining order against him*" (November 2013). In March 2015 he referred to the incident in which Donna Williamson assaulted him (March 2015).

**London Ambulance Service and Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital; Woolwich and University Hospital Lewisham)**

4.7.38. LAS and Lewisham and Greenwich NHS Trust had contact with both Donna Williamson and YZ.

4.7.39. In four of the police incidents outlined above, LAS were also called, including three alleged assaults by YZ. In June 2012 Donna Williamson was treated at the scene for a head injury having been hit by a bottle and LAS did a safeguarding referral; in September 2012 Donna Williamson was taken to hospital and treated (see police 3.6.16); in December 2015 she refused treatment by ambulance staff. Police called LAS in June 2013 as Donna Williamson had cut her hand; no further information is available.

4.7.40. LAS were also called due to Donna Williamson reporting feeling suicidal: in July 2012 the ambulance was sent to YZ's address, YZ stated that no female lived there; in April 2013 Donna Williamson was taken to hospital. The hospital referred Donna Williamson to Oxleas NHS Foundation Trust inpatient unit but the referral was not accepted because Donna Williamson had been taken into police custody having been arrested for breach of bail. In May 2013 a female (possibly Donna Williamson) was reported to have cut her hand, the ambulance was then cancelled.

4.7.41. In May 2015 Donna Williamson called with abdominal pain; she was treated and left at the scene.

4.7.42. A call was made by YZ in August 2012 in which he reported palpitations and shortness of breath; it was also recorded that his family member trying to strangle YZ's girlfriend. An ambulance attended, YZ refused help and was left at the scene. (Police were in attendance.)

**London Borough of Lewisham Adult Social Care**

4.7.43. Lewisham Adult Social Care only had contact with Donna Williamson.

4.7.44. Three referrals were made for Donna Williamson to Adult Social Care between 2012 and 2015. On the first occasion (referral from LAS June 2012) the Social Care Advice and Information Team (SCAIT) contacted Donna Williamson the same day. Donna Williamson reported that she and YZ had been together for over three years, that YZ was "*possessive and jealous … she is no angel, she has a criminal record and referred to a time when she stabbed him … [no] family [or] friends*". Donna Williamson stated police had not previously given her advice or information about domestic abuse and services. She was interested in gaining an injunction against him and was given the details of the National Centre for Domestic Violence (NCDV). Later that day SCAIT spoke again to Donna Williamson after YZ had been given a caution for the offence against her. She was recorded as feeling "*this*

*was unfair and because she's got seven previous convictions, the police had discriminated against her*". After a follow up call in which SCAIT were unable to speak to Donna Williamson (a voicemail was left), her case was closed as appropriate information had been provided. Information was sent to Royal Borough of Greenwich Adult Social Care in relation to the family member YZ cared for.

4.7.45. When a Manager was completing MARAC research in August 2012 it was identified that the above referral had not been logged as a safeguarding concern, and this was amended. Some notes from that MARAC meeting were recorded on the system.

4.7.46. On the second occasion (referral from police November 2013) the Team tried a number of times to contact Donna Williamson but were unable to and closed the case.

4.7.47. Following the third referral, from the Refuge IDVA Service (see 3.6.34) in December 2014, the Team were again unable to contact Donna Williamson and requested a welfare check by police. This was completed quickly by police but an update was not requested by or provided to SCAIT until more than two weeks later (in part due to the Christmas and New Year period). The police informed SCAIT that Donna Williamson was "*safe and well and had no suicidal thoughts*". There were no further records until Donna Williamson was in contact with the service in 2016.

**Royal Borough of Greenwich Adult Social Care**

4.7.48. Greenwich Adult Social Care primarily had contact with YZ's family member and YZ, but also briefly with Donna Williamson.

4.7.49. The service was in contact with YZ, and at times with Donna Williamson, from 2012 to 2015 due to YZ's family member being within the service. That family member was receiving a care package throughout this time; it came to an end in September 2013.

4.7.50. In 2011 they were notified by police of the allegation against YZ that he was financially abusing the family member he cared for; and had contact with YZ in which he reported being stressed with caring responsibilities, and problems with his girlfriend (Donna Williamson). They were contacted by another member of YZ's family in mid-2012, who reported the financial abuse again and said that they were afraid of YZ and his violent nature. Shortly after that contact, Adult Social Care met with YZ, Donna Williamson and YZ's family member to discuss the care package. No concerns were noted and YZ's family member was recorded as consistent that they wanted YZ to care for them.

4.7.51. Adult Social Care were notified by a relative of the issues ongoing for YZ in 2013 when YZ was on bail for the assault against Donna Williamson (September 2012, see 3.6.16). He was seen with his family member in September 2013 and no concerns were noted, and YZ's family member wanted YZ to continue to care for them; the care package then ended with very minimal contact from then on.

**Housing for Women**

4.7.52. Housing for Women only had contact with Donna Williamson.

4.7.53. Police referred Donna Williamson to Housing for Women in September 2012 for support following the incident in which YZ assaulted her (see 3.6.16); Donna Williamson was at that time also engaging with the IDVA service (see above).

4.7.54. The service contacted Donna Williamson the same day. Donna Williamson was in the process of finding a family member she could stay with. She was recorded as "*feeling really guilty that [YZ] is in [prison]*". The service called Donna Williamson again the next day and she referred to a "*housing appointment*" in Lewisham the following week (it was with Thames Reach, arranged with the IDVA) and also that she was due in court for racially abusing a police officer but "*she can't remember what happened as she was drunk so is going to plead guilty*". The worker talked to Donna Williamson about support for her drinking which Donna Williamson stated she wanted to stop, and also speaking with her GP about medication as "*when she gets down or upset she has one drink then that leads to another and another, she was feeling fine when she was on [medication]*". The worker offered Donna Williamson support with the housing appointment. (The next day, the IDVA called Donna Williamson who said there had been further incidents but she did not want to talk about it.)

4.7.55. In subsequent contact the worker could not identify which housing service Donna Williamson was due to attend (as they did not know about Thames Reach) and Donna Williamson herself was recorded as confused about it. The worker then called Greenwich Housing Options and Support Service (see below) to arrange a time for Donna Williamson to go in. The worker called Donna Williamson to find out how the appointment had gone, and Donna Williamson stated she had not been able to go due to illness. The worker made further contact with Greenwich Housing in which they updated that Donna Williamson had attended an appointment and they had searched for a specialist refuge. The worker made a note to call Donna Williamson the following day. There was no further contact with Donna Williamson recorded.

4.7.56. In December 2014 police attempted to refer Donna Williamson again, and the service advised the officer to refer Donna Williamson to the Lewisham IDVA service.

**Royal Borough of Greenwich Housing Options and Support Service**

4.7.57. Greenwich Housing only had contact with Donna Williamson (a brief contact was recorded with YZ outside of the Terms of Reference timeframe).

4.7.58. Donna Williamson attended Greenwich Housing in October 2012 following her contact with Housing for Women (see above). She was assessed for housing need / homelessness, in which the following was recorded: that her ex-partner was due in court that day having pleaded not guilty to assaulting her; there were reports of anti-social behaviour and

damage to her property; that "*[name]*" was going to refer her to Thames Reach (the housing officer recorded the name of the IDVA, but Donna Williamson did not state who they were and the housing officer did not have that information). Donna Williamson was offered a space in a refuge where additional support was offered in relation to substance misuse, which Donna Williamson declined. A DASH Risk Checklist was recorded as having been completed with Donna Williamson in which the score was recorded as 17; there was no record of who carried this out.

4.7.59. Following this the housing officer attempted to contact Donna Williamson a number of times. Once contact was made, it was recorded that Donna Williamson "*would welcome a referral to the HER Centre as she did not want to drink*" because it adds to her "*stress and isolation*". There was no record that the referral was made. The housing officer made further attempts to contact Donna Williamson that were unsuccessful, and her case was closed.

**CGL New Direction, Lewisham**

4.7.60. CGL New Direction only had contact with Donna Williamson.

4.7.61. CGL New Direction contact with Donna Williamson started November 2012. She was assessed, and the next record was six weeks later when she was called to arrange an appointment. The next record was a contact by the service to Donna Williamson in April 2013; there were no records in between.

4.7.62. The next record was in August 2013 when Donna Williamson attended an appointment with the service. She then attended appointments in September (three) and October (two, plus a telephone call) and December (one). In January 2014 Donna Williamson cancelled her scheduled appointment. There were then no records until September 2014 when Donna Williamson's case was recorded as closed "*due to disengagement*".

4.7.63. Donna Williamson came back into the service in October 2015 when she attended an assessment in which it was recorded that she was drinking 30 units of alcohol a day. She referred to her relationship with YZ who was a "*current CGL client*" and that there was "*domestic violence (between each other) within the relationship*". In November Donna Williamson missed one appointment (that was scheduled with NPS) and attended one appointment. In that appointment she stated she and YZ had split up and "*she was finding it hard to cope with*", she was in "*low mood and felt like hitting someone over the head with a hammer*". She wanted to get back in touch with her parents "*as she had lost contact because of her ex/partner YZ and the domestic violence he inflicted on her*". CGL New Direction had contact with probation (see 3.6.88) and with police regarding concerns for Donna Williamson.

4.7.64. Following failed attempts to contact Donna Williamson after that appointment, the service contacted the police to request a welfare check, which was done. Donna Williamson then

contacted the service with concerns that her door was now broken. A week later Donna Williamson cancelled her next appointment. In December 2015 the service was unable to contact Donna Williamson on two occasions, and she did not attend a scheduled appointment.

4.7.65. Her engagement with the service continued into 2016, see below.

**CGL Aspire, Greenwich**

4.7.66. CGL Aspire only had contact with YZ.

4.7.67. YZ's contact with this service started two months after Donna Williamson was first in contact with CGL New Direction (see above). He was referred in October 2012 by the Greenwich police drug intervention team, and was assessed while accompanied by his sibling. YZ reported "*being involved in domestic violence in the past*" and that he had to engage with CGL Aspire as part of his bail conditions (following the assault on Donna Williamson in September 2012). In November 2012 YZ attended two appointments, and received a medical assessment. The service attempted to contact YZ throughout December but was unable to speak to him, and his case was closed in January 2013.

4.7.68. In July 2013 YZ attended the 'open access' part of the service (i.e. self-referral). Again this coincided with Donna Williamson's contact with CGL New Direction (see above). Following this he attended one and missed one appointment. In August 2013 YZ attended approximately five appointments, following which he was referred on to the aftercare part of the service.

4.7.69. The following month (September 2013) YZ attended the service and stated he had relapsed, and was told to attend the open access service. The next record was in October 2013 when a text message was sent to YZ. In November 2013 the service wrote to YZ asking him to get in touch, and attempted to call him once. YZ then contacted the service, and an appointment was arranged which he did not attend. The following month his case was closed.

4.7.70. CGL recorded the Greenwich MARAC minutes from June 2015 with an action for the service to try to reengage with YZ. A record was made of an attempted call but the number was not responding.

4.7.71. YZ's final period of contact with the service began in August 2015 (shortly before Donna Williamson was re-engaged with CGL New Direction in October 2015, see above). On this occasion YZ was referred by police in Lewisham and was assessed: he reported having accessed CGL Aspire before, but that he had relapsed due to a breakdown in his relationship. He was recorded as having depression and anxiety, and physical ill health due to alcohol. He was recorded as living alone in a one-bedroom property. After this YZ missed one appointment and the service tried to contact him once and was unable to.

4.7.72. In September and October 2015 YZ missed four appointments and attended three. There was ongoing contact between CGL Aspire and the Greenwich police PIT who were working with YZ (see 3.6.25). YZ was discharged at the end of October 2015 because the PIT informed the service that YZ no longer wished to engage.

4.7.73. In December 2015 YZ attended open access and an appointment was made for him which he did not attend. This period of engagement continued into 2016, see below.

**National Probation Service**

4.7.74. NPS (probation) only had contact with Donna Williamson.

4.7.75. Donna Williamson appeared at court in March 2015 changed with assault against YZ (she had hit him over the head with a phone charger, see 3.6.18). Donna Williamson pleaded guilty, and probation completed a pre-sentence report with her to inform sentencing. Due to the nature of the offence Donna Williamson was registered as a domestic abuse perpetrator on the probation system. Donna Williamson was assessed as posing a high risk of harm to YZ. The report suggested the court "*might want to*" adjourn for Donna Williamson to be assessed for alcohol treatment. The firm proposal was for a community order with requirements of: a curfew; Rehabilitation Activity Requirement[8]; and to undertake the Female Aggression and Domestic Abuse (FADA) one-to-one activity with probation. This was imposed. FADA would have involved a specially trained Probation Officer delivering the programme 1-2-1 in supervision appointments with Donna Williamson.

4.7.76. Donna Williamson breached her curfew eight times between March and July; no action was taken because the offender manager was not aware of the breaches.

4.7.77. Of 35 appointments listed, Donna Williamson did not attend 23 of them (including two alcohol assessments) and attended twelve (including one alcohol assessment), albeit three of these she attended intoxicated. She had missed 14 and attended four when breach proceedings were initiated in August 2015. Donna Williamson was returned to court in September 2015, where she pleaded with the Judge for another opportunity so that she would not lose her accommodation and the community order was continued.

4.7.78. The FADA was never completed: probation in London had removed it from the list of available programmes in 2013, and the offender manager was not trained to deliver it.

4.7.79. The offender manager recorded a referral for Donna Williamson to Together for Mental Wellbeing in 2015; this progressed in 2016 (see below).

4.7.80. Towards the end of 2015 Donna Williamson presented to probation as "*tearful and threatening to kill herself*" and that "*if anyone annoyed her she would take a hammer and hurt someone*". This was at the same time as Donna Williamson was reporting this to CGL

[8] The requirement of the RAR is that the offender must comply with any instructions given by the offender manager to attend appointments or participate in activities (or both).

New Direction (see 3.6.71). The offender manager contacted Donna Williamson's GP for help and City Roads for Donna Williamson to access an alcohol detox facility, and they said that they would make enquiries (NB: access to this service was and is only through CGL New Direction). The offender manager also contacted SLaM who stated Donna Williamson would have to present at the Hospital Emergency Department, and that she would have to be sober. These concerns for Donna Williamson continued into 2016 (see below).

**Her Centre**

4.7.81. The Her Centre only had contact with Donna Williamson.

4.7.82. Police referred Donna Williamson to the Her Centre in January 2015. She was contacted and what the service could offer was explained. Donna Williamson spoke about her locks being changed as "*she fears other people*" but then declined support. The worker recorded that Donna Williamson sounded "*very confused, possible mental health*".

4.7.83. The Her Centre also received a referral for YZ, via the Greenwich MARAC in June 2015. The service made numerous attempts to contact him but were unable to.

**Victim Support**

4.7.84. Victim Support only had contact with Donna Williamson.

4.7.85. Donna Williamson was referred to Victim Support twice in 2015. In February, following an incident with YZ, Donna Williamson was referred as a victim of 'assault without injury', which was flagged as domestic abuse. In December she was referred as a victim of 'burglary in a dwelling', which was not flagged as domestic abuse: the police had recorded an incident in which Donna Williamson reported someone had forced their way into her flat and stolen the electricity meter and cause damage. Donna Williamson was recorded as telling probation it was YZ but Donna Williamson did not state this to police.

4.7.86. In both cases Victim Support were unable to contact Donna Williamson.

**Lewisham Multi-Agency Risk Assessment Conference**

4.7.87. There were four referrals in this time period for Donna Williamson as a high risk victim of domestic abuse from YZ (and a further two in 2016, see below). Meetings were held in July 2012 (referred by police), August 2012 (IDVA), October 2012 (IDVA), January 2015 (police). The minutes record very brief information shared by some agencies.

4.7.88. The information recorded for the July 2012 meeting was that Donna Williamson would like support for her alcohol use, and that she would like her property secured. One action was made for CGL New Direction and the IDVA to work together to support Donna Williamson and help her with her alcohol use. This was marked as complete when CGL New Direction were recorded as having an appointment with Donna Williamson.

4.7.89. Donna Williamson was referred again almost immediately as a repeat case[9] and a meeting held in August 2012: CGL New Direction shared that Donna Williamson had not attended the appointment made for her, and Lewisham Adult Social Care shared a note from their system from the ambulance service that Donna Williamson had had cigarette burns on her face and bruising on her arms and abdomen, and torn clothing (no further detail was provided in the minutes).

4.7.90. The actions made were for the IDVA to encourage Donna Williamson to re-engage with CGL New Direction, including speaking to her about out-of-office visits; for police to share the details of the incident at the end of June with Lewisham Adult Social Care who would then check their system for the report they mentioned at the meeting. These were subsequently marked as having been completed.

4.7.91. A repeat referral was made later in the year and Donna Williamson discussed at the October 2012 meeting. Concerns were raised at this meeting with regard to the family member YZ cared for, and an action made for police to provide the details to Lewisham Adult Social Care who were then to liaise with Greenwich Adult Social Care about them. This was subsequently marked as having been completed.

4.7.92. The next referral for Donna Williamson was in December 2014, followed by a meeting in January 2015. The following was recorded: case closed to IDVA who had referred to Adult Social Care because Donna Williamson was very distressed when spoken to, and said she was going to kill herself; doesn't want a refuge or to move home; she is afraid she will hurt YZ as he makes her angry; claims local drug addicts bully her and recently broke into her property.

4.7.93. Two actions were made at this meeting: for all agencies to flag Donna Williamson and YZ as MARAC cases; and for the case to be "*highlighted*" to Adult Social Care who had been unable to attend the meeting (this had not been marked completed in the documents submitted to the Review).

**Greenwich Multi-Agency Risk Assessment Conference**

4.7.94. Three referrals were made for YZ by police and meetings held in June 2012, March 2013, June 2015.

4.7.95. The June 2012 meeting followed a referral from Lewisham Police following an incident in May 2012 where YZ called police alleging Donna Williamson had stabbed him. There was a small scratch mark to the front of his chest. Both had been drinking and argued. He stated she had stabbed him but was unwilling to assist police any further. She stated he had attacked her and she armed herself for self-defence and he pushed himself up against

[9] An individual who has been referred to the MARAC must be re-referred (a 'repeat referral') if, within 12 months of their case being heard, there is an incident (reported to any agency) of violence, threats of violence from the same or different perpetrator, or where there is a pattern of stalking or harassment, or where rape of sexual abuse is disclosed by the victim.

the knife causing the mark. The MARAC referral stated that drink was a major factor in their arguments and generally Donna Williamson appeared to be the victim. Lewisham were recorded as dealing with Donna Williamson as the victim but wanted Greenwich MARAC to address YZ as he resided in Greenwich. YZ was recorded as previously known to Oxleas but the case was closed.

4.7.96. Actions were recorded for the Her Centre to make contact with Lewisham to find out who the "*actual*" victim was; it was recorded that YZ did not engage with Her Centre and that attempts were made to contact Lewisham, but no response was received. This action was marked complete; Her Centre have no record of this action and it is not possible to establish who they were trying to contact in Lewisham.

4.7.97. Police referred YZ to the MARAC meeting in March 2013, due to there being nine police reports since the previous meeting. YZ was noted to be on bail for grievous bodily harm against Donna Williamson; and that Donna Williamson had been arrested in February 2013 and charged with actual bodily harm against YZ and was also on bail and due at court in May 2013. Alcohol was noted to be an aggravating factor. Donna Williamson lived in Lewisham and Lewisham MARAC had been made aware. Donna Williamson was engaging with the IDVA, however it seemed likely that she would withdraw her statement against YZ. YZ had stated (it does not say to whom) that they both needed assistance with alcohol and would benefit from counselling, that YZ wanted to continue the relationship as they love each other. One action was made, which was to discuss a referral for alcohol support with YZ, this was subsequently marked complete.

4.7.98. The final referral to the meeting in June 2015 was again from police, and detailed concerns for Donna Williamson, YZ and the family member YZ cared for. It was recorded that: there had been more than seven reports in 2015 between these parties; both Donna Williamson and YZ had been arrested in 2015 for allegations of assault on the other (and that Donna Williamson was on a community order following one); there was an extensive domestic abuse history and level of violence known, with alcohol an aggravating factor in all incidents. The minutes noted the information that in the past Donna Williamson had stated that she would probably end up hurting YZ as he would drive her to it. YZ's involvement with CGL Aspire was noted; SLaM shared that they had previously been engaged with Donna Williamson (2009); and Oxleas that YZ had previously been engaged with them.

4.7.99. An action was recorded for Greenwich Adult Social Care to "*update*" on the care for YZ's family member, and Oxleas accepted a referral for them (this was marked complete). An action was made for YZ to be referred to CGL Aspire; this was subsequently marked as complete, as they had offered a service to YZ but he had not responded.

## 4.8. Chronology from 1 January 2016 to Donna Williamson's death

4.8.1. In 2016 (aged 44) Donna Williamson's involvement continued with: police, probation, CGL New Direction, LAS, Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital; Woolwich and University Hospital Lewisham), her GP, Refuge, London Borough of Lewisham Adult Social Care, and there were two more Lewisham MARAC meetings. She was involved for the first time SHIP, London Borough of Lewisham Crime Enforcement and Regulation Service, Together for Mental Wellbeing and the NCDV YZ continued to be involved with police, his GP and CGL Aspire.

4.8.2. In just over seven months, there were 226 records made by 16 agencies in relation to Donna Williamson, or YZ, or the two of them as a couple. For YZ's GP, LAS, the Lewisham and Greenwich NHS Trust, SLaM, NCDV, SHIP, Lewisham Crime Enforcement and Regulation Service, Together and Victim Support the involvement was brief and/or minimal. For police, Donna Williamson's GP, London Borough of Lewisham Adult Social Care, probation, Refuge, CGL New Direction and CGL Aspire, the contact was ongoing and/or extensive.

4.8.3. Donna Williamson's involvement with agencies varied over the months: from January to May the total was consistently between eight and eleven. This then declined significantly, with four in June and three in July and five in August. YZ was involved with no more than three agencies throughout this time, and from February this was only one or two; then in June and July he had no contact or involvement with any agencies, and in August he was only in contact with police.

4.8.4. They are presented separately, as Donna Williamson's involvement with agencies was significantly more extensive than YZ's

**YZ's involvement with agencies in 2016**

4.8.5. Except for the police involvement in relation to incidents involving YZ and Donna Williamson (outlined below), YZ only had contact in 2016 with his GP (2 appointments) and CGL Aspire.

4.8.6. Following a period of engagement with CGL Aspire at the end of 2015 (see 3.6.81), YZ was discharged from the service in early January 2016 having missed appointments. Ten days later YZ was signposted back to the service by officers at Lewisham Police Station, and he was assessed. His care plan included information about his engagement with the police domestic abuse PIT, and that the CGL Aspire key worker would "*explore the domestic violence*" with YZ. He then attended a medical assessment.

4.8.7. YZ had an appointment in January with his GP for support with his alcohol use, in which the GP recorded "*recent domestic argument with girlfriend – police were called … given bail conditions – not allowed in Lewisham / must engage with [CGL Aspire]*". YZ attended

again in May and was advised with regard to his alcohol use, and offered treatment for anxiety and a physical health issue.

4.8.8. In February YZ attended 4 appointments or group sessions with CGL Aspire. In March the service telephoned him once, and he missed one appointment. The service contacted the PIT to find out if they'd had recent contact with YZ, and they gave CGL Aspire a new number for him. They telephoned him and there was no answer. The service then heard (from another client) that YZ may have been in prison and they emailed probation to find out his whereabouts. The next record was one month later (April) when the service called the PIT and found out that YZ was not in custody, was "*still drinking alcohol and aggressive but did not wish to engage*". Ten days later the service received an email from the PIT that YZ did not wish to engage and his case was closed.

4.8.9. During this time, CGL Aspire were contacted (at the end of February) by CGL New Direction; there was no record of CGL Aspire returning the call. In March CGL New Direction emailed CGL Aspire with information from the Lewisham MARAC. No actions were requested.

**Donna Williamson's involvement with agencies in 2016**

4.8.10. The following table sets out the records for each agency relating to Donna Williamson in 2016. 'Failed' contacts refer to attempts to speak to Donna Williamson on the phone which did not get through, and appointments she did not attend.

4.8.11.

| Agency | Total records (re Donna Williamson) | Direct contact with Donna Williamson (+ failed) | Contact with another agency | Donna Williamson disclosed domestic abuse | DASH RICs done |
|---|---|---|---|---|---|
| Police | 20 | 19 | 1 | 11 | 6 |
| Lewisham Adult Social Care | 28 | 5 (6) | 12 | 1 | |
| GP | 17 | 17 | | 3 | |
| Probation | 41 | 10 (9) | 12 | 6 | |
| Together | 4 | 1 (1) | 1 | | |
| Refuge (IDVA) | 24 | 7 (2) | 9 | 6 | 1 |
| CGL New Direction | 27 | 6 (8) | 12 | 4 | |
| London Ambulance Service | 3 | 3 | | | |
| Hospital | 2 | 2 | | | |
| Lewisham Crime Enforcement | 11 | 1 | 7 | | |
| NCDV | 5 | 2 (3) | | 1 | |
| South London & Maudsley NHS Trust (SLaM) | 2 | (2) | | | |
| Victim Support | 9 | 4 (3) | | | |
| Lewisham SHIP | 2 | 1 | | 1 | |
| **TOTAL** | **195** | **78 (34)** | **54** | **33** | **7** |
| Lewisham MARAC meetings | 2 | N/A | N/A | N/A | N/A |

**January**

4.8.12. In the course of one day in early January, Donna Williamson was in contact with CGL New Direction, police and her GP (and probation recorded receipt of a letter from her GP). She told CGL New Direction that she "*wasn't good*" and that YZ had "*beaten her up and been arrested*". Donna Williamson was waiting for the police domestic abuse officer to attend "*as she felt unsafe*". An appointment was arranged, and the CGL key worker agreed that they would arrange to meet with Donna Williamson with her offender manager.

4.8.13. Donna Williamson called police to report that YZ was threatening her. Officers attended and Donna Williamson stated YZ had been abusive over the phone to her and called her names; she had told the 999 operator that YZ had said he was on his way to her flat, but told the attending officers this wasn't true. Officers gave Donna Williamson personal safety advice and completed the DASH Risk Checklist with her and identified her as at standard risk.

4.8.14. Donna Williamson telephoned her GP who recorded Donna Williamson "*allegedly bullied and beaten by boyfriend, bruise over right cheek*"; she also reported an absence of menstrual periods and requested a pregnancy test. The GP recorded that Donna Williamson said, if the test were positive, she would request a termination. There are no further records in relation to this.

4.8.15. Three days later Donna Williamson attended her scheduled reporting appointment with probation. She attended late and intoxicated, and reported assaults from YZ over the Christmas period, and said she felt very unsafe. She stated she would not disclose this to her landlord as she was on her final warning. The offender manager recorded that Donna Williamson had previously stated she wanted to go to detox but had not "*followed through*"; and that the offender manager had engaged with Donna Williamson's GP and Donna Williamson was now on anti-depressants, although Donna Williamson had confessed to selling them when intoxicated. The offender manager recorded a referral to Together for Mental Wellbeing, and a request to police for information on the alleged assaults by YZ over Christmas. That information was provided the next day.

4.8.16. The offender manager called Lewisham Adult Social Care the next day to seek support for Donna Williamson. Adult Social Care recorded that there was "*an ongoing domestic violence situation with her partner, YZ*"; that CGL were involved as Donna Williamson used alcohol, but Donna Williamson was "*not really engaging*"; police were involved frequently; a welfare check had been needed recently and the door was no longer secure; there was no electricity in place as YZ had allegedly damaged the connection. Donna Williamson did not want to consider moving or going to a refuge. It was noted that the offender manager was going to look at making a further referral to MARAC. It was further recorded that the

situation had "*been happening for a number of years and the concern is that Donna Williamson is not taking any steps to manage her own safety*". Adult Social Care agreed to contact Donna Williamson to discuss any support she may need, to ensure she has the number for Athena and to liaise with CGL New Direction.

4.8.17. Over the next ten days Adult Social Care made continued contacts (and attempts) with CGL New Direction, probation and Donna Williamson, during which the above information was repeated or shared. CGL told them that there were "*ongoing concerns*"; gave an updated mobile number for Donna Williamson; said they understood the police had fixed the door; and that detox and rehab were being looked in to, but Donna Williamson would need to attend meetings to "*show she's committed to changing situation*".

4.8.18. When Adult Social Care spoke with Donna Williamson, they recorded that her main concerns were that her housing benefit claim had been "*messed up*" and that her door was still broken, but had a board over it. Donna Williamson said she had no family contact and a few friends said she should leave YZ. She said she was "*not herself lately as she is not washing, eating, does not want to leave the house*". When asked about the future, Donna Williamson was recorded as stating "*one of us will end up dead and the other in prison*". They discussed the Athena service, and Donna Williamson was advised to contact CGL New Direction for advice around her benefits. Adult Social Care contacted CGL New Direction on Donna Williamson's behalf as she had no phone credit, and was not aware of her appointment that day. CGL New Direction did not record whether she attended or whether they called her.

4.8.19. Adult Social Care records also note the referral to MARAC and that they would await the outcome of that meeting if there was a further role for them with Donna Williamson.

4.8.20. At the same time, the offender manager followed up on the referral to Together with a brief discussion with the worker there regarding Donna Williamson's needs. An appointment was made. Two days later Donna Williamson attended her probation reporting appointment, also with the CGL New Direction key worker, and probation noted "*MARAC forms completed*" (NB: neither agency referred to MARAC). CGL New Direction records showed that Donna Williamson "*did not engage well in the meeting and seemed vacant*"; that she was still waiting for her door to be repaired; that there had been an incident with YZ (referred to as her "*ex-partner*") in which a bloody knife had been found at her property but she did not state whose blood it was and did not want to press charges. She agreed to engage with the CGL process towards an alcohol detox and rehab application. CGL New Direction and probation agreed to complete a MARAC referral after the meeting.

4.8.21. Three days later (mid-January) Donna Williamson called police three times in one day to her flat as she wanted them to remove YZ who had been "*shouting at her*". The first occasion they attended and YZ calmed down, no offences were detected. The second

occasion Donna Williamson called back to say YZ had left; officers attended and Donna Williamson was alone, there were no offences. Police were called again later as YZ had returned and was "*causing problems*"; officers attended. Donna Williamson said that YZ had threatened to kill her the day before, and that he had assaulted her two weeks prior (New Year's Eve) causing injuries to her back, knees and legs but she hadn't called police because she was scared. YZ was arrested but no further action was taken as Donna Williamson did not make a statement and YZ denied the offence. Police signposted YZ to CGL Aspire and he attended an assessment (see 3.7.6).

4.8.22. The police officer referred Donna Williamson to the MARAC and to the IDVA service. The referral mentioned that Donna Williamson's door remained broken. An IDVA called Donna Williamson that day; initially Donna Williamson stated she did not want to go to a refuge; the worker tried to explain that the service offered support in other areas as well, and Donna Williamson said she would call back as she had company. The IDVA tried calling Donna Williamson the next day, but Donna Williamson said she could not talk as she was asleep and asked for a call back the next day (the IDVA called two days later when Donna Williamson again requested to be called back the following day, the IDVA contacted her two days after that, see 3.7.25).

4.8.23. Lewisham Adult Social Care recorded at this time a conversation with CGL New Direction, in which Donna Williamson's key worker reported Donna Williamson was not engaging and would be unlikely to go to rehab. They reported their feeling that Donna Williamson was being offered a lot of support, e.g. from CGL New Direction, from probation and from the IDVA service. The key worker informed Adult Social Care that "*there was an Injunction on YZ to stop him from coming into Lewisham for one month*".

4.8.24. Donna Williamson called CGL New Direction the next day and reported that YZ had come to her home at the weekend and "*gave her a slap*", she had reported this to police and they were going to arrest him. It was recorded that there was a police officer with Donna Williamson who could take her to her probation appointment the next day. CGL New Direction advised Donna Williamson of groups the service offered that she could attend, and updated probation. On the same day YZ attended his GP for alcohol dependence, physical health and anxiety with depression. He referred to the domestic abuse and bail conditions (see 3.7.7). He attended a medical assessment with CGL Aspire the next day.

4.8.25. Lewisham Adult Social Care and the IDVA service contacted Donna Williamson the next day, and Donna Williamson attended her probation reporting appointment in the company of two police officers. At the probation appointment she reported a further incident with YZ. During the contact with Adult Social Care Donna Williamson was recorded as having to break off from the conversation repeatedly in order to vomit. Donna Williamson stated she was not seeing YZ anymore as she had been told they were not to have contact; she could

not think of any support she needed. With regard to her care needs, Donna Williamson reported that she could move about with her crutches; that she was often sick when she ate and her GP had given her anti-sickness medication; that she could wash and dress herself but "*can't be bothered*". A letter was sent to Donna Williamson with the contact details for Adult Social Care so that she could contact them again if she needed support. An update was provided to probation during which the offender manager referred to Donna Williamson reporting YZ had made threats to kill her, and that she had two police officers who were visiting her daily and helping her to get to appointments. The offender manager reported that Donna Williamson did not require any support with daily living tasks and mainly required support with her alcohol and safety in regards to her abusive relationship; and that the offender manager was planning to make a referral to MARAC. Adult Social Care then closed the case.

4.8.26. During Donna Williamson's contact with the IDVA service on this day, Donna Williamson again referred to her door and asked when it was going to be fixed; she could not speak to her landlord as he had already given her a final warning and would evict her. Donna Williamson reported feeling sick and could not be on the phone very long. She reported that she had not seen YZ. The IDVA exchanged emails with the CGL New Direction key worker about Donna Williamson who reported Donna Williamson's "*poor engagement*" with the service, and with probation to set up a meeting with the offender manager, IDVA and Donna Williamson.

4.8.27. The following week (five days later) the IDVA again spoke to Donna Williamson who said that someone had looked at her front door but couldn't do anything about it; she could not talk so the call ended there. Further emails were exchanged between CGL New Direction and the IDVA to arrange a meeting, in which the key worker stated they were making a referral to MARAC.

4.8.28. The next day, Donna Williamson did not attend her scheduled reporting appointment with probation due to illness following which CGL New Direction were updated, and a letter was sent to Donna Williamson warning her that she could be in breach of her order.

**February**

4.8.29. The following week Donna Williamson missed another probation reporting appointment, which was also scheduled to be with Together (this was then rearranged). The offender manager called Donna Williamson who was "*in tears stating she was unwell and unable to attend. She had also been the victim of an associate threatening her*". The offender manager liaised with the police officer who had been supporting Donna Williamson and updated CGL New Direction; a week later they shared this information with the IDVA. In CGL New Direction's record of the update from probation about this missed appointment,

they recorded that Donna Williamson could not attend the reporting appointment because she was "*too scared to come out of her home*".

4.8.30. The offender manager spoke with their manager who agreed to return Donna Williamson's order to court as it had become "*unworkable*"; they then discussed this with the probation legal proceedings officer (LPO). The offender manager explained that Donna Williamson "*had been failing to attend and also failing to engage with agencies she has been referred to … she is a vulnerable individual with issues regarding substance misuse, depression and domestic violence (she is both the perpetrator and the victim) … it has been very difficult to work with* Donna Williamson *as she does not follow through with referrals made for her.*" The LPO advised waiting until the MARAC meeting the following week and if Donna Williamson failed to attend future appointments to breach her. The offender manager recorded informing the LPO that the only alternative proposal they could make would be prison, which the LPO stated the Judge would be unlikely to follow.

4.8.31. In the same week Donna Williamson telephoned her GP because she kept vomiting and was advised to make an appointment. CGL New Direction attempted to contact Donna Williamson but could not reach her. The IDVA contacted probation to find out how their meeting with Donna Williamson went.

4.8.32. The MARAC meeting was held shortly after this, with Donna Williamson referred by police as a repeat case. The following was recorded about Donna Williamson: YZ had made threats to kill her and her family; was engaging with CGL Aspire; that Donna Williamson had a key worker at CGL New Direction due to alcohol use; was current to probation; many incidents since last heard at MARAC, some very violent, and that she and YZ both attended each other's properties; Donna Williamson had mobility issues due to a hip replacement; that she was privately renting and "*front door is insecure but afraid to approach landlord for fear of eviction*".

4.8.33. The offender manager was tasked with arranging a professionals' meeting with CGL New Direction and the IDVA. This action was recorded by probation and the IDVA service in their internal systems. Probation ensured that the IDVA could attend Donna Williamson's scheduled reporting appointment the next day. Attempts were recorded by probation to arrange the professionals meeting but it did not take place.

4.8.34. Donna Williamson attended that appointment (with probation and the IDVA) while intoxicated, and with a male (not YZ; the male then left). Donna Williamson was recorded by probation as "*not really interested but wants a lock for [her] front door*". The IDVA recorded that Donna Williamson stated she did not want to separate from YZ as she felt he was protecting her from "*acquaintances*" she believed herself to be at risk from. The professionals meeting was referred to again, which would aim to "*provide a package of support services Donna Williamson could access*". The IDVA completed a DASH Risk

Checklist with Donna Williamson and she was identified as standard risk having answered yes to six out of 24 questions, but the IDVA noted Donna Williamson had answered "*don't know*" to 16 of them: she did not want to complete it as she felt the service couldn't offer her anything as she wanted to stay with YZ. Within this she reported "*there were a number of people who have threatened her now that YZ is bailed away. They come to her house to use and* drink.[10]" The IDVA recorded Donna Williamson's case would now be managed as a 'helpline call' which meant that she would be kept as an open case (usually when someone declined the service their case would be closed) so that the IDVA could continue work with the other agencies working with Donna Williamson.

4.8.35. Following this meeting the offender manager updated CGL New Direction, who recorded that the male Donna Williamson attended the appointment with was the same who was recorded as making threats to her at the end of January. During this time, YZ was attending appointments with CGL Aspire (see 3.7.8).

4.8.36. Donna Williamson telephoned her GP the same day as that meeting in which she was recorded as being "*involved in domestic violence, reported to police, no children involved*" and her medications were discussed.

4.8.37. That week Donna Williamson did not attend two scheduled groups with CGL New Direction. The following week they tried to call her but there was no answer. They then contacted probation to discuss Donna Williamson's engagement; the offender manager informed the CGL New Direction key worker that they would now breach Donna Williamson. Four days later Donna Williamson attended her scheduled reporting appointment with probation and was recorded as too intoxicated to participate. The offender manager recorded that Donna Williamson's "*physical deterioration [was] very marked – mobility limited*" and that she was in the presence of the same male that attended the meeting the week before.

**March**

4.8.38. The following week Donna Williamson again attended probation too intoxicated to participate; this appointment was also with the worker from Together, who was unable to assess Donna Williamson due to her intoxicated state. Donna Williamson stated she did not want to engage with Together and the appointment was cut short. Probation noted in the records Donna Williamson's "*further decline in wellbeing*".

4.8.39. In that week, CGL New Direction emailed CGL Aspire with a summary of the information shared at the MARAC discussion in February. Following this CGL Aspire were unable to establish contact with YZ and he was discharged in mid-April (see 3.7.8).

[10] No recent police incidents can be identified that would indicate current bail conditions for YZ at this time.

4.8.40. Also in that week, three calls were made to police on consecutive days. A female called police from Donna Williamson's address asking for help as "*someone was trying to stab her with scissors*"; officers attended and it was quiet, those present stated a male had just left. Donna Williamson called the next day reporting a friend was refusing to give her back some money; the operator asked if she was in danger and Donna Williamson stated the friend had scissors and "*was starting on her*"; then that she had taken the scissors away; she called again shortly after to say the person had left and there was no need for police to attend. The next day Donna Williamson called reporting a friend (different from day before) wouldn't leave her flat; he was spoken to and agreed to leave.

4.8.41. The same day as the last police call, Donna Williamson called LAS as she was vomiting blood and experiencing abnormal breathing. An ambulance attended, Donna Williamson was found on the floor fully alert and intoxicated. She was taken to hospital (Lewisham and Greenwich NHS Trust). It was recorded by the hospital that a "*friend*" had accompanied Donna Williamson in the ambulance (no other details were recorded). Donna Williamson was treated and discharged later that evening.

4.8.42. The following day Donna Williamson called police to report that she when she got home after being discharged from hospital the previous evening the communal door and her flat door had been kicked in and the flat searched. She stated she believed it had been done by an old friend as he had made threats towards her in the past. Police attended and spoke to Donna Williamson who was very drunk and kept changing her account. A relative of Donna Williamson was present who said nothing had happened and the damage to the flat was old.

4.8.43. The next day CGL New Direction attempted to call Donna Williamson but could not reach her; a text message was sent. No records were made for three weeks after this.

4.8.44. The next day Donna Williamson telephoned her GP reporting anxiety and her recent hospital attendance, and discussed her medication. She was advised to make an appointment. The same day, police were called to Donna Williamson's flat: it was recorded that Donna Williamson and YZ had been arguing as he had accused her of being unfaithful to him; there were no offences and YZ left. As officers were leaving they saw YZ returning to the flat, he was drinking and said that people had definitely been in Donna Williamson's flat and he was going to do something about it. He was arrested for breach of the peace. Donna Williamson was identified as standard risk through the DASH.

4.8.45. Later that week Donna Williamson did not attend her scheduled reporting appointment with probation due to "*poor health, limited mobility and her home had been broken into by YZ*".

4.8.46. Two days later police were called to Donna Williamson's address. They recorded both Donna Williamson and YZ had been drinking, and had argued as YZ believed Donna Williamson was having an affair. No allegations were made and YZ was taken home to

prevent a breach of the peace. Donna Williamson was identified as standard risk through the DASH.

4.8.47. The next day probation called Donna Williamson as she had not attended the CGL New Direction group session; she reported "*more incidents with YZ*" and that her landlord was threatening her with eviction. The same day the IDVA spoke with the police officer who was supporting Donna Williamson and advised that Donna Williamson could contact the NCDV to apply for a non-molestation order. NCDV recorded a call the same day from Donna Williamson which was then progressed. The IDVA also emailed the offender manager about the professionals meeting they were tasked to arrange. Donna Williamson telephoned her GP the same day for anti-sickness pills and another prescription of diazepam as "*boyfriend took it*" (it was not prescribed) and reported chronic leg and hip pain. She was offered an appointment that day but was unable to take it as she had no money to get there.

4.8.48. The next day (mid-March) the offender manager emailed CGL New Direction and the IDVA with dates for the professionals meeting. Responses were received but a date could not be arranged that suited all three; due to annual leave and also that the IDVA was leaving the service and another IDVA would take Donna Williamson's case. The same day the IDVA recorded contact from the police officer supporting Donna Williamson that Donna Williamson had been asked to go back to court as she'd missed her probation reporting appointments; and that she had progressed the application with NCDV. Also that day NCDV recorded three attempts to contact Donna Williamson which were not successful.

4.8.49. Donna Williamson attended her GP the following day in which it was recorded she had "*symptoms of depression*". NCDV called Donna Williamson the same day and she advised she did not want to proceed with the non-molestation order.

4.8.50. Donna Williamson's neighbour emailed the London Borough of Lewisham Crime Enforcement and Regulation Service the next day about Donna Williamson. Issues included frequent noise pollution, intimidation of other residents, keeping a dog at the property which was a breach of the lease; drug dealing at the property; theft of communal electricity. The complainant outlined in their email that their main concern was that they felt Donna Williamson was a vulnerable adult who needed support to find safe alternative accommodation.

4.8.51. The service wrote to Donna Williamson to inform her of the complaint. They also made contact with the complainant. An email was sent to London Borough of Lewisham Adult Social Care providing details of the complaint. Lewisham Adult Social Care advised the service to inform police and the Lewisham MARAC Coordinator, which was done via email. Intelligence regarding Donna Williamson was also requested from police and MARAC. There was no further action requested of Adult Social Care, but they followed up on the

emails with a telephone call outlining the agencies involved with Donna Williamson. A further email was sent to police to alert them to potential wellbeing issues with Donna Williamson. Shortly after this, police informed the IDVA of the complaint and Donna Williamson's housing situation (no action was taken by the IDVA). The service contacted CGL New Direction and requested information on Donna Williamson's engagement; this information was provided.

4.8.52. Donna Williamson contacted the service after receiving the letter. She stated she suffered from depression and the noise heard was police "*kicking her door down as they thought that she had self-harmed*". She was recorded as worried about losing her flat and concerned that the next step would be to evict her. She gave her contact number. The service at that time had two database systems running; Donna Williamson's call was recorded on one, but the worker responsible for the complaint was not using that system and therefore did not know that Donna Williamson had called.

4.8.53. At this time Donna Williamson telephoned her GP requesting diazepam which was prescribed for anxiety. The same day, she telephoned probation stating she was too ill to attend, and a letter was recorded received from her GP confirming this. Donna Williamson telephoned again two days later when she did not attend another appointment. The offender manager "*informed her that I will write to her GP for clarification as she is failing to engage and without any proof [a certificate] I have no alternative than to return this order to Court, as she has been advised of previously*". The offender manager was instructed by their manager the next day to initiate breach proceedings.

4.8.54. Donna Williamson called the police the same day to "*ask what happens if someone kisses you and touches your breast and you don't want them to*" which had happened to her in the past but she hadn't reported it. She was told this was sexual assault. Donna Williamson stated she did not want to report now, just to ask the question. The 999 operator felt a welfare check was required and an officer spoke with Donna Williamson and she said she didn't feel at risk from the person who she alleged had done this to her. She was advised to report any further incidents to police.

4.8.55. A week later the CGL New Direction worker contacted probation to inform them they had received an email (from the Lewisham Crime Enforcement and Regulation service) that Donna Williamson is to be evicted following neighbour complaints; and asked the offender manager for an update on the professionals meeting that had been scheduled to take place while the CGL worker was on leave. There was no record of a response.

4.8.56. The next day probation recorded that Donna Williamson did not attend her schedule reporting appointment. This was marked as 'medical' and acceptable.

**April**

4.8.57. A week later probation recorded that Donna Williamson did not attend her schedule reporting appointment.

4.8.58. Two working days later a 'review of enforcement' was recorded by probation. Donna Williamson was telephoned and she was recorded as "*unable to walk and crawling around on floor*". Donna Williamson asked for a home visit and the offender manager said this could possibly take place the following week as they had just returned from annual leave.

4.8.59. Two days later CGL New Direction attempted to contact Donna Williamson but could not reach her and a text message was sent to remind her of a session the following week.

4.8.60. The same day Donna Williamson called police as she was concerned for the welfare of a friend (the same one who had attended two probation appointments with her). She attended an appointment with her GP reporting weakness below the knees for two weeks and difficult walking because of it. A review appointment was booked.

4.8.61. The next day LAS were called as Donna Williamson could not walk, was on the floor, intoxicated and not alert. An ambulance attended and Donna Williamson insisted she had not called and did not need help. She was observed to be standing and was left at home.

4.8.62. That same day, and three days after the 'review of enforcement' the probation worker contacted Lewisham Adult Social Care requesting an assessment for Donna Williamson as they were "*extremely concerned regarding her health and welfare*". Discussions between probation and Adult Social Care referenced Donna Williamson's alcohol use, upcoming eviction (no onward referrals had been made), that she had reported having lost the use of her legs, is depressed and is neglecting herself, that she refuses to engage with CGL New Direction and Refuge (as she was a victim of domestic abuse), has been presented at MARAC, and that the offender manager had not been able to arrange the professionals meeting as directed to at that meeting. Adult Social Care spoke with Donna Williamson who stated that the stress of her housing situation was impacting on her physical health; she was using crutches and a friend was helping with shopping. She felt if she could sort out her housing situation then everything else would improve. She declined support in the short term as she was focused on resolving her housing as the means by which other areas of her life would improve. She asked about her door getting fixed. Adult Social Care updated probation with all of their contact with Donna Williamson and the referral was closed.

4.8.63. Probation sent this information on to CGL New Direction and police and requested their presence at a home visit that the offender manager had scheduled with Donna Williamson for later that day. Probation also asked police for help in fixing Donna Williamson's door; police replied that this would need to be done by Donna Williamson or the landlord because it had been boarded up after they had attended but YZ had broken it at a later

date. There was no probation record of the home visit, but a police record from the same day referenced Donna Williamson's "*social worker*" arriving at the same time that they were responding to a call from Donna Williamson that someone had entered her flat by pulling the padlock off her front door. She said it may have been "*friends who had been staying in the flat while she was away*" but would not give details. Following this an automated referral was made to Victim Support who attempted to telephone Donna Williamson on another day but could not get through. They called again a month later and again could not get through; a voicemail was left. Two weeks later another call was made and Donna Williamson was spoken to. She said she needed her locks changed and Victim Support informed her they could not help with that as she was in private rented accommodation; her case was closed.

4.8.64. The offender manager telephoned Donna Williamson's GP reporting concerns with Donna Williamson's physical and mental state and an appointment was made for Donna Williamson to attend the next day and the GP agreed to fax a note explaining Donna Williamson not attending probation appointments. Donna Williamson also called that day reporting she was "*very run down and depressed*".

4.8.65. Donna Williamson attended the appointment the next day and the GP recorded it was "*a long one medical problems: mental health decline due to recent abusive relationship, excessive drinking … about to be evicted. Physical health: alcoholic gastritis prompting alcohol withdrawal symptoms, paroxetine[11] withdrawal. Letter to probation, letter to landlord referral for [hospital emergency department or mental health inpatient unit] (for [alcohol] detox and medical care), [medications] issued just in case does not attend [emergency department]*". Probation recorded receipt of the letter.

4.8.66. LAS were called the same day (afternoon) as Donna Williamson "*could not walk properly … was feeling suicidal*". An ambulance attended. Donna Williamson reported she was having suicidal thoughts and had been in a previous abusive relationship. Donna Williamson was taken to hospital, where she was referred to the Psychiatric Liaison Nurse in the Emergency Department (SLaM). The Nurse was then informed that Donna Williamson had left. Donna Williamson presented again that evening, and the Nurse was notified. When they attempted to find Donna Williamson two hours later she was found to have self-discharged. SLaM staff attempted a welfare check by calling Donna Williamson's home phone, which was not answered and there was no facility to leave a message. The Emergency Department Nurse Coordinator was informed and asked to contact the SLaM team if Donna Williamson presented again.

[11] A medication used to treat depression, obsessive-compulsive disorder and anxiety disorders.

4.8.67. Donna Williamson informed the offender manager of her visit to hospital that day, and said that the staff in the Emergency Department had "*sent her away as nothing could be done until she had been alcohol free for three days*".

4.8.68. Four days later (end of April) the offender manager visited Donna Williamson at home. Donna Williamson was recorded as being "*in distressed state; YZ present; she says she is living with him*". The offender manager noted that Donna Williamson's home was insecure "*having been broken into by another person*".

4.8.69. Three days later Donna Williamson attended a meeting with probation and CGL New Direction. She was not under the influence of alcohol, and stated she had reduced her intake (but understood she could not stop completely due to the risks as she was alcohol dependent). They discussed with Donna Williamson her "*lack of engagement with all agencies*". Donna Williamson was recorded as saying "*she was aware and gave reason that she had been in a lot of pain with her leg which she injured a few weeks ago."* It was recorded that this "*may have been from a domestic violent incident involving her on/off partner YZ*". She was recorded as agreeing to engage; the offender manager agreed to contact Adult Social Care for any help they could offer. Probation recorded that Donna Williamson's order was due to end soon.

**May**

4.8.70. The following week the IDVA contacted Donna Williamson (this was the first recorded contact since February, although the IDVA does recall making other attempts to contact Donna Williamson, who had previously declined the service); it is unclear why they made contact at this point but it may have been because of the MARAC meeting scheduled for the next day) who said she was "*fine now and didn't want the service*". The IDVA noted that it sounded as though "Donna Williamson *could not talk*". Donna Williamson called her GP on the same day and reported to them that she was "*better*" and focused on not drinking with help from CGL New Direction.

4.8.71. The MARAC meeting was held the next day. The minutes were brief and stated the following for Donna Williamson: "*Alcohol and crack cocaine. CGL keyworker is attempting to make contact. Privately renting. Some engagement with IDVA. On anti-depressants. Overdose in 2008. Not mobile – unable to walk any distance. Known to Probation – near end of her probation period – struggling to engage. A[dult] S[ocial] C[are] have liaised with GP. [Police] Op[eration] Dauntless nominal*[12]*. Soon to be evicted.*"

[12] From the police IMR: Operation Dauntless is part of the MPS Continuous Improvement Plan for Domestic Violence. It includes a number of actions police officers can take to improve the safety of victims and manage the risk of offenders.

4.8.72. Actions were made for CGL to attempt to make contact with Donna Williamson, and for the IDVA to discuss Homes Security Programme and refuge places with her. These were subsequently marked as having been completed.

4.8.73. The same day (records suggest it was during the MARAC meeting) the offender manager emailed the IDVA asking them to contact Donna Williamson as she had been in contact with probation and was "*down*", had "*spent the last few days with YZ*" and that earlier in the week he had been "*violent and aggressive towards her, he hit her a few times around the head and was threatening and abusive to her*"; Donna Williamson agreed for the offender manager to ask the IDVA to contact her, although she was "*adamant*" she would not leave her property. The IDVA emailed a reply that they would "*call Donna Williamson ASAP*". There are no further records of the IDVA making contact with Donna Williamson. (The worker has subsequently stated they did attempt to contact Donna Williamson but did not record it.)

4.8.74. The same day, Donna Williamson called police to her home as YZ was trying to break in, and had thrown food at her. Police attended and YZ had left; he called while they were present and Donna Williamson told him that if he returned he would be arrested. He returned, and was arrested for common assault. Officers completed the DASH Risk Checklist with Donna Williamson and she was identified as standard risk. A referral to Adult Social Care was made as Donna Williamson was identified as vulnerable.

4.8.75. In custody YZ became violent and as a result was arrested for assaulting officers. YZ was released on bail until mid-July 2016. The CPS authorised a charge of common assault against Donna Williamson, although she had not made a statement. When officers informed Donna Williamson that YZ was being charged she expressed worry that he would be sent to prison, and that then there would be no-one to look after her dog.

4.8.76. CGL New Direction called Donna Williamson the following day and she was recorded as being "*in good spirits*"; she was invited to attend a group session the following week. The next day there was email contact between CGL New Direction and probation in which an update was provided on the incident earlier that week for which YZ had been arrested and charged with common assault against Donna Williamson. His bail conditions (not to contact Donna Williamson, not to visit her address, and not to enter the London Borough of Lewisham) were part of the update.

4.8.77. The following week Donna Williamson had a scheduled reporting appointment with probation, there is no record of whether she attended or not, or was contacted. Her order expired at the end of that week.

4.8.78. That weekend (mid-May) Donna Williamson called police to report a rape that had allegedly occurred the previous year. Donna Williamson stated she couldn't remember if she had told police about it before, but the male kept "*bothering her and saying he is going to get her*".

She was intoxicated and the call taker recorded that as a result it was difficult for to get a full and clear account. An investigating officer attempted to contact Donna Williamson a number of times (including visiting, calling and writing to her) but was unable to until around three weeks later, when Donna Williamson stated she did not wish to pursue the allegations. A referral to Adult Social Care was made as Donna Williamson was identified as vulnerable. An automated referral was made to Victim Support and she was telephoned by that service. She requested a call back the following day; they called her two weeks later and Donna Williamson said she did not want to talk about it or receive support. The case was closed.

4.8.79. Shortly after this YZ attended his GP to discuss his alcohol use and anxiety. This was his last contact with the GP or any other agency.

4.8.80. Lewisham Adult Social Care received notifications from police in relation to this and the common assault by YZ for which he had been charged on the same day (the incidents were ten days apart; Adult Social Care received both over a week after the second incident). They contacted Donna Williamson, and she said there had been no further incidents and YZ had not attended her flat and wasn't allowed to; if he did, she would call police. She said that she was being evicted and had to leave the property in three weeks; and was planning to attend Lewisham Single Homeless Intervention and Prevention Service (SHIP) that week. Donna Williamson agreed to Adult Social Care contacting SHIP to give them information about her and an email was sent to the team manager with Donna Williamson's history and Donna Williamson's case closed.

4.8.81. The same day Donna Williamson had an appointment with her GP. She requested a letter addressed "*To whom it may concern*" setting out her history and situation. The letter referred to the deterioration of her physical and mental health, that she was "*vulnerable after recently ending an abusive relationship*", that she drank excessively, was "*clinically depressed and neglecting herself and as a result she has lost quite a lot of weight*". Donna Williamson was prescribed a food supplement due to her self-neglect and significant weight loss; and diazepam to help her sleep.

4.8.82. Two days later Donna Williamson called police as a male friend was at her flat and refused to leave; she passed the phone to him and he said she was being verbally aggressive to him. This was defined as a civil dispute and no action was taken.

4.8.83. The following week (end of May) Donna Williamson attended SHIP asking for help as "*she was being evicted for anti-social behaviour and domestic violence*". She was referred immediately for an Initial Housing Options Assessment which was completed during the same visit. It was noted that Donna Williamson was at the first and early stage of the eviction process; she was informed of her rights and options including the private rented sector (as her best route). With Donna Williamson's consent, an attempt was made to

contact her landlord to discuss and a message was left for them. Donna Williamson was given a list of the documents required to progress with the service. She did not return.

**June**

4.8.84. The next day, the IDVA recorded that two MARAC actions were still outstanding: for the CGL New Direction worker to contact Donna Williamson; and for the IDVA to discuss the Home Security Programme with Donna Williamson. There was no record of the IDVA having contacted Donna Williamson since May 2016 when she declined the service (but it was noted that it seemed she couldn't talk easily at that point, see 3.7.69). The following week, the IDVA closed Donna Williamson's case because "*client declined and no further contact requested*". The IDVA informed the Refuge IMR author that they had made multiple attempts to contact Donna Williamson between the MARAC meeting and closing the case but could not reach her; these were not recorded.

4.8.85. The same week, CGL New Direction (a new key worker) wrote to Donna Williamson to offer her an appointment for a week's time. Donna Williamson did not attend that appointment; the key worker called her and there was no answer. A letter was sent with a new appointment for two weeks later, which Donna Williamson did not attend and there was no answer on her phone.

4.8.86. During that time Donna Williamson telephoned her GP about "*an appointment with Marylebone*" she couldn't attend (no detail was recorded); that she was attending Alcoholics Anonymous meetings and there was "*stress at home*". She requested diazepam and this was prescribed. She called again the following week to request it again and it was prescribed. At an appointment the following week Donna Williamson requested diazepam (which was prescribed) and medication for nausea and allergies (not prescribed).

**July**

4.8.87. Donna Williamson cancelled an appointment with CGL New Direction early in July as she could not attend due to pain in her hip, and that she "*had a lot going on*" due to the upcoming eviction. The CGL New Direction key worker advised Donna Williamson to contact SHIP for housing, her GP for the pain and that she should attend a CGL New Direction group session that week. Over three weeks later (end of July) they contacted Donna Williamson and arranged an appointment for early August; Donna Williamson was advised if she did not attend that appointment her case may be closed. She did not attend.

4.8.88. Donna Williamson saw her GP two days later and reported significantly reduced alcohol intake, anxiety, low mood and paranoid thoughts, shaking and aches in both legs. She was prescribed medication for these.

4.8.89. At the end of July probation recorded a "*Termination risk assessment*" related to the end of Donna Williamson's community order (see 3.7.76).

**August**

4.8.90. In early August (a week before YZ killed her) Donna Williamson called police as YZ "*had turned up at the flat and banged on the door*". When she opened the door he pushed past her and laid down on the sofa. When she asked him to leave he went to the kitchen and got a knife. He put it down when she asked him, and Donna Williamson called police. YZ was arrested for breach of bail and presented at court the following day, when he was released on the same conditions. As YZ had been arrested on a Saturday, the arresting officer completed the case file on the relevant police system and submitted it electronically to for supervision and approval. YZ was put before the court on the Monday morning and admitted breaching bail. He stated that Donna Williamson had contacted him, and that he had subsequently contacted her twice with no reply, and had then gone to her home because he was concerned about her. The CPS Lawyer had not received the relevant arrest file at that time and YZ was not on the list of cases for that day. The police officer's supervisor had not been aware of the file submission, and had not been on duty to supervise it before YZ was presented to court. The CPS lawyer contacted the Police Liaison Officer in the court and papers were prepared using papers from the original bail hearing following YZ's initial arrest; it did not contain details of the most recent arrest. He was re-bailed on the same conditions and warned that a further breach would result in him being remanded to custody. Information provided by CPS to this Review show that the papers that were uploaded to the relevant system (at 11:50pm), subsequent to YZ's bail hearing, did not contain any further information about the breach of bail.

4.8.91. The investigating officer for the original offence for which YZ was on bail (May 2015) was not informed of this incident. A DASH Risk Checklist was completed with Donna Williamson at the scene and she was identified as standard risk.

4.8.92. Two days after this, Donna Williamson called to ask if YZ was still in custody; there was no answer in the custody suite and Donna Williamson was given the number to call herself.

4.8.93. That week, Donna Williamson's case was closed by SHIP as they had had no further contact from her.

4.8.94. On the day she died, Donna Williamson called her GP to request diazepam and medication for allergies.

4.8.95. Also on the day she died, Donna Williamson called police because someone was kicking her door and she believed it to be YZ. She called a few minutes later to cancel police, as it had turned out to be her cousin. Police attempted and checked the premises for signs of YZ, and no issues were noted. This incident is addressed in the section below covering the IPCC investigation.

## 4.9. Other Relevant Information

*Other police contact with Donna Williamson in 2016*

4.9.1. During the process of the DHR, it became clear that Donna Williamson had had contact with at least one, and possibly two Lewisham police officers, on a regular basis in 2016. The primary officer (then based in Lewisham Community Safety Unit) who was in contact with Donna Williamson has since left the Metropolitan Police Service. The independent chair carried out a telephone interview with the officer as part of the Review. A report of this conversation was written up and sent to that officer, who approved its inclusion in the Review. (This is explored in section 4, see 4.2.12.)

4.9.2. The officer outlined that their contact with Donna Williamson started in January 2016 following a police incident as a result of which YZ had been on bail. They had previously been aware of Donna Williamson from working in the Greenwich Community Safety Unit, where officers would discuss how they could respond to the fact that Donna Williamson reported incidents and then did not engage with prosecutions.

4.9.3. On starting the investigation for this incident, the officer pulled all the historical information available about Donna Williamson to try to understand why she didn't engage. As part of the investigation the officer had to interview YZ. The officer put YZ on bail, and kept him on there for as long as possible to allow time for the officer to engage with Donna Williamson and encourage her to support a prosecution. This was based on the officer's knowledge that YZ tended to follow bail conditions and not contact Donna Williamson. From then on the officer kept in regular contact with Donna Williamson, as well as with the Greenwich Perpetrator Intervention Team to keep aware of YZ's movements and actions. The officer told the chair that this regular contact with victims was not unusual for her to carry out on domestic abuse investigations.

4.9.4. Early on, Donna Williamson would tell the officer to go away, and say for example "*you've never helped in the past*". The officer felt Donna Williamson was testing them, to see whether they would stick around to support her. On one occasion the officer visited Donna Williamson and found that she didn't have any food, was sleeping on a mattress in the living room because she was in too much pain to move to the bedroom. Donna Williamson stated that prior to the incident with YZ in January, he had "*ripped up*" the last of her money. Donna Williamson had friends who would visit, and these people used alcohol like her and she felt comfortable around them and they didn't judge her.

4.9.5. On this occasion the officer took the mattress out of the living room and put it back in the bedroom, so that Donna Williamson would have to go to bed properly. The officer put Donna Williamson in the bath, and put washing on for her. The officer felt that Donna Williamson had no-one to look after her, and she couldn't look after herself. Donna Williamson did not know who to talk to.

4.9.6. The officer was then moved from the Community Safety Unit to the arrest team (moving officers around like this is standard practice in the police). The officer's duties meant that she could continue to regularly see Donna Williamson without impeding her job. The officer's aim was to keep an eye on Donna Williamson to stop her contacting YZ: the longer he was away, Donna Williamson would miss him and make contact.

4.9.7. Over time the officer felt Donna Williamson was improving: she was drinking less, had tidied up her flat, was eating again and the officer was taking her to her probation appointments. The officer made contact with Donna Williamson's family. Donna Williamson was motivated by wanting to see her family again, and she knew for that to happen she needed to stop drinking and stop seeing YZ. Donna Williamson told the officer she wanted to work and be independent again.

4.9.8. The independent chair asked the officer about documenting their contact with Donna Williamson. The officer responded that they documented it all in emails, primarily to probation, CGL New Direction and the IDVA service. The officer's line manager in the Community Safety Unit was also aware of the officer's actions, and knew that it was not unusual for this officer to take these actions with victims of domestic abuse. Looking back, the officer felt that they could have recorded some of the information on a Merlin report, but this would have been for notification purposes, not for recording information, so did not at the time feel appropriate.

4.9.9. Donna Williamson told the officer that YZ had beaten her up within three months of the relationship starting. YZ knew that Donna Williamson was vulnerable: she was still grieving for her lost baby. He isolated her from her family very early on.

4.9.10. Donna Williamson was "*honest as anything*" and YZ used that against her. He bought her the dog, then used it to control her – it was like their child, but having bought it for her YZ wouldn't let her keep it with her. The dog was always a tie for her and made it impossible for her to leave.

4.9.11. Donna Williamson was in agony every day from her hip. When YZ assaulted her, he would kick her hip at the start so that then she couldn't escape or protect herself. Everyone (Donna Williamson's friends) were scared of him.

4.9.12. The officer told the independent chair they felt they were "*getting somewhere*" with Donna Williamson, that Donna Williamson trusted them and needed someone to guide her.

4.9.13. In May 2016 the officer went on holiday and asked another officer to keep in contact with Donna Williamson during this time; when the officer returned from holiday, they felt that Donna Williamson "*had gone downhill*". At the same time, the officer was moved from the arrest team to a role that meant they were office based. This meant that they were unable to continue to visit or contact Donna Williamson regularly. The officer maintained contact with probation, CGL New Direction and the IDVA to pass on information about Donna

Williamson's situation (this contact is logged by these agencies). The officer also contacted Donna Williamson's landlord to try to stop them from evicting Donna Williamson, emphasising that Donna Williamson was ill and needed support.

4.9.14. Once the officer was unable to contact or visit Donna Williamson as regularly, Donna Williamson started to send them away and not answer calls. Donna Williamson said "*you don't care about me*". The officer felt that Donna Williamson needed someone to be with her, to support her and give her hope and a focus. The officer felt they fulfilled this for Donna Williamson for a time, and built a relationship of trust with Donna Williamson, but that when the officer was no longer able to be in such regular contact, they lost Donna Williamson's trust and Donna Williamson did not want to be in contact with them.

*Independent Office for Police Conduct*

4.9.15. The IOPC Investigation Terms of Reference covered the following police contact with Donna Williamson and YZ:

4.9.16. "*To investigate Metropolitan Police Service contact with Donna Williamson and YZ on [the date of the homicide] and to specifically examine:*

*a) The information available to Police regarding Donna Williamson and YZ;*

*b) The information assessed and shared during the PNC check of YZ."*

4.9.17. This specifically covered the contact police had on this day with Donna Williamson and YZ, outlined in section 3.1 above, and specifically to the incident in which YZ was apprehended in Lewisham and then let go despite bail conditions not to enter the borough. The investigation also addressed the response of the first contact operator who took Donna Williamson's final 999 call.

4.9.18. Actions were taken by the IOPC and MPS in response to the IOPC findings. The IOPC is unable to consider publication until following the Coroner's Inquest (see 1.11.5).

# 5. Analysis

## 5.1. Domestic Abuse/Violence

5.1.1. Donna Williamson was a victim of domestic abuse from YZ including coercive and controlling behaviours. This was documented by 14 agencies between 2010 and when Donna Williamson died: police, the IDVA service, her GP, CGL New Direction, probation, Royal Borough of Greenwich Housing Options and Support Service, Her Centre, Housing for Women, Victim Support, Lewisham Adult Social Care, LAS, Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital; Woolwich and University Hospital Lewisham), NCDV, London Borough of Lewisham Crime Enforcement and Regulation Service. Her family were also aware of some of the coercive control and other abuse, including possible sexual abuse: in their feedback to the Review, they said YZ "*controlled her brain ... [he] stripped her of her dignity*". Some of Donna Williamson's neighbours and friends knew that YZ was abusing her physically and verbally.

5.1.2. Donna Williamson was recorded by agencies as experiencing physical abuse from YZ including punching, hitting, kicking, pushing, pulling her hair, burning her with a cigarette and throwing objects at her. He was verbally abusive to her and may have used alcohol to increase his control of her. Donna Williamson was isolated from her family. Donna Williamson was afraid of YZ. Her physical impairment (due to her hip replacement and the physical impact of excessive alcohol use) meant she could not flee from abuse.

5.1.3. The DASH Risk Checklist was completed with Donna Williamson multiple times by police and by the IDVA, and one was recorded by Greenwich Housing. With police she never scored the level of ticks (i.e. yes answers) to be identified automatically as high risk[13]; she was identified as high risk on four occasions through 'professional judgement'[14]. On one occasion the IDVA noted that Donna Williamson had scored 16 (June 2012; a MARAC referral was discussed but not made as another agency had already referred Donna Williamson, the IDVA then attended the meeting). The record from Greenwich Housing identified Donna Williamson as at high risk as she scored 17 out of 27.

5.1.4. Donna Williamson perpetrated acts against YZ that fall within the definition of domestic abuse. She threw objects at him and persistently contacted him when he said he did not want her to. The DASH Risk Checklist was completed with YZ multiple times by police and

[13] In Lewisham the threshold for high risk and referral to MARAC is 14 ticks.

[14] Lewisham MARAC Operating Protocol (July 2016) referral criteria, in addition to meeting the 'visible' high-risk threshold (see footnote 12), includes: "*Professional Judgement: if a Professional has serious high risk concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence. … This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet [the other] criteria*"

he did not score the level of ticks to be high risk; he was identified as high risk by police through professional judgement on four occasions (although on one of these he was downgraded to standard following Donna Williamson's arrest, suggesting that the assessment of the risk posed was based on the proximity of Donna Williamson, not on YZ's answers, as on that occasion he did not answer the DASH questions).

5.1.5. Appendix 2 presents the DASH Risk Checklist completed for Donna Williamson using all of the information gathered by this Review. This was completed as if all information had been known at the point of YZ's last assault on Donna Williamson before he killed her, in May 2016. She scores 22 out of 27, a score that identifies her as not just high risk but at the upper levels of that category. This outcome is made more significant when the five questions relating specifically to children are disregarded (as neither Donna Williamson nor YZ had children) when her score becomes 22 out of 22.

5.1.6. When a similar exercise is completed for YZ, his estimated score is 7 out of 22, which includes a yes answer to one question about which the Review cannot be sure but based on submitted information may have been likely (question eight: whether Donna Williamson was constantly contacting YZ). This identifies YZ as standard risk.

## 5.2. Analysis of Agency Involvement

**Metropolitan Police Service**

5.2.1. The Metropolitan Police Service (police) IMR did not address the issue of YZ's bail restrictions on the day of Donna Williamson's death, as this was the subject of the IPCC investigation. This is addressed above (see 3.8.9).

5.2.2. The police IMR did not analyse every contact police had with Donna Williamson and/or YZ, but focused on those where domestic incidents took place. The IMR concludes as follows: "*Donna Williamson and YZ first came to the attention of police together for a domestic incident in 2010 in the early stages of their relationship. From then until the time of Donna Williamson's death, she and YZ came to the attention of police for domestic abuse incidents on 66 occasions; 22 of the incidents involved criminal allegations with Donna Williamson and YZ featuring both as victims and suspects. The couple's dependence on alcohol was a common theme in all reported incidents.*"

5.2.3. Few incidents ended with prosecution or conviction, largely due to Donna Williamson or YZ declining to give, or withdrawing, statements. This was in a context in which officers "*did not appear*" to make local enquiries to identify witnesses as part of their investigative strategies, despite nearly all of the incidents taking place in Donna Williamson's or YZ's homes.

5.2.4. The IMR author states "*each incident between Donna Williamson and YZ was dealt with in isolation and a holistic approach taking into account the background information was not always considered*" (for example Donna Williamson repeatedly stated that YZ was jealous and controlling) nor was there consideration of whether Donna Williamson's behaviour towards YZ amounted to harassment, or coercive and controlling behaviours. This extended to the risk assessments, resulting in a situation in which Donna Williamson was repeatedly identified as at standard risk from YZ, regardless of the number of incidents reported or the contextual information provided by her answers each time. An example of the lack of awareness of coercive and controlling behaviours was the police response to the incident of June 2010 (see 3.5.4) when Donna Williamson reported that YZ had "*ransacked*" her flat but police found that the items had been moved "*carefully*". Officers took this as evidence of Donna Williamson making up the allegation. With the new offence of controlling and coercive behaviours in place since 2015, were a similar incident to occur now, officers should see it as potential evidence that the perpetrator is acting in a way that puts the victim in fear, and doing it in such a way that they are unlikely to be believed.

5.2.5. A week before YZ killed Donna Williamson, he was arrested for breach of bail following an incident at Donna Williamson's home on a Saturday and was subsequently released on bail with the same conditions (see 3.7.89). Donna Williamson's family raised this in their feedback to the independent chair: they were shocked that more action had not been taken against YZ when he repeatedly breached bail in 2013/14, and again in 2016 shortly before he killed Donna Williamson. They felt it gave YZ the message that he could get away with anything and that the police should have shown "*more leadership*" in managing the risks to Donna Williamson.

5.2.6. The IMR also noted that the arresting officer did not inform the investigating officer (for the original offence for which YZ was on bail) of this arrest, and that this action was not in the Metropolitan Police Service bail toolkit. The toolkit has been changed during the course of this Review to ensure this is included, and the issue is further addressed through the following IMR recommendations: "*Greenwich and Lewisham Senior Leadership Teams dip sample custody records concerning breaches of bail linked to domestic abuse incidents to ensure the Investigating Officer is notified and a review of the risk assessment takes place*" and "*The 'Bail Management Toolkit – Frontline – Pre-Charge, Investigative & Post Charge Police Bail' is updated to include the following: When an arrest is made for breach of bail, it is the responsibility of the arresting officer to notify the Investigating Officer and their supervisor for the original offence in order for a review of the risk assessment with respect to victims and witnesses, to take place.*"

5.2.7. The MPS have updated the Review of the following actions in response to these recommendations:

*In Lewisham*: Dip sampling is ongoing demonstrating that where perpetrators are arrested for breach of bail, court papers are completed and suspects presented at court.
*In Greenwich*: Police have completed two proactive investigations which targeted offenders who were on bail or subject to court orders. The first operation in April 2017 led to 14 arrests. Nine of these arrests were by officers proactively evidencing a breach of a court order or court bail. It is highly unlikely that any of these offences would have come to light if it was not for this operation. By officers being able to evidence this breach as it occurred there was sufficient evidence to charge with detainees and be remanded to court. The second operation was based around the control strategy of safeguarding children. The operation proactively enforced court orders; this increased confidence with victims and arrested for a breach before another offence could be committed. Of the 23 arrests made during this operation, eleven were for breach of court orders which may have gone undetected.
Information was also provided on the electronic system used by police and the Crown Prosecution Service (COPA): police use it to gather information for charge decisions, prepare cases for first hearing and to manage memos and requests from the CPS. The system links directly to the CPS system and the courts system. All required documents are added to COPA, reviewed by a supervising officer and forwarded electronically to the CPS.

5.2.8. This Review makes a recommendation (2) to the Metropolitan Police Service (MPS) to feed back to the Safer Lewisham Partnership, for them to inform Donna Williamson's family, on the progress of bail-related IMR recommendations.

5.2.9. The IMR author identifies the following recurring themes:

5.2.10. *Intelligence and risk assessment*: intelligence checks following initial calls did not always cover the five-year cross border checks (across different systems) that are mandated in domestic abuse policy; and this was not always addressed in supervision of reports. The IMR sets out that in this respect Lewisham borough police had a policy that was not in line with the police-wide policy. This has been amended and an IMR recommendation is made to ensure this follows through to practice: "*Lewisham Senior Leadership Team dip sample non-crime domestic abuse incidents to ensure the risk is appropriately assessed and escalation of risk is being correctly identified in repeat cases.*

5.2.11. *Investigation*: consideration could and should have been given to prosecute YZ for the offence of 'controlling or coercive behaviour in intimate of familial relationships'. In addition, following an incident there were opportunities for officers to consider using a Domestic Violence Protection Notice / Order (DVPN / DVPO) to protect Donna Williamson. Two recommendations are made:
"*Lewisham and Greenwich Senior Leadership Teams to dip sample domestic incident reports: to ensure all domestic abuse investigations have comprehensive investigative*

*strategies and identify cases of coercive control; and to identify and pursue opportunities for evidence based prosecutions and DVPN/DVPO applications.*"

"*Lewisham and Greenwich to conduct a training needs analysis re DVPN/DVPO applications and identification of coercive control. If a training need is identified Senior Leadership Teams to deliver appropriate training."*

The following update has been provided: The number of applications for DVPNs and DVPOs is embedded in practice and the number of successful applications is increasing. There is a clear plan for officers to risk manage cases and they are supported by some proactive capability to arrest outstanding suspects through proactive methods to reduce/remove risks to victims. MPS Domestic Abuse toolkits have been updated to describe coercive and controlling behaviour and a list of how this may be evidenced when considering which offences may have been committed by the perpetrator.

5.2.12. The good practice identified by the IMR author is that officers arrested YZ (or Donna Williamson) whenever possible and appropriate. Officers often responded to Donna Williamson to sensitively, and her vulnerability was often considered: leading to referrals to Adult Social Care following three incidents and four referrals to MARAC.

5.2.13. Donna Williamson was supported by officers in the local team, as set out in section 3 (see 3.8.1). The detail of this contact only became apparent after Donna Williamson's death, as it was not recorded on any police system. Their contact with Donna Williamson ended three months prior to her murder.

5.2.14. Donna Williamson's family provided feedback on this matter: they were concerned that the actions of the police officer(s) could have increased Donna Williamson's risk and vulnerability. Following the family's comments the Panel discussed this.

5.2.15. The Panel agreed that the officer went above and beyond the actions usually expected of police officers. They were able to develop a trusting relationship with Donna Williamson, and continued to support Donna Williamson in the course of their day to day activities. The officer used their relationship with Donna Williamson to encourage her to engage with CGL New Direction and IDVA, and probation through taking her to appointments. Although their actions were not documented in police systems, they regularly shared information with those three agencies and this was logged by those practitioners. When the officer's contact came to an end they communicated this to these agencies, but could not enforce Donna Williamson's engagement with them so that she continued to be supported.

5.2.16. The police IMR author discussed these circumstances with the Lewisham Community Safety Unit, and was advised that the level of contact this officer had with Donna Williamson was not what was expected of officers in that team. Improved communication with existing and future officers will ensure that the safety and wellbeing of officers is managed through monitoring actions in support of victims.

5.2.17. YZ received support from the PIT in Greenwich as set out above (see 3.6.25). This is a service delivered by police, funded by Royal Borough of Greenwich council. The independent chair interviewed the managers of that team: one who had been present at the time YZ was engaged in the team (albeit they were not directly involved in that support) and the one who currently manages the team.

5.2.18. The original team manager informed the independent chair that the team had developed through recognition that ongoing risk management work took place with victims/survivors of domestic abuse, but not with perpetrators (aside from criminal justice interventions when incidents were reported). Cases were identified in which it was felt more in-depth work was required (potentially with a whole family) to manage risk and reduce further incidents; particularly those relationships where the victim/survivor did not want to leave their abusive partner, and where mental health issues, drug and alcohol misuse were also present. The focus with individual perpetrators was to support them to access help in relation to any issues, or for example support them to find work, or address other types of criminality they may be engaged in as well as domestic abuse. Home visits would be made, and the visibility of officers to these perpetrators was high. Support for the victim/survivor was provided by a parallel team of officers in the Domestic Violence Intervention Team (DVIT), with regular contact between the two teams.

5.2.19. The current team manager outlined that the service had been adjusted to reduce the number of perpetrators worked with, allowing the two officers on the team to focus more closely on a smaller number. The service engages closely with the MARAC, IDVAs and partner agencies to divert and disrupt domestic abuse perpetrators alongside the DVIT supporting victims/survivors. The service is welcomed and positively viewed in the borough.

5.2.20. The Lewisham borough police also provided information about their approach: The Domestic Abuse Intervention Team are a team of one sergeant and six police constables who are based at Lewisham Police Station. They are tasked with ensuring that domestic abuse prisoners who are not arrested at the scene of an incident are located and arrested as soon as possible. The officers also aim to enforce bail conditions and DVPO/DVPNs[15] to ensure they are not being breached. They also target the highest risk domestic abuse perpetrators by ensuring that any form of criminality they are suspected of committing is robustly dealt with.

[15] Domestic Violence Protection Notices and Orders can be used as a tool to make a victim as safe as possible following an incident by giving them a breathing space and temporary respite from the perpetrator through excluding them from the victim's home. https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/arrest-and-other-positive-approaches/domestic-violence-protection-notices-and-domestic-violence-protection-orders/ [accessed 17 August 2017]

### Independent Domestic Violence Advocacy Service, Refuge

5.2.21. During Donna Williamson's intensive period of contact with the IDVA service in 2012/13 the IDVA responded proactively and holistically to try to support Donna Williamson and to increase her safety. Donna Williamson was contacted promptly following referrals, and risk assessments were completed. The IDVA engaged with the MARAC, police, Lewisham Adult Social Care, CGL New Direction and Thames Reach to support Donna Williamson, as well as referring her to the Women Against Domestic Violence counselling service[16]. The IDVA continued to work with other agencies despite Donna Williamson at one point stating she did not want any further help.

5.2.22. One exception to this good practice was that the IDVA in January 2013 had intended to provide a welfare call to Donna Williamson and was unable to due to other commitments. The IDVA was advised by their manager to arrange for another member of staff to make the call; there was no record that this was done.

5.2.23. The IMR author found that many of the records relating to Donna Williamson were focused on the actions taken, and advice given, by the IDVA. There was little or no recording of what Donna Williamson was saying, or how she was feeling. As a result the Review Panel were unable to understand fully how Donna Williamson felt accessing the IDVA service.

5.2.24. Donna Williamson's period of support with the IDVA service appeared from the records to come to an end when the IDVA who had been working with her left. There was a gap of two weeks from her last contact with that IDVA, and her first contact from the IDVA who took over the case. Following that Donna Williamson was frequently uncontactable (e.g. phone switched off or no answer, or Donna Williamson said she could not talk at that time) although she did occasionally manage to speak with her and on those occasions offered support, particularly around the trial that eventually took place in January 2014. In April 2014 Donna Williamson left a phone message with the IDVA saying she wanted to speak, but there was no record of her being called back. The next time she was referred, in December 2014, she declined the service. There were also times when Donna Williamson requested (and was promised) a call back the next day, but the IDVA did not call back until two or three days later. In hindsight it is possible to see that Donna Williamson may have found it difficult to trust the IDVA service.

5.2.25. It is not known what handover process was followed when the IDVA left the service. The current service (Athena) was asked as part of the Review about their processes in relation to handover of clients when an IDVA leaves the service. The response was as follows: "*The leaving worker completes a written handover and meets with the manager/team leader to go through the cases, highlighting risks, planned dates of appointments etc. If a*

[16] This organisation no longer exists.

*new worker is in post then the leaving worker will if possible and safe to do so arrange to have a joint face to face meeting with the client. If a face to face meeting is not possible the client will be informed that a new worker will be starting and making contact with them. Any other agencies actively involved are informed of the change in worker. Where there may not be an opportunity for a planned handover e.g. the worker leaves on a Friday and the peripatetic worker cannot start until the Monday, the manager will take responsibility to go through the handover with the new worker before they make contact with all the clients."*

5.2.26. A recommendation (3) is made for the service to audit this process to ensure that handovers and staff turnover do not negatively impact on the ability of clients to continue to engage with the service.

5.2.27. In early 2016, having not been able to speak to Donna Williamson properly, the IDVA arranged to meet with her at a probation appointment, which was proactive and a good way of attempting to engage Donna Williamson. After this meeting, in which Donna Williamson declined the service, she was listed as a 'helpline call' which meant that she could remain an open case (usually cases would be closed at that point) enabling the IDVA to maintain contact with the other agencies working with Donna Williamson, and to make contact with Donna Williamson albeit not regularly, as she had declined. A new IDVA contacted Donna Williamson two months later (and three months after the joint meeting with probation) and Donna Williamson declined the service, although the IDVA noted that it sounded as though Donna Williamson couldn't talk. It was at this time that Donna Williamson was presented at the MARAC, and an action was given to the IDVA to discuss the Home Security Programme and refuge places with Donna Williamson, as well as a request from probation to contact Donna Williamson which the IDVA committed to do; yet Donna Williamson's case was closed one month later with no recorded contact with Donna Williamson. The IMR author interviewed the IDVA who stated that they had tried to contact Donna Williamson repeatedly and been unable to reach her; and a recommendation is made to address this in relation to recording.

5.2.28. The IMR outlines that during Donna Williamson's contact with the service it has changed: the Athena Violence Against Women and Girls service was commissioned in April 2015, which replaced the existing IDVA and refuge services with a specialist independent gender-based violence advocacy (IGVA) team to support women and men who at are at risk of serious harm; a specialist service for girls aged 13-19 years; group support; a peer support scheme to reduce isolation; emergency refuge accommodation.

5.2.29. The following IMR recommendations are made (the recommendations were areas for the Review Panel member to check and review; the actions taken are included here):

- Refuge's Casework Management policy and Effective Casework training should be reviewed to ensure that all staff understand the requirement to record all contact with

helpline cases on to their electronic case record. The Review Panel member "*double-checked my organisation's Casework Management policy and there is great emphasis on maintaining 'accurate and up-to-date records'. I also spoke to the senior expert practitioners who deliver our effective casework training and they have confirmed that the training always covers the requirement to record all contact/attempted contact and also why this is important. I was satisfied that the policy and training covers this adequately and that no changes are needed.*"

- Refuge's independent audit of services should specifically include a review of the process being used to record contact and attempted contact with helpline cases to ensure that the Casework Management policy is being followed. The Review Panel member "*reviewed Refuge's guidance on conducting independent audits of services and was satisfied that the desktop audit of casework quality covers the full range of casework processes from referral to exit which would pick up whether Refuge's referral procedures for IDVA and outreach services were being followed. The referral procedures are extremely comprehensive and are in turn closely monitored by experienced specialist managers.*"
- A record must be made on the client's electronic casework record of completed MARAC actions that are the responsibility of Refuge and a reason recorded for any that could not be achieved including any attempts made to follow up with the client or relevant agency. Although it may be appropriate to maintain a record of the MARAC actions for other agencies this should not be on the client's support plan and it is the responsibility of the MARAC co-ordinator to follow these up with the relevant agencies. "*The Casework Management policy clearly states the requirement to maintain 'accurate and up to date records' and IMPACT, Refuge's customised specialist electronic case management system, specifically requires every micro action required in the client's support and safety plan to be recorded and noted when completed. The policy states that 'Staff are required to ensure there are always clear professional case records that flow from referral through to exit on Refuge's standardised forms which denote best practice'. Managers are also required to routinely dip-sample case records and I can confirm that through this process I can see that MARAC actions are being recorded on client's support plans as is the date that these have been completed.*"
- Refuge's Casework Management policy and/or training should be reviewed to ensure that it is explicit that the same requirements to ensure pre-arranged contact takes place applies to both helpline cases and referrals which have been admitted to the service. "*This point is fully and very seriously covered throughout Refuge's Casework Management policy which makes explicit what staff at Refuge must do and why for example: 'Staff will give high priority to keeping their appointments with clients. It is a*

*brave step for a survivor to seek help around domestic violence. We regard an appointment with a client as a serious commitment. In the event of any potential problem affecting the keyworker being available to attend an arranged keywork session, she must alert her line manager in advance to discuss priorities. Only a manager can authorise staff cancelling an appointment with a client. The manager will seek to ensure that wherever possible in circumstances where a keyworker is unable to attend the session, another member of staff including potentially the manager herself will step in to progress the support plan'.*"

- Refuge's Casework Management policy and/or training should be reviewed to consider whether the current case recording practice sufficiently captures the relevant information from interactions with clients. The Review Panel member has "*discussed this issue with the senior expert practitioners who deliver Refuge's Effective Casework training which is mandatory for all staff to attend and they have stated that they 'spend a lot of time addressing this in casework management training, in particular ensuring that in the needs assessment they are giving some context around the situation and current needs so anyone can pick up the case and understand what is happening'.*"

**Donna Williamson's General Practice**

5.2.30. Donna Williamson's GP attended the Review Panel and presented their findings. They outlined that they had a longstanding relationship with Donna Williamson, and that from their perspective Donna Williamson had "*had trouble all of her life*". The GP felt that, although Donna Williamson had disclosed the domestic abuse from YZ to them, it was "*being taken care of by [other] agencies*". As a result the GP had learning around the need to not take anything for granted, and to follow up on things more deeply. The GP also felt that it would have been helpful for other agencies to keep them informed, so that they had a more accurate picture of Donna Williamson's life.

5.2.31. This Review has found that the GP's response to the domestic abuse Donna Williamson was subject to from YZ was not robust. The most significant example of this was when Donna Williamson came to the practice seeking help in April 2015, which resulted in the practice calling YZ to collect her and take her to hospital. Donna Williamson consented to YZ being called; but she should not have been placed in the position of calling for help from someone who had physically, emotional and verbally abused her. Donna Williamson was a vulnerable individual and for YZ to take her at that point was inappropriate and potentially dangerous; it is notable that there are no records of Donna Williamson attending hospital that day. The GP had a duty to safeguard her; contacting YZ, even with her consent, did not do this.

5.2.32. As well as outlining that their awareness and understanding of the nature of domestic abuse could be improved, the GP stated that they were not aware of the specialist

agencies in the area; if they had needed to refer someone for domestic abuse, they would refer to the Multi-Agency Safeguarding Hub (MASH). The Royal Borough of Greenwich Community Safety Officer (Violence Against Women and Girls Lead) on the Review Panel outlined that this would only be if there were children involved, and the Review Panel agreed that it was essential for all GPs to know where to refer individuals. The Review Panel agreed that an engagement with the MARAC process would also have assisted the GP in supporting Donna Williamson.

5.2.33. In this case Donna Williamson, a Lewisham resident, was registered with a Greenwich-based GP. It may not be realistic for GPs to know the services available across boroughs, but if they have a clear pathway in the borough in which they are based, then cross-border issues can be addressed through that pathway.

5.2.34. Since this Review has started the practice has made a number of changes, which were outlined to the family at the meeting with the Panel and are summarised here:

- Appointed a Safeguarding Lead for the Practice.
- All GPs, Nurses, Healthcare Assistants and non-clinical staff have undertaken Adult Safeguarding training.
- Held a meeting with the Clinical Commissioning Group Safeguarding Lead in November, with a further meeting to be scheduled for 2018.
- The GPs will attend domestic abuse training in December 2017, with feedback to other clinicians to be arranged.
- The Practice is encouraging better documentation of details provided by patients in respect of domestic abuse in consultations so that all clinicians aware of situation.
- The Practice has promoted internally the awareness of MARAC and other agencies.

5.2.35. A recommendation (4) is made by this Review for the Greenwich Clinical Commissioning Group to work with all General Practices in the borough to extend and deepen their understanding of and responses to issues of domestic abuse amongst their patients (both potential victims and perpetrators), including the two General Practices involved in this Review. This can draw on the learning in Lewisham where IRIS (Identification and Referral for Improved Safety[17]) has been rolled out to around half the General Practices, and improvements have been noted in their responses to domestic abuse through this.

**YZ's General Practice**

5.2.36. The IMR from YZ's GP set out that YZ was provided with the appropriate clinical and medical management, and referrals to relevant agencies. The GP maintained contact with CGL Aspire during YZ's periods of engagement with them.

[17] http://www.irisdomesticviolence.org.uk/iris/ [accessed 5 July 2017]

5.2.37. Further questions were sent to the GP from the independent chair and Review Panel, and responses were received.

5.2.38. YZ disclosed domestic abuse to his GP five times (September 2010, September 2013, November 2013, March 2015 and January 2016): on four occasions YZ could be construed to be the perpetrator of abuse, and in one he disclosed Donna Williamson had assaulted him. The GP took no action in relation to this, for example exploring the issue with YZ or finding out if there were appropriate services that he could be referred to (at the time there was a perpetrator service in the borough, although this is no longer in place). The action consistently taken by the GP was to refer, or encourage YZ to attend, CGL Aspire because his alcohol use was identified as "*the main risk*" or the "*main issue*". These were missed opportunities to address YZ's abusive behaviours towards Donna Williamson and her violent behaviour towards him.

5.2.39. See the above recommendation (4) for Greenwich Clinical Commissioning Group and GPs, in paragraph 4.2.35.

**London Ambulance Service NHS Trust**

5.2.40. The IMR from LAS sets out that procedure and protocol were followed on all occasions of contact with Donna Williamson and YZ.

5.2.41. LAS explained to the Review Panel that although the total number of calls from Donna Williamson over the Terms of Reference time period was high (27), because it was spread over that time period, she would not have been identified as a 'frequent caller'. LAS are unable to link calls due to the volume they deal with.

5.2.42. LAS explained to the Review Panel that all ambulance staff are able to and encouraged to make safeguarding referrals every time they have a concern: in some cases the pathway for this will be through the hospital to ensure this takes place (when individuals are taken to hospital) or through the police (on occasions they are also in attendance). Ambulance staff raised safeguarding concerns on one occasion each for Donna Williamson and YZ, which the LAS IMR agrees was appropriate.

5.2.43. LAS have in place a Domestic Abuse Policy which sets out the referral pathway to the National Domestic Violence Helpline for those patients who consent to a referral. There is no current pathway for patients who do not consent. This policy was reviewed by Women's Aid when it was established.

5.2.44. LAS, like many Ambulance Trusts, do not have the capacity to engage with MARAC meetings. Information is provided to MARACs when requested, and referrals are made to local authorities in relation to concerns around domestic abuse.

**Lewisham and Greenwich NHS Trust (Queen Elizabeth Hospital; Woolwich and University Hospital Lewisham)**

5.2.45. The IMR for Lewisham Trust explains that on the one occasion when Donna Williamson attended the Emergency Department and disclosed domestic abuse (September 2012) there was no relevant policy in place to support staff in responding appropriately. This was in place within the Safeguarding Policy from 2013. Since February 2017 the Trust has a separate Domestic Violence Policy which ensures patients are signposted to the appropriate agencies, and includes procedures for situations when a patient does not wait to be assessed. All staff have training on it as part of their induction. In addition, a Domestic Violence Advocate is in place for staff to refer directly to.

5.2.46. Within maternity services, children and young people's services and the emergency department staff can now flag patients who are identified as high risk domestic abuse victims. Work is ongoing to extend this to the rest of the Trust and recommendations are made to ensure the learning from this Review is incorporated into that.

**Princess Royal University Hospital**

5.2.47. This hospital identified that Donna Williamson and YZ had attended but the records could not be accessed.

**London Borough of Lewisham Adult Social Care**

5.2.48. The Lewisham Adult Social Care IMR sets out that the SCAIT involvement with Donna Williamson was nearly always carried out by the same Senior Access and Information Officer (who was interviewed as part of the IMR process). Contact was made with Donna Williamson on the telephone (she was never seen in person) promptly and there was on the whole consistent and thorough liaison with other agencies, particularly those who had referred Donna Williamson. SCAIT also engaged with the MARAC process on the four occasions that Donna Williamson was discussed.

5.2.49. With regard to the MARAC meetings in 2012, the IMR highlights that the engagement and follow up from Adult Social Care was not robust. This has since improved and records were made in relation to later MARAC meetings, including the decisions made.

5.2.50. In early 2016 when probation contacted SCAIT with concerns for Donna Williamson, the IMR states that there should have been more communication with probation, as they appear (when they contacted again in the April) to have been left not knowing what actions SCAIT had taken with Donna Williamson.

5.2.51. Otherwise the IMR author concludes that appropriate actions were taken by SCAIT whenever contact was made with Donna Williamson. Staff described her as friendly, never rude, and generally receptive to contact although she was difficult to contact at times. Donna Williamson declined support for SCAIT on each occasion. One area of improvement is that all of the contact with Donna Williamson was on the telephone: although she

declined an assessment, the author identifies that a joint home visit with probation and/or CGL New Direction may have been appropriate to provide a more in depth view of Donna Williamson's environment and mobility.

5.2.52. The IMR author further states that "*the number of agencies involved may well have given a false sense of security as to how well Donna Williamson was in fact being supported around the domestic violence issues, and there appears to have been no discussion between these agencies as to who was taking the lead in relation to Donna Williamson*"; a meeting of all agencies involved could have clarified the roles of each in supporting Donna Williamson.

5.2.53. Further information provided by the service outlines that there were two large workshops for SCAIT staff in 2016 on domestic abuse and the Care Act, and the role of Athena and the MARAC. Mandatory briefing sessions for new staff and MARAC leads are planned as part of induction, and for senior SCAIT staff to attend a MARAC as part of their induction.

5.2.54. The IMR makes the following recommendation: "*If faced with a similar situation in the future, where a number of agencies are involved, and there are repeated contacts with SCAIT and high levels of concerns re domestic violence, but where the service user declines Adult Social Care involvement, consideration should be given to carrying out a joint visit, and/or a multi-agency meeting so that agencies are clear about each other's role and remit, and which agency is leading on the case."*

**Royal Borough of Greenwich Adult Social Care**

5.2.55. Greenwich Adult Social Care's involvement in this case was primarily with the family member YZ cared for. This brought them into contact with YZ and Donna Williamson, with concerns raised in 2015. While Adult Social Care could not have been expected to directly attempt to work with Donna Williamson, there were opportunities to communicate concerns with other agencies who could then provide a response (e.g. police).

5.2.56. The IMR identifies that Adult Social Care's engagement with, and recording in relation to, the Greenwich MARAC required improvement and this has been addressed through a recommendation: "*Further raising awareness methods to highlight the purpose, process and positive outcomes of the MARAC framework; through communication tools and face to face methods in Adults Services.*"

5.2.57. Further learning was identified in relation to the care provided to YZ's family member, with the following recommendation: "*Remind/highlight to all RBG Adults Services workforce of the 'Warnings Section' function, to flag risks/including domestic violence whether from residents or visitors to the property/person recorded on that case record, including for closed cases.*"

5.2.58. They additionally outlined that the Greenwich Safeguarding Adults Board is developing domestic abuse training for Adults Services; and that MARAC workshops have been delivered in 2017.

**Housing for Women**

5.2.59. The Housing for Women worker engaged with Donna Williamson and advocated on her behalf to Greenwich Housing Options and Support Service in September/October 2012.

5.2.60. The IMR from Housing for Women sets out a number of issues relating to their contact with Donna Williamson: Donna Williamson's history was not gathered from police following the initial referral; recording of their contact with Greenwich Housing was not complete (e.g. surnames of workers); and that contact with Donna Williamson appeared from the records to come to an abrupt halt, and it was not possible to identify why or what happened. Her Centre were told by Greenwich Housing that they had done a DASH Risk Checklist with Donna Williamson and she had scored 17; this should have prompted a discussion between the two services about making a MARAC referral.

5.2.61. The service has addressed the recording issues with staff through compulsory training. They have also reviewed their engagement with MARAC to ensure that risk assessments are completed with clients during the first call, and referrals to MARAC made where necessary.

5.2.62. In addition to the internal learning, this Review has also highlighted that Housing for Women were in contact with Donna Williamson at the same time that she was engaging with the IDVA service in Lewisham, most likely because the police officer who referred Donna Williamson to Housing for Women had responded to an incident involving Donna Williamson in Greenwich, and was not aware that Donna Williamson was accessing services in Lewisham.

5.2.63. Housing for Women contacted Donna Williamson and she talked to them about the most recent incident in which YZ had assaulted her. When the IDVA called Donna Williamson a few days later, Donna Williamson said there had been further incidents but she "*doesn't want to talk about it*". There was confusion for both services, and for Donna Williamson, about an appointment with "*housing*"; this was in fact with Thames Reach (in Lewisham, arranged by the IDVA), and Donna Williamson did not attend.

5.2.64. Domestic abuse services confirmed that they ensure that they ask clients which other agencies they are engaged with. A recommendation (5) has been made to ensure that this situation is not repeated through domestic abuse support agencies reviewing the effectiveness of those processes.

**Royal Borough of Greenwich Housing Options and Support Service**

5.2.65. Donna Williamson was referred to Greenwich Housing by Housing for Women in September/October. She was assessed for support and a place in a domestic abuse refuge

was offered; the service has changed since then and homeless applications and ongoing case work are now provided.

5.2.66. The system noted that a CAADA-DASH Risk Checklist had been completed, with a score of 17, but it was not recorded who had done this with Donna Williamson; Greenwich Housing have informed the Review that it was not the Housing Officer, as if this had been done the checklist would have been saved on the file, which it wasn't. The service states that a CAADA-DASH Risk Checklist would now always be done and if required lead to a MARAC referral. The service has two MARAC representatives who are responsible for presenting MARAC cases referred by the service and engaging with the process in relation to other cases.

5.2.67. The officer stated they would refer Donna Williamson to Her Centre, and there were no records to indicate that this was done and the member of staff has since left the service (and so this cannot be checked). Staff guidance now requires them to feedback to referrers in every instance.

5.2.68. The service has domestic abuse working practices in place; the Review was informed that these are currently being reviewed and formulated into a new Domestic Abuse Policy and Procedure, which will include protocols with local specialist services for referral pathways. The service has accessed domestic abuse training through the Greenwich Safeguarding Children's Board. In 2016/17 frontline officers attended mandatory domestic abuse training. Two officers have also attended external DASH training.

**CGL New Direction, Lewisham**

5.2.69. The CGL New Direction IMR found some areas of good practice: that there was consistent communication between them and probation with regular updates, joint meetings with Donna Williamson and encouragement from both to Donna Williamson to engage with the services. On some occasions, there was follow up with Donna Williamson when she missed an appointment.

5.2.70. The IMR also identifies clearly the learning the service has taken: There was no record of domestic abuse safety planning; specific actions were not recorded following/during liaisons with other professionals; updates/outcomes from MARAC and crisis (detox) admission discussions were not recorded; given the pattern of Donna Williamson not engaging but still being in contact with service (via phone) there was an opportunity for the key worker to take Donna Williamson's case to the CGL team for review and discussion about alternative options and approaches to engaging Donna Williamson.

5.2.71. This addresses the issues identified through the Review that there were significant gaps between recorded contacts with Donna Williamson; and that at times there was no follow up when she did not attend or they could not contact her. CGL (nationally) have an Engagement and Re-Engagement Policy for situations such as this, which is very positive

as it recognises that, while an individual cannot be forced to engage with a service, the service and its staff have a responsibility to facilitate that engagement as far as possible. It is unfortunate that this policy did not appear to have been followed for Donna Williamson, and she was identified as "*failing to engage*" without staff taking the time to understand her situation and work constructively to support her engagement.

5.2.72. The IMR recommendations address the learning:

- CGL staff to identify, explore and record DV risks and safety plans – training/workshop on use of adult safeguarding maps and safeguarding module.
- Establish a system that raises an alarm with regards to issues on domestic abuse that brings a team of multi-agency professionals together to look at support and prevention.
- To ensure MARAC meeting minutes are circulated to all members of the CGL: Lewisham staff team.
- Liaise with the National Safeguarding Lead to request a review of the domestic violence policy. Currently it sits within the Safeguarding for Adults Policy and the CGL New Direction Review Panel member will ask if a specific domestic violence policy can be developed that acts as a standalone policy.
- Review and refresh with the New Direction team the missed appointments checklist and re-engagement protocols.
- CGL management will undertake a review of open domestic abuse service users with clear and SMART actions where appropriate. This will be carried out by the Senior Safeguarding Lead and be completed by 30 May 2017. This review will include risk and recovery planning, joint working and engagement.

5.2.73. CGL New Direction and CGL Aspire both recognised that they could and should have communicated with each other over the fact they were working with Donna Williamson and YZ at the same time. This would have supported improved risk management and engagement attempts with each of them.

5.2.74. Both services have taken action to ensure that this situation does not occur again and multi-agency professionals' meetings are being arranged to discuss specific cases when cases cross borders. A Terms of Reference for these meetings is being developed.

**CGL Aspire, Greenwich**

5.2.75. The IMR from CGL Aspire analysed the service's contact with YZ and found good practice in relation to the service's regular communication and engagement with the Greenwich police PIT with regular updates and encouragement from both to YZ to engage with services.

5.2.76. The following learning was identified:

- Although communication between services was regular and there was a risk management plan in place there was little detail gained and recorded following our

liaison with the PIT regarding the level/change or escalation of the risk that YZ presented to Donna Williamson.

- No evidence of a multi-agency risk plan or multi-agency meetings. A summary was received from CGL Lewisham following a MARAC presentation in March 2016. There were no actions or safety strategies listed within this summary and no further information was requested by CGL Aspire.
- CGL workers would have also benefitted from seeking and gaining additional support from within the service to take advantage of the knowledge, experience, skills and guidance of the whole team.
- There were some attempts made by CGL to contact probation but they were not sufficient.

5.2.77. The information listed above would not have altered the treatment pathway for YZ, however the re-engagement process could have been more rigorous given the known risks. YZ may still have been discharged from the service through lack of engagement but it may have provided the service with a greater understanding as to how his alcohol use may increase the risk he presented.

5.2.78. CGL Aspire have provided the Review with the following update on actions already undertaken, and planned:

"*We have held an integrated governance team meeting in which the team explored this case on the 26.01.2017. The key points / learning from this team discussion not already included in the IMR are:*

- *CGL Greenwich did not check his partner's treatment with CGL Lewisham.*
- *Did not refer client to our psychologist.*
- *CGL did not follow up client's physical health issues with the GP.*
- *Some contacts not reflected on CRiiS [CGL database].*
- *We have discussed CGL's ability to set a flag for MARAC and the answer from our central team was that safeguarding would flag DA.*
- *CGL Greenwich will routinely request historical minutes / reports from agencies involved where there is domestic abuse history or current risk.*
- *CGL Greenwich have created a separate space for domestic abuse discussion within the weekly clinical meetings.*
- *We are now proactively organising multi agency meetings for all domestic abuse cases to create a risk plan.*
- *We have a meeting planned for 4 May 2017 to look at Domestic Abuse with the team. We have invited outside agencies to attend including PIT, Domestic Violence Intervention team and specialist Health Visitor for Domestic Violence and Abuse.*
- *MARAC actions are recorded on to the safeguarding module on criis.*

- *We are currently auditing all safeguarding and domestic violence cases as part of the designated safeguarding leads routine duties.*
- *We will ensure that CGL are well represented within Greenwich safeguarding boards' domestic abuse training."*

**National Probation Service**

5.2.79. The records from probation suggest that the offender manager allocated to Donna Williamson was able to develop a good and helpful relationship with Donna Williamson, and took many actions to increase Donna Williamson's safety in recognition of the risk she faced from, as well as the risk she posed to, YZ. They referred to and/or communicated with Lewisham Adult Social Care, CGL New Direction, the IDVA, Together and police. On two occasions they visited Donna Williamson at home when it became apparent she was not attending appointments in the office. A home visit was made in April 2016 (at which YZ was present), followed by a joint meeting with Donna Williamson and CGL New Direction, and after this there does not appear to be any further contact. Donna Williamson's order was coming to an end, bringing to a close her requirement to be supervised by probation. But this left Donna Williamson with no support in place, and many of her issues (abuse from YZ, her at-risk housing situation) unaddressed and not passed on to another professional.

5.2.80. Donna Williamson could have been breached much earlier than she was, as she repeatedly breached her curfew requirement; but as no officer requested these records it was not identified until the IMR author completed the review. Donna Williamson could also have been breached for missing multiple reporting appointments. There are no records to show why the breach was not pursued until August/September 2015 nor why further breaches were not made following this. While this may be contrary to probation policy, it can be seen as supportive to Donna Williamson in that it recognised her vulnerability and her inability, through her situation and external factors such as the abuse from YZ, to fully adhere to the requirements of the order; and that prison was unlikely to be the right place for her in light of her vulnerability and health.

5.2.81. The IMR outlines the following learning from their review of Donna Williamson's time under the supervision of probation:

- The sentence proposal in the pre sentence report (PSR) should have contained a firmer proposal for an alcohol treatment requirement. Donna Williamson had a demonstrable history of alcohol related offences of violence and dishonesty she should have been assessed for alcohol treatment and this should have formed the cornerstone of the subsequent community order.
- The PSR author is said to have requested police call out information but this had not come in time to inform the PSR. The officer was a temporary member of staff; if this

information was ever served it would have been to that person's individual workplace e-mail. When they left, access to that information was lost: the police response to requests for call outs was never made available to inform sentence planning and risk assessment; it was re-requested later and made available.

- The PSR proposed a Rehabilitation Activity Requirement with FADA. The offender manager who supervised the case had no experience with FADA and could not have delivered this intervention. The senior offender manager in Lewisham has been unable to locate any member of staff qualified to deliver this intervention.
- The risk of harm was assessed as high and imminent but was not reviewed within current organisational guidelines.
- The curfew requirement was not properly monitored and breaches not considered and acted upon. The requirement was not terminated at the proper time, the risk assessment was not reviewed when it was terminated.
- The MARAC instruction to convene a professionals meeting was not carried through and this matter was not referred back to the senior offender manager in line with the offender manager's instructions.
- In light of the failure to convene a professionals meeting there should have been an escalation to MAPPA[18] but this did not occur primarily because the senior offender manager was not informed.

5.2.82. To act on this learning, probation had set out the following recommendations:

- NPS should clarify the expectations and eligibility of the FADA programme; it is still technically available but not supported by personnel trained to deliver the intervention. *Update: probation in London have confirmed that the FADA programme ceased to exist in 2013, and therefore should not have been recommended in the pre sentence report. All probation officers are now trained on working with all offenders on domestic abuse.*
- The Lewisham probation office should clarify the expectations of offender managers undertaking police and other organisational checks to use office e-mail box for audit trail.
- The Lewisham probation office should clarify its processes around monitoring and enforcement of curfews.
- Breach/enforcement action should have been more effective; the proposal to revoke and re sentence to custody for therapeutic reasons although well made out was

[18] Multi-Agency Public Protection Arrangements: statutory process through which the National Probation Service, police, prisons and other partners manage the risk of violent and sexual offenders. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

draconian and could have proposed a different outcome; especially if enforcement had been taken at an earlier stage of the order.

- Better tracking of high risk of harm risk assessments should be developed by the offender manager and her senior offender manager.
- There are gaps in the recording in the probation database of MARAC meetings: suggest practice be reviewed.

5.2.83. The IMR author highlighted some issues in relation to the MARAC engagement: there was a MARAC flag on the system, which should have prompted the offender manager to speak to the probation MARAC representative; who in turn should have added more detail to the database system from the MARAC meetings. A MARAC referral was discussed by the offender manager in August 2015 and the MARAC representative advised that police records be requested to inform this; the response to this unfortunately came in while the offender manager was on sick leave for two months, and could not be picked up by the officer covering Donna Williamson's supervision. This Review notes that, if the offender manager were sufficiently concerned for Donna Williamson's risk (which they appeared to be), then a MARAC referral could have been made regardless of any information from police. The Panel confirmed that the Lewisham team of the National Probation Service has very strong engagement with the Lewisham MARAC.

5.2.84. Information was requested on the MARAC engagement of the London Community Rehabilitation Company (CRC); the following information was provided: in Lewisham an Operational Manager has responsibility for strategic engagement with MARAC, and a single point of contact has been identified to engage operationally with the monthly MARAC including attending meetings and liaising between the CRC and partner agencies.

**Her Centre**

5.2.85. This service covers Greenwich; Donna Williamson lived close to the border of Lewisham and Greenwich which likely led to police referring her to this service, rather than a Lewisham domestic abuse service. The IMR provided to the Review did not contain any analysis. The independent chair collated questions from the Review Panel and these were sent to Her Centre, who provided responses to all questions.

5.2.86. Donna Williamson was referred to this service by police in January 2015, following which she had one conversation with a worker. Although the worker was concerned for Donna Williamson, she declined the service. Her Centre informed the Review they did not have capacity to follow up on referrals. The referrer was informed, which is now done routinely.

5.2.87. Her Centre were asked by Greenwich MARAC to contact YZ in June 2012 and June 2015. Her Centre does not have records for 2012. In 2015 he could not be contacted. The Review has established that this should not have been done, as the service is not commissioned to work with men.

**Lewisham Multi-Agency Risk Assessment Conference**

5.2.88. This Review notes that a MARAC is not a service, but a process that supports the coordination of existing agency actions and work with a victim and/or perpetrator. A full discussion of the MARAC process in this case is contained in section five.

5.2.89. Donna Williamson was referred to and discussed at the Lewisham MARAC on six occasions: three in 2012, one in 2015 and two in 2016. The last MARAC discussion took place three months before she was killed. The IMR identifies the following two themes:

- *Identifying repeat victims*: Donna Williamson should have been referred to the MARAC more than the six times that she was between 2012 and 2016. Donna Williamson came to notice of other agencies in this period, and, according to the Operating Protocol, should have been referred as a repeat victim, as previously done.
- *Escalating outstanding actions*: the two outstanding actions from the August and October 2012 meetings were appropriately referenced in the subsequent MARAC meetings, and ultimately completed. However, the probation action from February 2016 was not referenced in the March 2016 minutes, thus indicating that it was not raised during mandatory discussions of outstanding actions, prior to the start of every MARAC meeting (although we know from email trails and discussions with the MARAC Coordinator, that the probation representative was contacted for an update). Also, when discussed again in May 2016, there is no evidence in the minutes that the previously outstanding action from February 2016 was discussed, although it was recorded separately along with the list of previous actions from earlier referrals

5.2.90. The IMR sets out four recommendations to address learning, some of which (the IMR states) are already in progress:

- Review of all actions with an outstanding status from 2015.
- Record all instances where agencies are chased for updates on actions.
- MARAC Steering Group to discuss platform options for how MARAC information is shared.
- MARAC Steering Group to arrange a seminar on MARAC Flags, and how cases are recorded.

**Greenwich Multi-Agency Risk Assessment Conference**

5.2.91. As stated above, a full discussion of the MARAC process in this case is contained in section five.

5.2.92. YZ was referred to and discussed at the Greenwich MARAC on three occasions: 2012, 2013 and 2015. The IMR outlines that for the first two meetings, there was not a MARAC Coordinator in place and minutes were taken by member agencies: as a result they were often brief and did not list the full actions. Therefore it was been difficult to establish a full picture of what took place at and as a result of those two meetings. By 2015 a MARAC

Coordinator was in post, hence there is more information available about that referral and meeting.

5.2.93. The IMR outlines the difficulty in this case that YZ and Donna Williamson lived in different boroughs, and this appeared to present a barrier to effective information sharing and safety planning: the work from the Greenwich MARAC was focused in Greenwich. While it is clear to this Review that where Donna Williamson and YZ lived presented some difficulties, actions could have been made at the Greenwich MARAC in 2015 for cross-border working to take place. A recommendation is made in the IMR to improve cross-border communication on complex MARAC cases.

5.2.94. The IMR states that "*both Donna Williamson and YZ were victims and perpetrators on different occasions*". This use of 'victim/perpetrator' to describe both Donna Williamson and YZ could have led to confusion over what actions to set in response to the situation: whose safety were agencies trying to improve, and whose risk was being managed? A more nuanced understanding of the dynamics of the relationship, through discussions with Lewisham agencies, could have led to a more robust set of actions.

5.2.95. The issues of language, and cross-border working, are discussed further in section five.

**Victim Support**

5.2.96. Victim Support's direct contact with Donna Williamson was minimal. Following the first two referrals (2015) she could not be contacted and the cases were closed as per procedure; the first had been flagged as domestic abuse and therefore the referrer (police) were notified of the non-contact.

5.2.97. In the next contact (2016), following an incident of criminal damage to Donna Williamson's property, she requested support to get her locks changed and the Victim Support officer explained that they could not help because Donna Williamson was in private rented accommodation. This referral was not flagged as domestic abuse (it was not recorded as such with police) but the Victim Support officer could have identified that this was the third referral for Donna Williamson and therefore explored further her support needs. Donna Williamson declined the service following the fourth referral (2016) but again Victim Support should have identified Donna Williamson as a repeat victim.

5.2.98. This is particularly significant, because these two referrals came close to each other, and therefore Donna Williamson was getting calls from different Victim Support officers at the same time.

5.2.99. Victim Support has identified the learning relevant to this case, and has set out clear recommendations which have already been acted upon:

Pan-London recommendations:

- Victim Contact Officer staff to undertake robust research of repeat victim flagged cases where domestic violence or sexual violence is outlined/flagged and to seek advice from a team leader.
- Victim Contact Officers to attend a DASH refresher workshop.
- Quarterly dip sampling of Domestic Abuse/Sexual Violence–repeat cases.

Local recommendations:

- Domestic Abuse awareness workshops to be provided quarterly to South Victim Care Officers by the Bromley Independent Domestic / Sexual Violence Advocate Team.
- Where local lock fitting service is borough applicable and crime related (victim repeat flagged) all requests for to be filtered to the target hardening project for evaluation.
- Victim Contact Officers refer all sexual violence cases in the South Area to Rape Crisis South London (RASASC), with the consent of the victim.

**South London and Maudsley NHS Foundation Trust**

5.2.100. The substantial contact SLaM with Donna Williamson was in June 2009, when she was referred into the addiction services they delivered at that time. These services are now delivered by CGL in Lewisham and in Greenwich. Donna Williamson progressed through the treatment and was then discharged to her GP. Donna Williamson was appropriately offered counselling in response to her disclosure of traumatic events in her past, which she declined. Donna Williamson initially informed the service that she had broken up with her boyfriend but at later points talked about him again. The IMR identifies these as opportunities that staff should have taken to discuss with Donna Williamson her relationship and carry out enquiry in relation to domestic abuse.

5.2.101. SLaM have now developed a Trust-wide Domestic Abuse Policy, with training, that addresses this issue.

5.2.102. While SLaM did not have direct contact with Donna Williamson when she attended (and then left) the hospital emergency department in April 2016, there was learning in relation to this. Donna Williamson had presented as suicidal; having left before assessment, this raised concerns for the team and a welfare call was attempted. But, when that call was unsuccessful, there should have been more follow up to establish the safety and situation of Donna Williamson.

5.2.103. SLaM have made a recommendation to address this issue: "*SLaM adult liaison services across all sites to carry out an audit to assure themselves that they are correctly managing patients who go missing from emergency departments.*"

**Oxleas NHS Foundation Trust**

5.2.104. Oxleas provided services to YZ in 2008 (before his relationship with Donna Williamson started) and 2011 in relation to his mental health. Subsequent to this Oxleas recorded the

notifications that YZ had been referred to the Greenwich MARAC, but this was after he had been discharged and he did not come back into the service after this.

5.2.105. In 2011 YZ disclosed to Oxleas staff that he had argued with his girlfriend (and that she had been arrested for smashing a window), and in the same contact mentioned that he had knives that he slept with due to concerns for his own safety. This should have alerted staff to the possibility of domestic abuse – either from Donna Williamson towards YZ, or from YZ towards Donna Williamson given the two statements made.

5.2.106. The IMR states that Oxleas has, since 2016, had a Domestic Violence and Abuse Practice Guidance in place for all staff, which sets out how they should work with adults who have experienced or may be at risk of domestic violence and abuse, as well as how to work with adults who are or may be perpetrators of abuse. This has been supported by training.

5.2.107. In addition Oxleas have a team of trained leads who engages with the Greenwich MARAC.

**Crown Prosecution Service**

5.2.108. The CPS were approached for additional information prompted by the information presented in the MPS chronology and IMR. These specifically concerned occasions in which the CPS had not authorised charges against Donna Williamson or YZ, or where no evidence had been offered at court when Donna Williamson and YZ had been charged with offences.

5.2.109. CPS supported the Review through searching for relevant information and providing what was available. For three cases (July and August 2012 and February 2013) the files had been destroyed under the CPS's file retention policy. In one case the trial had taken place in the Crown Court rather than the Magistrate's Court, and CPS were unable to find the file. This was the case in which YZ was found not guilty of grievous bodily harm but guilty of common assault against Donna Williamson following an incident in September 2012 but the case did not come to trial until January 2014. It is therefore not possible to understand the details of the case, or identify why the delay occurred, although the Review is aware that cases in the Crown Court can take a long time to take place due to volume.

5.2.110. The Review asked the CPS to outline why no further action was taken against YZ following an allegation by Donna Williamson that YZ had punched her in the face several times (March 2015). In this case Donna Williamson withdrew her statement stating that she lied; her friend who had not witnessed the assault but seen Donna Williamson's injuries did not make a statement; and YZ denied the assault. Police officers were recorded as having used Body Worn Video cameras but at the time this was on trial in the borough and systems were not adequately in place to ensure that the footage could be shared across borough and with CPS. Nevertheless, the CPS felt that, as the footage only recorded Donna Williamson's account of the incident, not the incident itself, it would not be sufficient

to proceed with an 'evidence-based' (also called 'victimless') prosecution without Donna Williamson's statement.

5.2.111. Since Donna Williamson's death, the Metropolitan Police Service has begun the roll out of Body Worn Video cameras across the service, to all emergency response officers, to enhance the evidence gathering process. The Body Worn Video camera pilot evidenced an increase in early guilty pleas in domestic abuse cases.

**London Borough of Lewisham Single Homeless Intervention and Prevention Service (SHIP)**

5.2.112. SHIP had contact with Donna Williamson on one day in May 2016 in which she presented and was assessed. The IMR outlines that Donna Williamson's disclosure (during the initial contact) that she was being evicted for anti-social behaviour and domestic abuse issues was perceived as a situation in which Donna Williamson was the perpetrator of domestic abuse. The officer recognised Donna Williamson's vulnerabilities and progressed her through to an immediate assessment (rather than discharging her because she was not at risk of homelessness within 28 days). In the assessment that immediately followed this initial contact (which was carried out by an officer trained on domestic abuse), Donna Williamson did not mention domestic abuse.

5.2.113. SHIP have now amended their protocols to ensure that officers have procedures for responding to alleged perpetrators as well as victims of domestic abuse:
"*Current practice within SHIP is to ensure that any customer advising that they are a victim of abuse are given an initial housing options assessment, a CAADA completed and a referral made to MARAC [if appropriate]. This practice will be extended out to anyone reporting domestic abuse as a victim or a perpetrator."*

5.2.114. Donna Williamson was not imminently at risk of homelessness: the notification she had received from her landlord gave her at least six months' notice of eviction and in some cases (in SHIP's experience) landlords use it as a way of warning a tenant, and eviction sometimes does not take place. Given this, and the volume of cases dealt with by the service, Donna Williamson's situation did not prompt any need to follow up with her when, after the assessment, she did not return with the documentation requested.

5.2.115. When Donna Williamson attended, officers in the service were not aware of the email sent to them by Lewisham Adult Social Care in May 2016. At that time, SHIP could not have recorded the information received because Donna Williamson was not on their database; and she could only be added to that database when she presented seeking help for homelessness. The service is now looking to develop a formal referral form that other services and agencies can use in these situations, so that the information can be recorded and used if/when individuals approach them. This will include all individuals referred to MARAC.

5.2.116. SHIP made the Review aware that new legislation will be coming into force in 2017/18 putting a duty on all public bodies to make a referral to Housing when they are aware that an individual is threatened with homelessness. Lewisham Housing Needs Department will in 2017 be providing information and guidance to all relevant bodies to support them in fulfilling this duty.

**London Borough of Lewisham Crime Enforcement and Regulation Service**

5.2.117. This service only had one direct contact with Donna Williamson in March/April 2016 (which due to the issue of using two database systems at that time was not followed up on); the remainder of their contact was with the person making the complaint about Donna Williamson and with other agencies/services. The case was closed because the complainant did not make any further complaints; but the key issue of their initial communication, which was that Donna Williamson was a vulnerable adult in need of coordinated support, was not addressed.

5.2.118. The IMR sets out that the protocol in place for responding to cases was not fully followed. In addition, the officer was very new to the service and may not have fully understood the procedure. As a result of this finding, the service has amended the service's protocol to set out in detail how cases like this one should be managed, specifically that referrals should be made in relation to vulnerable adults, domestic abuse and mental health. The protocol also sets out what should be done if those referrals are not acknowledged / responded to by the other service or agency.

5.2.119. These changes are welcomed by the Review, which identified that there was a great deal of information sharing in response to the complaint, but none of it appeared to have a clear purpose. Services who received the information (police, MARAC, Lewisham Adult Social Care, CGL New Direction) were either asked to 'note' the information or to provide an update on Donna Williamson's contact with them; when that update was provided, no action was taken.

5.2.120. The Review heard that this has also been addressed through regular audits of case files which identify what actions have been taken in cases including referrals to domestic abuse services, Adult Social Care, and mental health. More direct communication between the service's staff and the MARAC process is developing: the service sits in the Local Authority in the same Department as the MARAC Coordinator and Violence Against Women and Girls lead. A new database system is in place to ensure that cases are better managed by the service as a whole. A recommendation (6) is made to ensure that domestic abuse is being adequately identified and responded to.

**Together for Mental Wellbeing**

5.2.121. Donna Williamson was referred to this service through probation in early 2016, during the course of her community order. Donna Williamson attended the third scheduled

appointment intoxicated and it was not possible to assess her, and she declined the service.

5.2.122. The Together IMR sets out that their usual process is for a detailed referral form to be completed by the offender manager, setting out the history and circumstances of the individual being referred. In Donna Williamson's case, this was not done. A brief history was provided but not the level of detail that the offender manager had access to. The Together IMR concludes that, had Donna Williamson's history and situation been more fully understood, they would have taken more, or different, steps (following that appointment with Donna Williamson to engage her in the service.

5.2.123. As a result of this learning, Together now ensure that they gain full referral forms for every individual coming into their service, including liaising with offender managers to ensure this is done.

5.2.124. A further update was received towards the end of the Review: "*Together has successfully implemented a mandatory referral process that offender managers are required to complete. This has meant that vital information such as the services involved and safeguarding concerns are brought to our attention at referral stage. … [As a] voluntary service a service user may not wish to proceed with an assessment with our practitioner. In such cases we will continue to provide ongoing mental health support to the offender manager on a consultative basis.*"

**Thames Reach**

5.2.125. During the course of the review, the housing-related support provided by Thames Reach changed provider to One Housing.

5.2.126. They were able to provide the information and analysis before the transfer took place, and identified the following: it was positive that Donna Williamson was offered repeated appointments when she was unable to during the four months of contact in mid-2012, and there was regular communication between the service and the IDVA who was supporting Donna Williamson. Given Donna Williamson's circumstances it may have been better to arrange a home visit with Donna Williamson (with the IDVA in attendance) which could have supported Donna Williamson in engaging with the service.

5.2.127. The learning, along with the wider learning from this case, was provided to the new service who reviewed the draft Overview Report.

**National Centre for Domestic Violence**

5.2.128. Donna Williamson contacted the NCDV in March 2016 on the advice of the police officer who was supporting her, for her to obtain a non-molestation order to prevent YZ from contacting her. This was progressed but Donna Williamson then stated she did not wish to proceed.

5.2.129. If the police officer had referred Donna Williamson to NCDV, rather than Donna Williamson contacting them herself, then NCDV would have alerted the police officer to the fact that Donna Williamson had declined to go ahead. This point was taken by the police Review Panel representative and fed back to the relevant team.

**London Fire Brigade**

5.2.130. London Fire Brigade had two contacts with Donna Williamson; the second contact is significant as it related to a fire in her flat. Donna Williamson had called police stating "*her belongings were piled on top of her cooker and it was switched on*". She then called London Fire Brigade who attended and recorded "*cooking left unattended on the hob with an underlying fact that the occupants appeared to be under the influence of alcohol.*"

5.2.131. Police were noted to be in attendance due to a domestic incident and would have been the responsible authority to follow up on any safeguarding issues.

## 5.3. Equality and Diversity

5.3.1. At the first meeting, the panel agreed that the following protected characteristics and additional vulnerabilities were relevant in relation to what was known about Donna Williamson and YZ at that time: *sex* (male to female intimate partner abuse; plus Donna Williamson's use of violence towards YZ); *disability* (Donna Williamson's physical impairment / health issues / Donna Williamson's and YZ's mental health issues); Donna Williamson's and YZ's *problematic alcohol use*; YZ's role as a *carer* for a member of his family.

5.3.2. *Sex:* this protected characteristic will always be a feature of DHRs, due to the recognised gendered nature of domestic abuse. In this case, Donna Williamson was female and YZ is male: aligning their situation to the majority of both domestic abuse and domestic homicides as male to female violence and abuse within an intimate relationship. This picture was complicated by the fact that Donna Williamson also was violent against YZ. As a key line of enquiry in this Review, this is addressed in detail in section five.

5.3.3. *Disability*: A number of agencies were aware of the physical impairment Donna Williamson experienced as a result of the hip replacement operations she had undergone in 2007. In 2016, probation and Lewisham Adult Social Care noted that this was having an impact on Donna Williamson's day to day living, including that she was walking with crutches. She was also noted by her GP to be walking with the aid of a child's pushchair. There were also agency records of Donna Williamson disclosing YZ had deliberately targeted her hip area during physical assaults.

5.3.4. Probation made an appropriate referral to Lewisham Adult Social Care in early 2016 in recognition of Donna Williamson's vulnerability which was increased by her physical impairment. Adult Social Care only spoke to Donna Williamson on the phone: it would have

enhanced their assessment of her needs to have made a home visit. This is addressed in the relevant section above (see 4.2.51).

5.3.5. Other than this, there did not appear to be a recognition collectively by agencies of the impact Donna Williamson's physical impairment – combined with her multiple other issues and needs – on her situation. This is addressed in detail in section five.

5.3.6. *Problematic alcohol use*: this is addressed in detail in section five.

5.3.7. *Carer*: YZ was recognised as a carer for his family member, and he disclosed the stress this put him under to a number of agencies including his GP, CGL Aspire, Greenwich Adult Social Care and police. His family member was for some time engaged with Adult Social Care, and they attempted to engage with them and with YZ about their needs, including advising YZ to contact his GP to address the strain of caring on him. A carer's assessment was not offered, and it should have been. Greenwich Adult Social Care have confirmed that the full social care assessment form contains a prompt to remind staff to offer a carer's assessment. A recommendation (7) is made. Some agencies linked together YZ's living and caring situation with the domestic abuse he perpetrated against Donna Williamson (or the violence she perpetrated against him), for example Lewisham Adult Social Care alerted Greenwich Adult Social Care of the situation following their contact with Donna Williamson. Again, as with Donna Williamson, there was a lack of seeing YZ in the context of all of his needs and issues, rather than addressing the one presenting issue. This is addressed in detail in section five.

5.3.8. *Race / Nationality; religion and belief; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity*: These were not considered to be relevant to this case.

# 6. Conclusion and Lessons to be Learnt from the Review

## 6.1. Conclusion

6.1.1. Donna Williamson was described by her family as kind and bubbly. Services that had contact with her described her as coming across as intelligent and polite. Donna Williamson was open about the issues and problems in her life, telling many agencies and friends what was happening for her. She was a vulnerable individual who had experienced a great deal of trauma in her life.

6.1.2. Donna Williamson and YZ had involvement with 27 agencies over an eight year period, amounting to nearly 800 agency records. During this time Donna Williamson was isolated from her family, and friends and neighbours expressed concern to agencies about Donna Williamson's health, safety and wellbeing.

6.1.3. In Donna Williamson's life she contended with the following:

- Persistent, ongoing domestic abuse, including coercive and controlling behaviours, from YZ to the extent that she feared him.
- Poor physical health as a result of earlier hip operations and the physical effects of excessive alcohol use, impairing her ability to flee abuse.
- Poor mental health as a result of earlier traumatic events (including the early death of her boyfriend, having a stillborn baby, experiences of sexual assault) and ongoing domestic abuse from YZ.
- Uncertain housing through the threat of eviction by her landlord and following the damage caused to her door initially by police and later allegedly by YZ.
- Isolation from her family as a result of her relationship with YZ and also due to her drinking, leading to loneliness.
- Shame and guilt over her assaults against YZ and the apparent perception that she was a perpetrator of domestic abuse.
- Fear that he would kill her, or that she would kill him.
- A criminal history of incidents and convictions.
- The belief that YZ was the only one who loved her, and that he protected her from other people who posed a risk to her.
- Excessive alcohol use: possibly as a coping mechanism following her experiences of trauma and the abuse from YZ; possibly used by YZ as a means of control.
- Concerns for her dog on the occasions that either she or YZ were not in a position to take care of it.

6.1.4. Donna Williamson maintained in most of her contact with agencies that she wished to remain with YZ, and at times this was recorded by agencies as her reason for not engaging

with them. She stated she loved him and was lonely without him. At other times she expressed a wish to escape from him. Donna Williamson appeared to find help-seeking difficult, often relying more on emergency services than more ongoing, long-term support agencies: this can be a deliberate tactic used by victims of ongoing coercive control, who are living in chronic fear of the perpetrator, as a way of managing risk on a day to day basis.[19]

6.1.5. YZ contended with excessive alcohol use, recurring mental health issues, and caring for his family member. He reported incidents of abuse by Donna Williamson to police that he then did not provide statements for. At times he told police he wanted Donna Williamson to stop contacting him but never reported being in fear of her.

**Missed Opportunities**

6.1.6. There were a number of significant opportunities in which agencies could have better safeguarding and supported Donna Williamson. It is not possible to say with certainty that had these opportunities been taken, that she would have survived: only one person is responsible for that, and that is YZ.

- *Lewisham MARAC*: many agencies attended the six meetings in which Donna Williamson was discussed, and actions were made. Most significantly, an action was made in February 2016 for NPS to arrange a professionals meeting in recognition of the complex nature of Donna Williamson's situation; there was no follow up when this was not completed.
- *National Probation Service*: the professionals meeting, which could have better supported and safeguarded Donna Williamson, was not arranged.
- *Metropolitan Police Service*: opportunities were missed to identify, and attempt to prosecute YZ for, offences of coercive and controlling behaviour.
- *IDVA Service (Refuge)*: the handovers when staff left and new IDVAs took over Donna Williamson's case could have been handled more sensitively in relation to Donna Williamson's needs and her difficulties in engaging with services, and she was then not supported by a specialist domestic abuse service.
- *Donna Williamson's GP*: Donna Williamson attended and spoke with her GP frequently, disclosing her many issues and needs, including the abuse she experienced from YZ. The GP could have been more proactive in making referrals to specialist services; reception staff should not have contacted YZ to collect Donna Williamson when she attended in a distressed state (April 2015).

[19] Monckton Smith, J. and Williams, A. with Mullane, F. (2014) *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* Palgrave Macmillan

- *Lewisham Adult Social Care*: the service could and should have made a home visit to Donna Williamson to fully assess her needs.
- *Multi*-Agency: An agency should have taken responsibility for working with Donna Williamson to ensure that her door was fixed in 2016.

## 6.2. Lessons to be learnt from the Review

6.2.1. At the start of the Review process, the Review Panel set out (in the Terms of Reference) the following key issues for analysis, that are relevant for all DHRs:

- The communication, procedures and discussions, which took place within and between agencies.
- The co-operation between different agencies involved, on an operational and strategic level.
- The opportunity for agencies to identify and assess domestic abuse.
- The opportunity for agencies to identify and assess risk in relation to domestic abuse, including (but not limited to) MARAC.
- Agency responses to any identification of domestic abuse issues.
- Agencies' access to specialist domestic abuse agencies.
- The policies, procedures and training available to the agencies involved on domestic abuse issues.

6.2.2. These issues were addressed in agency IMRs, and in Review Panel meetings and questions sent to agencies and the answers are outlined in the analysis for each agency in section four.

6.2.3. In addition the following issues were identified as specific to this case:

- Problematic alcohol use by Donna Williamson and YZ.
- Mental ill-health for Donna Williamson and YZ.
- Poor physical health issues for Donna Williamson.
- Clients who engage and disengage in relation to Donna Williamson and YZ.
- Situations in which a victim of domestic abuse (Donna Williamson) is also identified as a perpetrator.

6.2.4. These are addressed individually below, in addition to a discussion on the MARAC process and the extent to which agencies responded to Donna Williamson's needs.

6.2.5. A key finding from this Review is that a great deal of work happened with Donna Williamson and YZ to support them, including communication between agencies and joint working. The risk YZ posed to Donna Williamson (and at times vice versa) was identified on a number of occasions, and appropriate referrals were made to the MARAC, as well as for Donna Williamson to Lewisham Adult Social Care. There were many instances of practitioners (police officers, IDVA, the offender manager) working hard to improve the

safety and wellbeing of Donna Williamson including home visits, regular phone calls and advocacy to partner agencies on her behalf. Nearly all agencies showed some awareness of the nature of domestic abuse, and an understanding of the framework for responding to it (including risk identification, MARAC referral, and IDVA support).

6.2.6. Nevertheless, there were areas where lessons need to be learned and recommendations identified to address these. In addressing these issues, the independent chair and Review Panel have been mindful of the fact that this is the seventh DHR in Lewisham, and that despite the advances that have been made in responses to victims and perpetrators of domestic abuse, some of the areas of learning are the same or similar to earlier reviews.

6.2.7. These issues are addressed individually, to highlight where lessons have been learnt: but this Review has identified that continuing to see these issues as separate, requiring specific responses in isolation from each other, is a failure to address the totality of a person's lived experience, and this is discussed in the final section (see 5.2.72).

**Alcohol use by Donna Williamson and YZ**

6.2.8. Alcohol was a significant issue in the lives of Donna Williamson and YZ, and in their interactions with agencies. They were both at times engaged with a support agency to reduce their drinking, with varying outcomes in the short term but in the long term with no evident impact.

6.2.9. The Review Panel agreed that Donna Williamson's problematic alcohol use was a significant barrier in her ability to be supported by agencies. At times this was because it resulted in her being unable to attend appointments, or in attending appointments so intoxicated that she could not engage in the conversation or assessment.

6.2.10. Some agencies (such as the IDVA, probation, Lewisham Adult Social Care and police) at times maintained a broader view of Donna Williamson encompassing her experience of abuse and violence from YZ and her physical vulnerability. For others (for example Donna Williamson's GP), Donna Williamson's alcohol use obscured her other issues while the agency focused exclusively on it. This was also the case for YZ's GP, who focused on YZ's alcohol use as the "*main issue*" and as a result responded to YZ's disclosures of domestic abuse only by referring again to CGL Aspire, not by referring to a specialist domestic abuse service.

6.2.11. When probation contacted SLaM in November 2015 with concerns for Donna Williamson's mental health, the offender manager was informed that Donna Williamson would have to attend the hospital emergency department sober in order to be seen and assessed. For someone like Donna Williamson who was alcohol dependent, this created a barrier to accessing mental health support that she would have been unlikely to overcome alone.

6.2.12. All agencies recognised Donna Williamson's alcohol use as a factor in her difficulties in continuing to engage with services. The responsibility for this was placed on Donna

Williamson needing to 'try harder' to engage, which did neither recognised nor addressed the fact that her behaviour was not an informed or rational 'choice' but often driven by her alcohol dependency, complicated and exacerbated by her other issues and experiences.

6.2.13. CGL nationally recognise the barriers faced by alcohol dependent clients in accessing services; that someone not being 'willing to engage' should never be a reason (alone) to exclude them from services. CGL have a policy and procedure for working with clients in this context; it should have been used with Donna Williamson and YZ. It has been shared through this Review and a recommendation (8) has been made to ensure other agencies learn from this and take action to improve attempts to engage clients. A recommendation (9) is also made to both CGL New Direction and Aspire to audit their case files to ensure that the procedure is being used and this is evidenced in the ways in which clients are encouraged and supported to engage with the service.

**Mental health issues for Donna Williamson and YZ**

6.2.14. The issue of Donna Williamson's alcohol use appeared to prevent her from being able to access mental health services. It is notable that, despite repeated disclosures by Donna Williamson that she was not coping, or struggling to self care, particularly in light of her history of attempted or threatened suicide, she was at no time referred to a mental health service, either statutory (SLaM) or in the community (with the exception of April 2016 when they attempted to see her in the Emergency Department).

6.2.15. Donna Williamson's GP, the IDVA, Lewisham Adult Social Care and CGL New Direction could have directly referred Donna Williamson into mental health services for assessment and possible treatment or support. Donna Williamson's GP managed Donna Williamson's mental health through medication and ongoing support during appointments, but did not refer her to a specialist service. The GP told the Review that they had the perception that mental health services would not accept a referral for someone, like Donna Williamson, who was addicted to alcohol. This was challenged by Review Panel members who highlighted the presence of dual diagnosis policies in mental health trusts. Other than this, only probation acted directly to support Donna Williamson's mental health.

6.2.16. When probation contacted SLaM to seek advice as the offender manager felt Donna Williamson needed mental health input: SLaM informed probation that Donna Williamson would have to wait until her level of intoxication reduced so that they could accurately assess her. This was repeated following the offender manager's referral to Together for Mental Wellbeing, where Donna Williamson could not be assessed due to her level of intoxication. The Review Panel agreed that Together was a service that could have made a real difference to Donna Williamson if she had been able to engage.

6.2.17. Agencies have policies in relation to dual diagnosis, and the issue of clients having both mental health needs and alcohol/drug dependency is well known and long standing for all

agencies in these sectors. For an individual the issues are rarely separate but intertwined in ways that cannot easily be explained; in Donna Williamson's case this was combined with her previous experiences of trauma (including sexual violence), the ongoing domestic abuse from YZ, the threat of eviction from her home and her offending history.

6.2.18. This has been identified in research looking at the life experiences of women and girls and their experiences of social inequality, violence and abuse, and other 'negative' life experiences:

"*By the time women at risk reach adulthood their lives may well have been on a negative trajectory for some time and opportunities to intervene have either been missed or had a limited impact.*"[20]

6.2.19. The Review Panel heard of recent developments in Lewisham in relation to dual diagnosis, in which drug and alcohol agencies and the mental health trust (SLaM) are working at senior levels and operationally to ensure effective strategy and practice is in place. A recommendation (10) has been made to ensure that the learning from this case feeds into that.

6.2.20. The Review Panel discussed the developments in the domestic abuse sector, well known to the mental health sector, towards a 'trauma informed response'. This is championed by Women's Aid's new Change That Lasts approach, which places the individual at the centre of their journey to safety and wellbeing[21], and has been a significant focus for AVA (Against Violence and Abuse) leading to the publication of *Practice Guidance: Engaging with young women experiencing domestic and sexual violence, substance use and mental ill-health*[22] and *Complicated Matters: A toolkit addressing domestic and sexual violence, substance use and mental ill-health*[23]. In the latter, trauma-informed approaches are at the centre of ensuring that a victim/survivor/client is "*treated like a human being*".

6.2.21. A recommendation (11) is made for the mental health agencies (statutory and voluntary sector), drug and alcohol services and specialist domestic abuse agencies in Lewisham and Greenwich to amend their policies, procedures, training and practice taking account of these toolkits in working with clients who present with mental ill-health, substance use, and experiences of domestic and/or sexual violence.

**Physical health issues for Donna Williamson**

6.2.22. Donna Williamson had two hip replacement operations in 2007, including an extended period in hospital. Over her years of interactions with agencies, Donna Williamson

[20] McNeish, D. and Scott, S. (2014) *Women and Girls at Risk: Evidence Across the Life Course* DMSS Research

[21] https://www.womensaid.org.uk/our-approach-change-that-lasts/ [accessed 20 June 2017]

[22] https://avaproject.org.uk/wp/wp-content/uploads/2016/03/YWI-Practice-Guidance-FINAL.pdf [accessed 20 June 2017]

[23] https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Complicated-Matters-A-toolkit-addressing-domestic-and-sexual-violence-substance-use-and-mental-ill-health.pdf [accessed 20 June 2017]

mentioned it and the physical difficulties it led to. She also disclosed that YZ deliberately targeted that part of her body during physical assaults. Her poor physical health was also a result of her excessive alcohol use, which caused muscle wastage and other side effects.

6.2.23. Probation specifically referred to Donna Williamson's physical deterioration in early 2016, and referred her to Lewisham Adult Social Care as she was seen not to be able to 'self care' for example not eating, getting dressed or going out. This was an opportunity for agencies including probation, Lewisham Adult Social Care and CGL New Direction to work together to fully understand and try to address Donna Williamson's situation and needs, which was not taken. Adult Social Care relied on phone interactions with Donna Williamson in which she stated that housing was her only issue: had they visited her at home, with probation, they may have assessed her needs differently.

6.2.24. Donna Williamson was entitled to receive an assessment under the Care Act 2014 which would have been carried out by Adult Social Care.

6.2.25. The panel discussed whether Donna Williamson would have reached the threshold for support through the Care Act 2014 had she received that assessment. She would have had to meet two conditions: that her "*needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors*" and that "*as a result of the adult's needs, the adult is unable to achieve two or more of the outcomes specified in the regulations*".[24]

6.2.26. Review Panel members disagreed (based on the information available to the Review) whether Donna Williamson would have met these two conditions, and in the absence of an assessment we cannot know what outcome was possible, but it could have led to a coordinated response to address her needs.

**Clients who engage and disengage in relation to Donna Williamson and YZ**

6.2.27. All agencies that had contact with Donna Williamson and YZ experienced both of them engaging and disengaging from services. This included making initial approaches and then not responding to follow up; not attending appointments; declining services and being unable to be contacted. For Donna Williamson this was more pronounced, because the number of agencies she had contact with was much higher than YZ and her periods of engagement were longer.

6.2.28. Some agencies saw Donna Williamson holistically, identifying the many issues she was contending with. Nevertheless, she then had to engage separately with each separate agency for each issue: CGL New Direction for her alcohol use; her GP for pain management and mental health treatment (plus LAS and the hospital for acute mental health issues); the IDVA for safety planning in relation to the abuse from YZ; SHIP and

[24] http://www.scie.org.uk/care-act-2014/assessment-and-eligibility/eligibility/criteria-adults-care.asp [accessed 5 July 2017]

Thames Reach for help with housing; NCDV for help with a non-molestation order; police for immediate safety concerns.

6.2.29. Most agencies encouraged her engagement with others; but none, from the records made and provided to this Review, demonstrated that practitioners reflected on the ways in which they could support Donna Williamson to engage, or the difficulties that her situation led to that would have presented barriers to her engagement. For example, there were times when Donna Williamson's engagement dropped or stopped when the member of staff she had been engaging with left and was replaced by another. While this situation is an unavoidable one for all agencies, Donna Williamson's response to it shows that it is an area that needs to be managed closely and carefully by agencies.

6.2.30. Donna Williamson was described as "*failing*" to engage with services, suggesting her involvement with them was a test she could pass or fail, rather than a process involving both her and the practitioner(s), in the context of the many issues she faced on a daily basis. There were few occasions when workers attempted anything other than repeated phone calls to Donna Williamson, for example a home visit or joint meeting with her and another agency. Given the number of times Donna Williamson was recorded as having a new mobile number (her family told the Review she had to keep changing it because of YZ's abuse, see 3.1.10) it was unsurprising they couldn't always reach her. Agencies were asking Donna Williamson to fit in with their own prescribed process, at times without addressing the issues that were fundamentally important to her. The most pertinent example of this is the broken door to Donna Williamson's flat (see 5.2.63).

6.2.31. Donna Williamson's dis-engagement from agencies was often seen in isolation by each agency. No one agency formed the view that Donna Williamson's disengagement was often from all agencies at the same time, for example in the three months before she died.

6.2.32. When Donna Williamson disengaged from agencies it was not seen as increasing her risk level: when in the context of her relationship with an abusive man it could have been seen as reflecting times when his coercive control of her increased.

6.2.33. The Review Panel recognised that, in a context of agencies having internal and external pressures to work with a high volume of clients, and time pressures in relation to that, practitioners and teams are often not in a position to reflect more broadly on their approaches to engaging clients. This is a luxury afforded to the DHR process, which can look at the picture as a whole, taking account of all the information that may not have been available to individual agencies at the time.

**Situations in which a victim of domestic abuse (Donna Williamson) is also identified as a perpetrator**

6.2.34. The Review Panel discussed the nature of Donna Williamson and YZ's relationship in the context of the definition of domestic abuse set out in section four, and whether Donna

Williamson could be seen as a perpetrator of domestic abuse as a result of her behaviour and violence towards YZ. Agencies labelled Donna Williamson as such, particularly those in Greenwich due to YZ being presented at the MARAC as the victim, and probation who worked with Donna Williamson as a result of an assault she committed against YZ. Records suggest that Donna Williamson saw herself as a perpetrator of domestic abuse, including her own fears that she would hurt YZ.

6.2.35. Some panel members felt that Donna Williamson's behaviour was sufficient to label her as a perpetrator of domestic abuse. Others felt that her behaviour could be seen as the direct result of being a victim of domestic abuse from YZ, meaning that she was a perpetrator not of domestic abuse but of 'violent resistance'. This has been articulated by Kelly and Johnson as a category of violent behaviour used by individuals who "*in attempts to get the violence to stop or to stand up for themselves, react violently to their partners who have a pattern of Coercive Controlling Violence.*"[25]

6.2.36. The gendered nature of domestic abuse is set out in many studies, research and data. Hester underlined this in a review of police incidents in which women were arrested as perpetrators: 92% of those identified by the study as intimate partner abuse perpetrators were male. Despite this, in the cases analysed, women "*were three times more likely than men to be arrested when they were identified as the primary aggressor in a particular incident, and the police appeared more ready to arrest women despite patterns of violent behaviour that were less intense or severe than the patterns exhibited by men. … women were arrested every three incidents in which they were deemed perpetrators … but men were only arrested in about every 10 incidents*."[26]

6.2.37. There is little evidence in this Review that work was done directly with Donna Williamson to understand and account for her use of violence against YZ: to aim to prevent further instances and the harm it could cause, and as a means of supporting Donna Williamson to see herself differently in relation to it. This could have been achieved through the probation Female Aggression and Domestic Abuse intervention, had it been available during the community order. What does come through is that Donna Williamson appeared to see her behaviour as similar to YZ's: she told CGL New Direction in October 2015 that there was "*domestic violence (between each other)*" in the relationship. On the occasion that Donna Williamson was arrested for assaulting YZ she admitted it immediately; she admitted at other times the risk she posed to him because he "*made her angry*". She referred a number of times to an occasion when she "*stabbed*" YZ and her guilt over it: the records for that

[25] Kelly, J and Johnson, M. 'Differentiation Among Different Types of Intimate Partner Violence: Research update and implications for interventions' Family Court Review 46 (3)

[26] Hester, M. (2012) 'Portrayal of Women as Intimate Partner Domestic Violence Perpetrators' *Violence Against Women* 18 (9); http://journals.sagepub.com/doi/pdf/10.1177/1077801212461428 [accessed 20 June 2017]

incident suggest the injury inflicted, while not excusable, was not as serious as Donna Williamson outlined and also that it may have been done in self-defence (see 3.6.103). YZ never admitted to any abuse or violence against Donna Williamson, and never sought help for any behaviours he used against her.

6.2.38. This Review needs to address how this labelling affected Donna Williamson's understanding of herself as being at risk from YZ, and her perception of how agencies could help her – and those agencies' perceptions of the help they could offer to her and to YZ. Donna Williamson at times saw YZ as someone who could protect her from others, and named him as her only source of love, care and support and that she would be lonely without him. She also reported being in fear of him.

6.2.39. There was evidence from agencies and from the Greenwich MARAC that despite her occasional use of violence, Donna Williamson was seen as the 'primary' victim of ongoing domestic abuse and coercive control. But at times agencies were caught in the binary of victim / perpetrator leading to Her Centre trying to offer support to both Donna Williamson and YZ at different times, and the DASH Risk Checklist being completed with each of them at police incidents that followed one other.

6.2.40. Police necessarily respond to incidents in which they have to identify the perpetrator (of any offences) and the victim (of those offences), and they are required to respond to offences committed regardless of whether the perpetrator of the offence (in this case Donna Williamson) is the ongoing victim of coercive control from the victim of the offence (YZ). It is necessary for any agency to be clear on 'who is doing what to whom'[27] so that appropriate responses and services are offered.

6.2.41. The Review Panel heard that some areas of service delivery in Lewisham are moving towards a response that is not based on labels such as 'perpetrator' or 'victim' but on assessing an individual's 'contextual risk'. This is addressed further in the discussions below.

6.2.42. The College of Policing, in response to the HMIC (Her Majesty's Inspectorate of Constabulary) report *Everyone's Business: Improving the Police Response to Domestic Abuse*[28] has developed, with Safe Lives, a new training module for police first responders called Domestic Abuse Matters. It "*focuses on the issue of domestic abuse and coercive controlling behaviour and is structured with a view to implementing long-term attitudinal and behavioural change in*" [29] the police. While the MPS has not taken this training on, they

[27] Hester, M. (2009) *Who Does What to Whom? Gender and Domestic Violence Perpetrator*s Bristol: University of Bristol in association with the Northern Rock Foundation; also see Respect guidance www.respect.uk.net [accessed 20 June 2017]

[28] www.justiceinspectorates.gov.uk/hmicfrs/wp-content/uploads/2014/04/improving-the-police-response-to-domestic-abuse.pdf [accessed 10 August 2017]

[29] www.safelives.org.uk/training/police [accessed 20 June 2017]

have internally developed their own training package that similarly focuses on coercive and controlling behaviours, based around the film 'Murdered by my Boyfriend' (BBC, 2014).

6.2.43. The MPS Training Unit informed the MPS Review Panel Member that all training is developed in conjunction with MPS subject area specialists who in turn have interaction with the College of Policing. The MPS have recently (in 2017) finished a training run for frontline officers regarding domestic abuse which involved training at 10 sites per day for three months to reach all officers. This is separate to the ongoing training of new recruits which covers eight classes over two training sites on early and late shifts. All training packages are reviewed every two years.

**The MARAC and multi-agency response**

6.2.44. It is remarkable in this case that there were nine multi-agency meetings in the course of five years, and yet a lesson learned in this Review is that agencies did not always work together effectively to manage the risk posed by YZ to Donna Williamson (and vice versa) and the address the safety, health and wellbeing needs of Donna Williamson.

6.2.45. The Review Panel felt strongly that the MARAC process should have been used as a more proactive and creative opportunity to review all of the information held by all agencies in the development of a complete and holistic picture of Donna Williamson and YZ, their risks, needs and context, and to establish a joint agency action plan to address these.

6.2.46. Donna Williamson's family fed back that they felt, on reading the Overview Report, that agencies had "*written things down*" but then done nothing; and that more preventative work could have been done with Donna Williamson – contact with her instead was "*repetitive*", and did not "*put things together*" about Donna Williamson, her life and her relationship with YZ.

6.2.47. The specific issues identified by the Lewisham MARAC have been addressed through their recommendations (see 4.2.88). It is the role of this Overview Report to address more broadly the concerns around the MARAC process that were discussed at Review Panel meetings.

6.2.48. In this case, there was evidence of agencies not recording MARAC referrals, research, attendance and actions in their own agency/service databases. Not all agencies are currently able to 'flag' MARAC cases, which means that they cannot identify repeat referrals if further incidents are disclosed to them.

6.2.49. There were two periods when Donna Williamson could have been referred to MARAC as a 'repeat referral' due to the further incidents of abuse from YZ that she disclosed: July 2012 to October 2013, and from January 2015 to when she died. Only two agencies referred Donna Williamson (or YZ) to MARAC: police and IDVA. Probation, CGL New Direction, Housing for Women and Greenwich Housing Service all had information that could have led to MARAC referrals, and in some cases this was discussed but not progressed. The

Review Panel discussed the possibility that agencies felt that others would make a referral and therefore they did not have to; or that they did not recognise Donna Williamson as a repeat MARAC case, because agencies are not flagging cases.

6.2.50. The issue of Donna Williamson living in Lewisham (and being discussed at the Lewisham MARAC) and YZ living in Greenwich (and being discussed at the Greenwich MARAC) was an issue: there are policies and procedures in place for MARAC to MARAC transfers when a victim moves areas; these are not in place for situations which cross two boroughs. One action for the June 2012 Greenwich MARAC was for Her Centre to "*make contact with Lewisham to find out who the actual victim was*": it was not clear who in Lewisham was to be contacted, or what would be done if further information were gained. There were no similar actions at the 2013 or 2015 meetings. The only action from the six Lewisham MARACs relating to Greenwich was for Lewisham Adult Social Care to liaise with Greenwich Adult Social Care with regard to YZ's family member.

6.2.51. Lewisham has set up a new process to address this, in which MARAC cases involving a perpetrator who lives outside of Lewisham are highlighted, and contact is made with the MARAC of that area. Information is provided to that MARAC about the perpetrator, to enable that area to take appropriate actions in relation to the risk they may pose. Information is requested about the perpetrator from that area to support the risk management actions made at the Lewisham MARAC, and to advise other agencies so that they may take appropriate risk management actions. The same process applies for victims who previously resided in another borough, and now live in Lewisham. The Lewisham MARAC Steering Group is currently updating its Operating Protocol to capture this.

6.2.52. A recommendation (12) is made that this procedure is adopted by the Greenwich MARAC.

6.2.53. A recommendation (13) is made that this procedure is highlighted at the London MARAC Coordinators Forum as good practice to be adopted across London, and that Safe Lives promotes this nationally.

6.2.54. It was clear that services were striving to engage with the MARAC constructively, and the Review Panel were keen to identify ways of further improving the process so that, should another case like Donna Williamson's come through again, the response would be more robust.

6.2.55. The following questions are put:

- Does the MARAC exist simply as a forum for sharing information about high risk victims and perpetrators?
- Do agencies view a MARAC referral as the end / beginning / part of an ongoing process of managing high risk victims?
- How much information do agencies share at MARAC meetings, for example the extent of the history of domestic abuse or just the most recent incident/contact?

- Do agencies fully take on that the MARAC does not hold cases, but is a forum to facilitate agencies working better together in taking action they should already be taking?
- Are actions made at the MARAC purposeful and effective in managing risk?
- How are agencies held to account for the ways, and extent to which, they engage with the MARAC process and carry out risk management actions before and after meetings?
- How can MARAC better support effective multi-agency working outside of MARAC meetings, for example through the identification of a lead professional who coordinates agency actions, through the use of additional multi-agency meetings to discuss complex cases, or through a structure that allows for the ongoing management of some cases?

6.2.56. A recommendation (14) is made for an audit to be carried out of the referrals made to one meeting to assess how many would benefit from a deeper/broader multi-agency approach of the kind outlined in the last bullet point above.

6.2.57. The MARAC is a means through which agencies can work together while at the same time fulfilling their own individual responsibilities and duties to their clients. It does not replace anything; it should enhance service responses. The evidence submitted to this Review suggests that some agencies acted as though the MARAC were a service in itself, and did not take action in relation to Donna Williamson (or YZ) unless the MARAC directed them to.

6.2.58. A further recommendation (15) is made with a focus not on changing the MARAC process itself, but on ensuring that individual agencies both understand and adhere to their own responsibilities in relation to cases that are heard at MARAC; and that there is accountability throughout the system in relation to these responsibilities. The recommendation calls for a multi-agency review of the Lewisham MARAC to take place, involving all those agencies that currently engage with it. This review should address all of the questions above.

6.2.59. The Review Panel heard about a new way of approaching some cases in Lewisham centred on understanding the 'contextual risk' and vulnerabilities of an individual who is receiving services. How this could relate to MARAC is addressed below.

**Responding to Donna Williamson's Needs**

6.2.60. Many agencies worked with Donna Williamson to address her needs, or those that they were aware of. As outlined above, this usually involved referral to other agencies, leading to Donna Williamson's needs being compartmentalised according to the specialism of each agency. Also discussed above the MARAC did not succeed in being a vehicle through which information about Donna Williamson and YZ could be shared, followed by a comprehensive safety plan to address her needs and improve her safety.

6.2.61. Donna Williamson was seen as 'complex', and this Review has highlighted her many issues and needs. It is possible this this clouded the views of practitioners: she was seen as complicated, complex and chaotic (as well as "*failing to engage*") and the sheer number of agencies (and 'issues') actually seemed to work against the ability of practitioners to address her needs. Research has shown that:

"*When women enter services it is often because of something that is wrong with them – their drug use, offending behaviour, prostitution or mental illness – rather than because of what has happened to them, and in the process they are categorised in ways that often render their lived experience invisible.*"[30]

6.2.62. The most obvious example of this was Donna Williamson's broken door.

| Date | What Happened |
|---|---|
| mid-November 2015 | ▪ CGL New Direction worker concerned about Donna Williamson who has threatened suicide; on not being able to reach her, contacted police to request a welfare check.<br>▪ Welfare check completed by police: entry was forced as Donna Williamson not present. Donna Williamson returned and was advised to contact her landlord to get her door fixed. |
| November 2015 (next day) | ▪ Donna Williamson contacted CGL New Direction and reported that police had knocked her door down. Donna Williamson concerned as she could not pay for the door and did not want to tell her landlord as she was on a final warning. Worker agreed to check with police who was liable for damage to the door.<br>▪ Donna Williamson called police as she did not feel safe in her home since police had broken the door down; she wanted police to pay for the door and was given information on how to claim for compensation. |
| December 2015 (5 weeks later) | ▪ Donna Williamson called police to report that someone had forced entry to her flat, stolen the electricity meter and caused damage. (She later told probation it was YZ but did not make this allegation to police at the time; police concluded Donna Williamson and her friends had caused the damage). |
| January 2016 (2 weeks later) | ▪ Probation offender manager called Lewisham Adult Social Care for support for Donna Williamson, and reported that Donna Williamson's door was not secure, and there was no electricity in place following the incident in December. |
| January 2016 (next working day, 3 days later) | ▪ Lewisham Adult Social Care spoke to CGL New Direction worker who stated they thought police had fixed the door. |
| January 2016 (next day) | ▪ Lewisham Adult Social Care spoke with Donna Williamson who reported the door had a board over it but was still broken. |
| January 2016 (3 days later) | ▪ CGL New Direction meeting with Donna Williamson, she stated she was still waiting for her door to be fixed. |

[30] Reference: see footnote 19

| | |
|---|---|
| January 2016 (next working day, 3 days later) | ▪ Lewisham Adult Social Care spoke to CGL New Direction worker who stated Donna Williamson's property is permanently unsecure following the police forcing entry to the flat. Donna Williamson had not told her landlord for fear of eviction.<br>▪ Referral to IDVA by police for Donna Williamson stated Donna Williamson's door not secure but landlord refusing to pay for it. IDVA called Donna Williamson who was unable to talk. |
| January 2016 (5 days later) | ▪ Lewisham Adult Social Care contact with probation offender manager who reported police were in the process of fixing the door and would be attaching a lock today.<br>▪ IDVA spoke with Donna Williamson who asked when her door was going to be fixed. IDVA to send referral to Home Security Programme, but they could only fit extra locks, not replace the whole door. |
| January 2016 (5 days later) | ▪ IDVA spoke to Donna Williamson who said that someone had looked at the door but couldn't do anything. |
| February 2016 (2 weeks later) | ▪ Donna Williamson attended probation with IDVA also present, Donna Williamson wanted a lock for her front door. IDVA recorded that the Home Security Programme referral had been done but the door was too badly damaged following the incident when police broke the door to access the property. The IDVA recorded that police had accepted a MARAC action to look at fixing the door. |
| March 2016 (3 weeks later) | ▪ Donna Williamson called police to report she had returned home and the communal door and her flat door had been kicked in and the flat searched; Donna Williamson's family member was present and said the damage was old. |
| April 2016 (7 weeks later) | ▪ Lewisham Adult Social Care contacted probation offender manager reporting conversation with Donna Williamson in which Donna Williamson had asked about the door being fixed, and asked the offender manager to pick this up with Donna Williamson (Social Care case closed).<br>▪ Probation offender manager sent CGL New Direction and police the update from Lewisham Adult Social Care, and that offender manager was intending to visit Donna Williamson that afternoon and would give her contact details for agencies offering housing advice.<br>▪ Police officer responded to email stating that the door would have to be fixed by Donna Williamson or the landlord, as it was boarded up after police attended but YZ had broken it on a later date.<br>▪ Donna Williamson called police reporting that someone had entered her flat by pulling the padlock off the door. She told police her landlord would be replacing the door. |
| May 2016 (4 weeks later) | ▪ Lewisham Adult Social Care, following an alert from police for an incident she had reported, contacted Donna Williamson who said that her door was unsecure, but it's the same state it's been for a long time (no further damage had been caused). |
| June 2016 (1.5 weeks later) | ▪ IDVA recorded a MARAC action (meeting May 2016) to discuss Home Security Programme and refuge places with |

| | |
|---|---|
| | IDVA. No contact with Donna Williamson made following this. Case closed one week later. |

6.2.63. Reading this chronology, it is striking that Donna Williamson, at this time recognised appropriately as a vulnerable individual in need of help, with a number of agencies trying to support her, was left fundamentally unsafe and unsecure in her own home due to an apparent inability to identify how to help her. The damage was too severe for one service to fix; was not the responsibility of other agencies to fix; and she did not feel able to report it to her landlord who had already indicated they wanted to evict her.

6.2.64. Donna Williamson's door was noted to still be broken by the officers who attended her home during the earlier call on the day she died. One made a statement which included the following: " Donna Williamson*'s door had been damaged at some point as there was a large wooden plank over it, I then noticed that there were two eyelet screws on the door frame and door to be used with a padlock which is a method used by boarding up agencies to secure properties, there was no padlock on the door, as I touched the front door it opened a fraction.*"

6.2.65. Agencies were focused on her alcohol use, her physical wellbeing and self-care, and the domestic abuse she experienced from YZ. Yet, her door not being fixed left her at heightened risk from him because she simply could not protect herself in her own home. It also almost certainly made it more difficult to address her other difficulties or needs: the widely recognised 'Hierarchy of Needs' (Maslow) sets out that shelter is one of the physical requirements for human survival: if not met, other needs (such as safety, social belonging and self-esteem) cannot start to be met[31].

6.2.66. The Lewisham Adult Social Care IMR author made the point that "*the number of agencies involved may well have given a false sense of security as to how well Donna Williamson was in fact being supported*"; the Review Panel agreed. Despite the high number of agencies, some of Donna Williamson's needs were still not met. A significant missed opportunity was the professionals meeting that should have been held as directed by the Lewisham MARAC. Practitioners at times seemed to make the assumption that other agencies were taking the lead, or meeting Donna Williamson's needs, or for example by making a MARAC referral.

6.2.67. Research by Mockton-Smith, Williams and Mullane suggests that part of the problem with responding to people such as Donna Williamson is her relative 'status' in the eyes of society and agencies. They outline that victims of ongoing coercive control, combined with the "*chronic fear*" created by the abuser, can work against some women:

[31] See for example: https://www.simplypsychology.org/maslow.html [accessed 20 June 2017]

"*the victim of domestic abuse can easily become the subject of frustration and contempt. A woman who suffers low level assaults from her live-in husband has very low status. She may further lose status if she fails to respond to criminal justice and other interventions in a way which fits with the agenda of a particular organisation. For example, when a woman refuses to support a prosecution, or withdraws her complaint, police officers and lawyers can become frustrated and will often feel there is nothing they can do to help. This can reduce the enthusiasm with which they approach repeated calls for help from that victim. She becomes the problem, she can be seen as a time waster, as mentally ill, as a drunk. This victim then loses nearly all status, and may be isolated from any of the help available*".[32]

6.2.68. In Donna Williamson's case there were some practitioners who went above and beyond expectations in trying to support Donna Williamson; for others the frustration was clear. It is not for this Review to question or judge those individual practitioners: they were working within a system and an environment that shaped their responses, as well as working within the possible restrictions of high caseloads and external deadlines. It is the role of this Review to make recommendations that aim to change the way people such as Donna Williamson and YZ are viewed and responded to, and this is outlined in the next section.

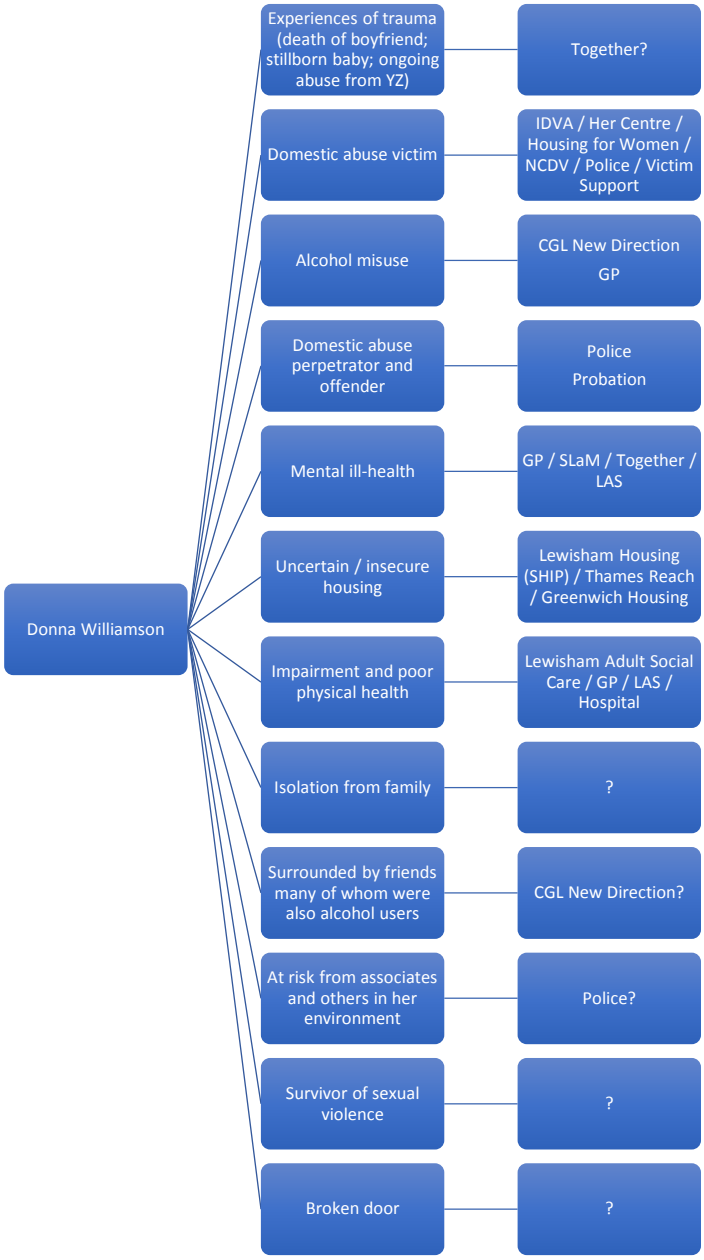
6.2.69. In addition, it is important to address how practitioners were supported by management and internal agency structures to work with someone like Donna Williamson whose life appeared so 'chaotic'. Records from some agencies show supervision but this was sporadic and did not always reflect the complexities of Donna Williamson's case and how the practitioner was trying to work with her.

6.2.70. A recommendation (16) is made for all agencies who had involvement with Donna Williamson to conduct reviews of caseload and supervision structures surrounding practitioners working with clients with particular reference to those working with clients with many and complex needs such as Donna Williamson.

**Contextual Risk**

6.2.71. Agencies focused on Donna Williamson as 'someone who misused alcohol', or 'someone who experienced domestic abuse' or 'someone who was a domestic abuse offender': this is set out in the diagram below.

[32] Monckton Smith, J. and Williams, A. with Mullane, F. (2014) *Domestic Abuse, Homicide and Gender: Strategies for Policy and Practice* Palgrave Macmillan




6.2.72. Donna Williamson needed an agency or practitioner who could step between the first column and the second to support her holistically, even if that led to a referral to another agency, provided they worked together. The IDVA went some way to try to do this; as did the offender manager. But their roles were limited to the scope of their agency, and in probation's case to the length of Donna Williamson's community order.

6.2.73. Donna Williamson needed to be understood in the context of her being in a relationship with a man who was abusive, with no family support, and whose few friends were, like her, drinkers (but were at times a source of support in relation to YZ), and within a trauma-informed approach that fully acknowledged her past and recent experiences and the impact on her.

6.2.74. The Review Panel agreed that, if agencies (supported by the MARAC process) had addressed the contextual risk in relation to Donna Williamson and the context of her life, environment and network (i.e. the people around her), then the approach to engaging with and supporting her could have looked very different. This draws on recent research with young people that can be made applicable to victims/survivors of domestic abuse: "*Contextual safeguarding promotes the idea that young people's behaviours, levels of vulnerability and levels of resilience are all informed by the social/public, as well as private, contexts in which young people spend their time.*"[33]

6.2.75. This could have led to a focus on the practical: Donna Williamson's housing situation (both the broken door and threat of eviction); and how her experiences of trauma impacted on her life, experiences and ability to make choices. This should have been in done in dialogue with Donna Williamson and what she felt her needs and options were, and recognition of any resilience she had, particularly the fact that she had survived up to then despite the domestic abuse from YZ and her other experiences.

6.2.76. The multi-agency response to her could then have been directed towards addressing those needs that directly impacted on the contextual risks and vulnerabilities identified for Donna Williamson. Agencies could have been brought together through a central point of coordination (e.g. MARAC and a lead professional, or a professionals meeting) to minimise the repeated contacts Donna Williamson had to make and to aim to ensure that information continued to be shared with all those who needed it and changes to circumstances (including e.g. Donna Williamson disengaging from a service) and risk could be responded to dynamically.

6.2.77. This recommendation takes account of the fact that this is the seventh DHR to be conducted in Lewisham. Five have been published and one is awaiting publication following approval by the Home Office DHR Quality Assurance Panel. Included in the development of the recommendations in this section was a review by the independent chair and Review Panel of the recommendations made in the previous six Reviews.

6.2.78. The recommendation (17) is for all agencies within the partnership response to violence against women and girls to develop their assessment, practice, policies and training to incorporate the learning from this case in relation to 'contextual risk'.

6.2.79. The Review was given information about new services in Greenwich and Lewisham which set out to meet the needs of victims of domestic abuse such as Donna Williamson. In Greenwich a 'complex needs' service has been established to work with victims of domestic abuse who also misuse alcohol/drugs and have mental ill-health. In Lewisham a

[33] https://www.beds.ac.uk/ic/current-projects/contextual-safeguarding-programme [accessed 15 August 2017]

'complex needs worker' will support women in the domestic abuse refuge who have these issues.

6.2.80. The Greenwich service is a Department of Communities and Local Government (DCLG) funded pilot of a Multiple Needs and Intensive Support Project, aimed at improving support to victims of domestic violence and abuse with multiple complex needs (such as substance misuse, mental ill-health, worklessness and immigration concerns). The project will aim to support these victims and their children. The project will ensure pro-active, persistent and intensive support to complex and hard to reach victims, that is not time limited. It will support victims to get the help they need to escape the cycle of abuse, whilst allowing them to address other challenges they may face. It will help them access specialist accommodation based services and assist those victims that cannot currently access generic or specialist refuge due to their high level of support needs. The intensive support will aim to ensure that women (and their children) who are supported into refuge are also able to access universal services and move towards independent living, thus freeing up bed spaces for future victims.

6.2.81. The Lewisham service, like Greenwich, is DCLG funded. The project aims to ensure a trauma informed approach to supporting women and children in Lewisham refuges, through the provision of two specialist roles. The roles, a full-time mental health nurse and a complex needs worker based with the Athena Service, will increase capacity to support victims of domestic violence presenting with additional complex needs

6.2.82. In the course of the Review information was submitted about another service in Lewisham that may have helped Donna Williamson if she had been able to access it. Community Connections is a short term service that aims to signpost or link people up with community groups and services that could help them. Referrals can be from any agency and individuals themselves or their friends or family. They are assigned a facilitator who meets with the individual to talk to them about what a normal day looks like for them, and what their needs and wishes are. Given the isolation Donna Williamson experienced, this could have provided an opportunity for her to access a local community based project or service, or informal group, that could have supported her and reduced that isolation, and dependence on YZ.

6.2.83. The Community Connections service, through involvement in this Review, has recognised that it may have a role in supporting domestic abuse specialist services in reducing isolation for domestic abuse victims/survivors. They have now engaged with the Violence Against Women and Girls lead in Lewisham to identify development opportunities, and also attended a team meeting with the Lewisham Athena Violence Against Women and Girls service to deliver a briefing.

# 7. Recommendations

## 7.1. Recommendations from Agency IMRs

These recommendations were made by agencies when they completed their IMRs at the end of 2016 and the beginning of 2017. All agencies have provided updates to the Review on how these recommendations have been implemented, and these updates have been provided in Section Four.

7.1.1. CGL Aspire (Greenwich) have held an integrated governance team meeting in which the team explored this case. The key points / learning from this team discussion not already included in the IMR are:

a. "*CGL Greenwich did not check his partner's treatment with CGL Lewisham.*
b. *Did not refer client to our psychologist.*
c. *CGL did not follow up client's physical health issues with the GP.*
d. *Some contacts not reflected on CRiiS [CGL database].*
e. *We have discussed CGL's ability to set a flag for MARAC and the answer from our central team was that safeguarding would flag DA.*
f. *CGL Greenwich will routinely request historical minutes / reports from agencies involved where there is domestic abuse history or current risk.*
g. *CGL Greenwich have created a separate space for domestic abuse discussion within the weekly clinical meetings.*
h. *We are now proactively organising multi agency meetings for all domestic abuse cases to create a risk plan.*
i. *We have a meeting planned for 4 May 2017 to look at Domestic Abuse with the team. We have invited outside agencies to attend including PIT, Domestic Violence Intervention team and specialist Health Visitor for Domestic Violence and Abuse.*
j. *MARAC actions are recorded on to the safeguarding module on criis.*
k. *We are currently auditing all safeguarding and domestic violence cases as part of the designated safeguarding leads routine duties.*
l. *We will ensure that CGL are well represented within Greenwich safeguarding boards' domestic abuse training.*"

7.1.2. CGL New Direction (Lewisham)

a. CGL staff to identify, explore and record DV risks and safety plans – training/workshop on use of adult safeguarding maps and safeguarding module.
b. Establish a system that raises an alarm with regards to issues on domestic abuse that brings a team of multi-agency professionals together to look at support and prevention.

c. To ensure MARAC meeting minutes are circulated to all members of the CGL: Lewisham staff team.
d. Liaise with the National Safeguarding Lead to request a review of the domestic violence policy. Currently it sits within the Safeguarding for Adults Policy and the CGL New Direction Review Panel member will ask if a specific domestic violence policy can be developed that acts as a standalone policy.
e. Review and refresh with the New Direction team the missed appointments checklist and re-engagement protocols.
f. CGL management will undertake a review of open domestic abuse service users with clear and SMART actions where appropriate. This will be carried out by the Senior Safeguarding Lead and be completed by 30 May 2017. This review will include risk and recovery planning, joint working and engagement.

7.1.3. Housing for Women

a. Address recording procedures with staff, so all staff are aware of providing surnames where provided or reasons why if surnames are not recorded.
b. Look at processes around referral and information officers completing risk assessments for high risk callers, and making referrals to MARAC where appropriate.

7.1.4. Lewisham and Greenwich NHS Trust

- Lewisham & Greenwich NHS Trust will consider the impact of any partner agency reviews / recommendations on its own process.
- Lewisham & Greenwich Trust has a system in place at present which flags high risk patients of domestic violence; this is mainly across Maternity and Children & Young People, and people with learning disabilities. There is ongoing work to implement this fully across adults.

7.1.5. Lewisham Multi-Agency Risk Assessment Conference

a. Review of all actions with an outstanding status from 2015.
b. Record all instances where agencies are chased for updates on actions.
c. MARAC Steering Group to discuss platform options for how MARAC information is shared.
d. MARAC Steering Group to arrange a seminar on MARAC Flags, and how cases are recorded.

7.1.6. London Borough of Lewisham Adult Social Care

a. If faced with a similar situation in the future, where a number of agencies are involved, and there are repeated contacts with SCAIT and high levels of concerns re domestic violence, but where the service user declines Adult Social Care involvement, consideration should be given to carrying out a joint visit, and/or a multi-agency

meeting so that agencies are clear about each other's role and remit, and which agency is leading on the case

7.1.7. London Borough of Lewisham Crime Enforcement and Regulation Service

a. The CER service procedure prior to this case outlined that for cases where domestic violence appears to be an issue referrals should be made to the police and the Athena Service. Checks should also be made with DV MARAC coordinator to establish if that individual is known to the MARAC. However we have since updated this procedure in our service protocol.

7.1.8. London Borough of Lewisham SHIP

a. It is noted from this case that Donna Williamson was seen as someone being evicted for issues of domestic abuse and ASB as a perpetrator. Current practice within SHIP is to ensure that any customer advising that they are a victim abuse are given an initial housing options assessment, a CAADA completed and a referral made to MARAC. This practice will be extended out to anyone reporting domestic abuse as a victim or a perpetrator.

b. An element of this case not seen as satisfactory is the way other agencies send correspondence to Housing Options and then feel that their duty to refer to housing is complete. In this case, an email "For Information Only" was received from Lewisham Adult Social Care. Moving forwards, the Housing Needs Department are looking to develop and implement an Online / Offline Referral Form for this kind of notification so that referrers are expected to give more details of a case and that this will be logged on the housing system directly ensuring that a central log is held of such correspondence other than it simply being emailed to one person.

c. New legislation coming into force within the next 12 months will place a duty on all public bodies to make a referral to the Housing Department when they are aware that an individual is threatened with homelessness. Housing Needs will over the next 6 months provide information and guidance to relevant bodies so that they may fulfil this duty.

7.1.9. Metropolitan Police Service

a. Greenwich and Lewisham Senior Leadership Teams dip sample custody records concerning breaches of bail linked to domestic abuse incidents to ensure the Investigating Officer is notified and a review of the risk assessment takes place.

b. The 'Bail Management Toolkit – Frontline – Pre-Charge, Investigative & Post Charge Police Bail' is updated to include the following: When an arrest is made for breach of bail, it is the responsibility of the arresting officer to notify the Investigating Officer and

their supervisor for the original offence in order for a review of the risk assessment with respect to victims and witnesses, to take place.

c. Lewisham Senior Leadership Team dip sample non-crime domestic abuse incidents to ensure the risk is appropriately assessed and escalation of risk is being correctly identified in repeat cases.

d. Lewisham and Greenwich Senior Leadership Teams to dip sample domestic incident reports: to ensure all domestic abuse investigations have comprehensive investigative strategies and identify cases of coercive control; and to identify and pursue opportunities for evidence based prosecutions and DVPN/DVPO applications.

e. Lewisham and Greenwich to conduct a training needs analysis re DVPN/DVPO applications and identification of coercive control. If a training need is identified Senior Leadership Teams to deliver appropriate training.

7.1.10. National Probation Service

a. NPS should clarify the expectations and eligibility of the FADA programme; it is still technically available but not supported by personnel trained to deliver the intervention.

b. The Lewisham probation office should clarify the expectations of offender managers undertaking police and other organisational checks to use office e-mail box for audit trail.

c. The Lewisham probation office should clarify its processes around monitoring and enforcement of curfews.

d. Breach/enforcement action should have been more effective; the proposal to revoke and re sentence to custody for therapeutic reasons although well made out was draconian and could have proposed a different outcome; especially if enforcement had been taken at an earlier stage of the order.

e. Better tracking of high risk of harm risk assessments should be developed by the offender manager and her senior offender manager.

f. There are gaps in the recording in the probation database of MARAC meetings I suggest practice be reviewed.

7.1.11. Refuge recommendations were areas for the Review Panel member to check and review, therefore the actions taken are also included here.

a. Refuge's Casework Management policy and Effective Casework training should be reviewed to ensure that all staff understand the requirement to record all contact with helpline cases on to their electronic case record. The Review Panel member "*double-checked my organisation's Casework Management policy and there is great emphasis on maintaining 'accurate and up-to-date records'. I also spoke to the senior expert practitioners who deliver our effective casework training and they have confirmed that the training always covers the requirement to record all contact/attempted contact and*

*also why this is important. I was satisfied that the policy and training covers this adequately and that no changes are needed.*"

b. Refuge's independent audit of services should specifically include a review of the process being used to record contact and attempted contact with helpline cases to ensure that the Casework Management policy is being followed. The Review Panel member "*reviewed Refuge's guidance on conducting independent audits of services and was satisfied that the desktop audit of casework quality covers the full range of casework processes from referral to exit which would pick up whether Refuge's referral procedures for IDVA and outreach services were being followed. The referral procedures are extremely comprehensive and are in turn closely monitored by experienced specialist managers.*"

c. A record must be made on the client's electronic casework record of completed MARAC actions that are the responsibility of Refuge and a reason recorded for any that could not be achieved including any attempts made to follow up with the client or relevant agency. Although it may be appropriate to maintain a record of the MARAC actions for other agencies this should not be on the client's support plan and it is the responsibility of the MARAC co-ordinator to follow these up with the relevant agencies. "*The Casework Management policy clearly states the requirement to maintain 'accurate and up to date records' and IMPACT, Refuge's customised specialist electronic case management system, specifically requires every micro action required in the client's support and safety plan to be recorded and noted when completed. The policy states that 'Staff are required to ensure there are always clear professional case records that flow from referral through to exit on Refuge's standardised forms which denote best practice'. Managers are also required to routinely dip-sample case records and I can confirm that through this process I can see that MARAC actions are being recorded on client's support plans as is the date that these have been completed.*"

d. Refuge's Casework Management policy and/or training should be reviewed to ensure that it is explicit that the same requirements to ensure pre-arranged contact takes place applies to both helpline cases and referrals which have been admitted to the service. "*This point is fully and very seriously covered throughout Refuge's Casework Management policy which makes explicit what staff at Refuge must do and why for example: 'Staff will give high priority to keeping their appointments with clients. It is a brave step for a survivor to seek help around domestic violence. We regard an appointment with a client as a serious commitment. In the event of any potential problem affecting the keyworker being available to attend an arranged keywork session, she must alert her line manager in advance to discuss priorities. Only a manager can authorise staff cancelling an appointment with a client. The manager will*

*seek to ensure that wherever possible in circumstances where a keyworker is unable to attend the session, another member of staff including potentially the manager herself will step in to progress the support plan'.*"

e. Refuge's Casework Management policy and/or training should be reviewed to consider whether the current case recording practice sufficiently captures the relevant information from interactions with clients. The Review Panel member has "*discussed this issue with the senior expert practitioners who deliver Refuge's Effective Casework training which is mandatory for all staff to attend and they have stated that they 'spend a lot of time addressing this in casework management training, in particular ensuring that in the needs assessment they are giving some context around the situation and current needs so anyone can pick up the case and understand what is happening'.*"

7.1.12. Royal Borough of Greenwich Adult Social Care

a. To review policies and procedures regarding domestic violence within safeguarding procedures.

b. Remind/highlight to all RBG Adults Services workforce of the 'Warnings Section' function, to flag risks/including domestic violence whether from residents or visitors to the property/person recorded on that case record, including for closed cases.

c. Further raising awareness methods to highlight the purpose, process and positive outcomes of the MARAC framework; through communication tools and face to face methods in Adults Services.

d. Further training for staff around mental capacity and duress.

e. When MARAC Minutes are received by the Safeguarding Adults Team, to ensure all recorded actions for specific relevant Adult Services cases are put onto the relevant case record (adding to the existing recordings and communications used), unless there is a professional judgement that this would not be appropriate.

7.1.13. South London and Maudsley NHS Foundation Trust

a. SLaM adult liaison services across all sites to carry out an audit to assure themselves that they are correctly managing patients who go missing emergency departments.

7.1.14. Together for Mental Wellbeing

a. Together practitioners will work with the NPS Offender Managers to ensure that a collaborative Referral Form is produced at the point of referral. This will ensure that the Together practitioner has a written record of the information they need to make an informed decision about the type and duration of contact they might have with the service user.

7.1.15. Victim Support

Pan-London recommendations:

a. Victim Contact Officer staff to undertake robust research of repeat victim flagged cases where domestic violence or sexual violence is outlined/flagged and to seek advice from a team leader.
b. Victim Contact Officers to attend a DASH refresher workshop.
c. Quarterly dip sampling of Domestic Abuse/Sexual Violence–repeat cases.

Local recommendations:

d. Domestic Abuse awareness workshops to be provided quarterly to South Victim Care Officers by the Bromley Independent Domestic / Sexual Violence Advocate Team.
e. Where local lock fitting service is borough applicable and crime related (victim repeat flagged) all requests for to be filtered to the target hardening project for evaluation.
f. Victim Contact Officers refer all sexual violence cases in the South Area to Rape Crisis South London RASASC, with the consent of the victim.

## 7.2. Overview Report Recommendations

7.3. The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Lewisham Partnership within six months of the review being approved by the Partnership.

7.4. Progress by agencies on their IMR recommendations should be completed as quickly as possible, with an update provided to the Safer Lewisham Partnership within six months of the review being approved by the Partnership.

7.5. Where recommendations have been made for one borough (Lewisham or Greenwich) the other borough should consider this recommendation and provide assurances to the Safer Lewisham Partnership in relation to the area of learning.

7.6. **Recommendation 1** (ref 1.9.12)

Safer Lewisham Partnership to update the family on the progress of the Overview Report recommendations.

7.7. **Recommendation 2** (ref 4.2.7)

Metropolitan Police Service to feed back to the Safer Lewisham Partnership, who in turn will inform Donna Williamson's family, on the progress of the bail-related IMR recommendation.

7.8. **Recommendation 3** (ref 4.2.25)

The Refuge Lewisham Athena service to carry out an audit of cases in 2017 in which the allocated IDVA has left or changed to identify whether the handover process was followed as per policy, including producing data on whether the client continued to engage following handover. To report the findings to the DHR Task and Finish Group.

7.9. **Recommendation 4** (ref 4.2.34)

The two GPs involved in this Review to work with the Greenwich Clinical Commissioning Group to extend and deepen their understanding of and responses to domestic abuse among their patients (potential victims and perpetrators) including the development of policies, care pathways and training to ensure they can recognise and assess the risk of domestic abuse and make appropriate referrals. Greenwich Clinical Commissioning Group to share this learning all other Greenwich General Practices. To report the outcomes to the DHR Task and Finish Group and Safer Greenwich Partnership.

7.10. **Recommendation 5** (ref 4.2.63)

Greenwich and Lewisham domestic abuse specialist agencies to report to the DHR Task and Finish Group on how their procedures, assessments and training cover the need to establish with a client which other agencies they are working with, and how they satisfy themselves that this discussion is had with clients.

7.11. **Recommendation 6** (ref 4.2.119)

London Borough of Lewisham Crime Enforcement and Regulation service to carry out a dip-sample audit of cases where domestic abuse has been identified, to establish how this has been recorded and responded to, and what the outcome of those cases were. To report on this audit to the DHR Task and Finish Group and identify any actions required to enhance the response of the service to domestic abuse cases.

7.12. **Recommendation 7** (ref 4.3.7)

Royal Borough of Greenwich Adult Social Care to carry out a dip sample audit of open cases to establish whether a carer's assessment has been offered; and if it has been declined, that appropriate support has been offered to the carer(s) and that their role in the family is understood and addressed where possible. To report the outcomes to the DHR Task and Finish Group and Safer Greenwich Partnership.

7.13. **Recommendation 8** (ref 5.2.13)

Safer Lewisham Partnership member agencies to review the CGL engagement policy to incorporate the good practice within their existing policies, procedures, engagement strategies and training. To report the developments to the DHR Task and Finish Group.

7.14. **Recommendation 9** (ref 5.2.13)

CGL New Direction and CGL Aspire to carry out a dip sample audit of cases to establish whether the engagement procedure has been used (when required) and that this is evidenced in the ways in which clients are encouraged and supported to engage with the service. To report the outcomes to the DHR Task and Finish Group and Safer Greenwich Partnership, and internally within national CGL.

7.15. **Recommendation 10** (ref 5.2.19)

SLaM and CGL New Direction to ensure that the learning from this DHR is incorporated into the ongoing dual diagnosis work. To report back on this to the DHR Task and Finish Group.

7.16. **Recommendation 11** (ref 5.2.21)

Mental health agencies (statutory and voluntary sector), drug and alcohol services and specialist domestic abuse agencies in Lewisham and Greenwich to review, and amend if necessary, their policies, procedures, training and practice to take account of the toolkits for working with clients who present with mental ill-health, substance use, and experiences of domestic and/or sexual abuse/violence. To report the developments to the DHR Task and Finish Group.

7.17. **Recommendation 12** (ref 5.2.52)

Greenwich Multi-Agency Risk Assessment Conference to adopt the procedure, developed in Lewisham, of cross-borough checks on perpetrators who live out of the borough. To report on progress to the DHR Task and Finish Group and Safer Greenwich Partnership.

7.18. **Recommendation 13** (ref 5.2.53)

The London Multi-Agency Risk Assessment Conference Coordinators Forum to highlight to all London boroughs the good practice of Lewisham's procedure in relation to cross-borough checks for perpetrators living outside of the borough. To report progress to the DHR Task and Finish Group.

7.19. **Recommendation 14** (ref 5.2.56)

Lewisham MARAC Steering Group to carry out an audit of all the referrals for one month to assess how many are 'complex' in the same way as this Review has shown, and could benefit from a more in-depth approach. To report the outcome to the DHR Task and Finish Group, and for a multi-agency discussion to follow this on the next best steps for managing these cases.

7.20. **Recommendation 15** (ref 5.2.58)

Safer Lewisham Partnership to carry out a multi-agency review of the Lewisham MARAC to answer the following questions:

- Does the MARAC exist simply as a forum for sharing information about high risk victims and perpetrators?
- Do agencies view a MARAC referral as the end / beginning / part of an ongoing process of managing high risk victims? How much information do agencies share at MARAC meetings, for example the extent of the history of domestic abuse or just the most recent incident/contact?
- Do agencies fully take on that the MARAC does not hold cases, but is a forum to facilitate agencies working better together in taking action they should already be taking?

- Are actions made at the MARAC purposeful and effective in managing risk?
- How are agencies held to account for the ways, and extent to which, they engage with the MARAC process and carry out risk management actions before and after meetings?
- How can MARAC better support effective multi-agency working outside of MARAC meetings, for example through the identification of a lead professional who coordinates agency actions, through the use of additional multi-agency meetings to discuss complex cases, or through a structure that allows for the ongoing management of some cases?

For the review to produce an action plan for the MARAC Steering Group, with progress reported to the Safer Lewisham Partnership and shared with the pan-London MARAC Forum.

7.21. **Recommendation 16** (ref 5.2.70)

All agencies who had involvement with Donna Williamson to review policies, procedures and structures in place with regard to managing caseload and supervision for practitioners working with clients, with particular reference to how those working with clients with many and complex needs such as Donna Williamson are supported and supervised.

7.22. **Recommendation 17** (ref 5.2.78)

All agencies within the Lewisham violence against women and girls partnership response to amend their assessment, practice, policies and training to incorporate the learning from this case in relation to ‘contextual risk’. To report on developments to the DHR Task and Finish Group.

## 8. Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review is being completed to learn any lessons from the experiences of Donna Williamson and YZ following the death of Donna Williamson. The Domestic Homicide Review is being conducted in accordance with *Domestic Violence Crime and Victims Act 2004 Section 9(3)*.

### Purpose

1. To review the involvement of each individual agency, statutory and non-statutory, with Donna Williamson and YZ during the relevant period of time 1 January 2008 to the date of Donna Williamson's death. To summarise agency involvement prior to 1 January 2008.
2. 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.
3. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
4. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
5. The Independent chair will:
    a) chair the Domestic Homicide Review Panel;
    b) co-ordinate the review process
    c) quality assure the approach and challenge agencies where necessary; and
    d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
6. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
7. On completion present the full report to the Safer Lewisham Partnership.

### Definitions: Domestic Violence and Coercive Control

8. The Overview Report will make reference to the terms domestic abuse and coercive control. The Review Panel agrees that domestic abuse is not only physical violence but a wide range of abusive and controlling behaviours. The Review Panel understands and agrees to the use of the cross government definition as a framework for understanding the domestic abuse experienced by the victim in this DHR.
9. The cross government definition of domestic violence and abuse (March 2013) states that domestic violence and abuse is:

"*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*
*Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*
*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*"
This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group

**Ethnicity, Equality and Diversity**

10. The Review Panel considered the protected characteristics of both Donna Williamson and YZ. The Review Panel concluded that there were no relevant local area protected characteristics to consider.
11. The Review Panel identified the following characteristics of Donna Williamson and of YZ as requiring specific consideration for this case: disability (physical and mental) and gender.
12. The Review Panel agree it is important to have an intersectional framework to review Donna Williamson's and YZ's life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand their journeys and experiences with local services/agencies and within their community.

**Membership**

13. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
14. The following agencies are on the Panel:
    a) Change, grow, live (CGL) Aspire
    b) Change, grow, live (CGL) New Direction
    c) General Practices for Donna Williamson & YZ
    d) Greenwich Council, Adult Social Care
    e) Greenwich Council, Community Safety
    f) Her Centre, Greenwich

g) Housing For Women
h) Lewisham Council, Adult Social Care
i) Lewisham Clinical Commissioning Group
j) Lewisham Council, Crime and Enforcement and Crime Reduction
k) Lewisham Council, Housing
l) London Ambulance Service
m) London Fire Brigade
n) Lewisham and Greenwich NHS Trust
o) Lewisham Reach
p) London Ambulance Service
q) Metropolitan Police Service, Lewisham
r) Metropolitan Police Service, Specialist Crime Review Group
s) National Probation Service
t) NHS England
u) Oxleas NHS Foundation Trust
v) Refuge
w) South London and Maudsley NHS Foundation Trust
x) Victim Support

15. The Review Panel recognise that there are particular issues in this case that require expertise:
    a) Drug and alcohol use
    b) Mental health
    c) Physical health issues
    d) Response to perpetrators of domestic abuse, including female perpetrators
16. The Panel feel that expertise on (a), (b) and (c) are adequately met by Panel members. A member of the Greenwich Domestic Violence Intervention Team will be invited to act as expert on (d) to advise the Chair. The Chair will also liaise with Marc Pigeon, a recognised expert in responses to perpetrators, as required during the Review process.
17. An Independent Police Complaints Commission (IPCC) investigation has been established. The Review Panel agrees to run the DHR in parallel to the IPCC investigation. The DHR Chair will keep in contact with the IPCC investigation lead to aim to avoid duplication or delay.
18. The role of Standing Together Against Domestic Violence (STADV) and the Panel: the Safer Lewisham Partnership has commissioned STADV to independently chair this DHR. STADV have in turn appointed their Associate Althea Cribb to chair the DHR. The STADV DHR team consists of an Administrator and Manager. The STADV DHR team Administrator will provide administrative support to the DHR and the STADV DHR Team Manager will have oversight of the DHR. The STADV Manager may at times attend a panel meeting as an observer. The STADV DHR team will quality assure the Overview Report before it is sent to the Home Office.

The STADV DHR team will liaise with the Safer Lewisham Partnership around publication. The contact details for all of the STADV team will be provided to the panel.

### Collating evidence

19. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
20. Chronologies and IMRs will be completed by the following organisations known to have had contact with Donna Williamson and/or YZ during the relevant time period, and produce an Individual Management Review (IMR):
    a) Change, grow, live (CGL) Aspire
    b) Change, grow, live (CGL) New Direction
    c) General Practices for Donna Williamson & YZ
    d) Greenwich Council, Adult Social Care
    e) Her Centre, Greenwich
    f) Housing For Women
    g) Lewisham Council, Adult Social Care
    h) Lewisham Council, Crime and Enforcement
    i) Lewisham Council, Housing
    j) London Ambulance Service
    k) London Fire Brigade
    l) Lewisham and Greenwich NHS Trust
    m) Lewisham Reach
    n) Metropolitan Police Service
    o) National Probation Service
    p) Oxleas NHS Foundation Trust
    q) Refuge
    r) South London and Maudsley NHS Foundation Trust
    s) Victim Support
21. Lewisham Council and Greenwich Council will provide information to the Review on the Lewisham and Greenwich Multi-Agency Risk Assessment Conferences. The full minutes, actions and contextual information will be provided in addition to an IMR for each.
22. Further agencies will be asked to completed chronologies and IMRs if their involvement with Donna Williamson and YZ becomes apparent through the information received as part of the review.
23. Each IMR will:
    a) Set out the facts of their involvement with Donna Williamson and/or YZ.
    b) Critically analyse the service they provided in line with the specific terms of reference.

c) Identify any recommendations for practice or policy in relation to their agency.
d) Consider issues of agency activity in other areas and review the impact in this specific case.

24. 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 Donna Williamson and YZ in contact with their agency.

**Analysis of findings**

25. In order to critically analyse the agencies' responses to Donna Williamson and/or YZ, this review will consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved, on an operational and strategic level.
    c) Analyse the opportunity for agencies to identify and assess domestic abuse.
    d) Analyse the opportunity for agencies to identify and assess risk in relation to domestic abuse, including (but not limited to) MARAC.
    e) Analyse agency responses to any identification of domestic abuse issues.
    f) Analyse agencies' access to specialist domestic abuse agencies.
    g) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

    In addition, the following have been identified as specific issues for all agencies to address in their IMRs:

    h) Drug and alcohol use by Donna Williamson and YZ
    i) Mental health issues for Donna Williamson and YZ
    j) Physical health issues for Donna Williamson
    k) Clients who engage and disengage in relation to Donna Williamson and YZ
    l) Situations in which a victim of domestic abuse (Donna Williamson) is also identified as a perpetrator

*As a result of this analysis, agencies should identify good practice and lessons to be learned. The Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.*

**Development of an action plan**

26. Individual agencies take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies

should report to the Safer Lewisham Partnership on their action plans within six months of the Review being completed.

27. Safer Lewisham Partnership will establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary.

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

28. Sensitively attempt to involve the family and friends of Donna Williamson in the Review, once it is appropriate to do so in the context of on-going criminal proceedings. The Chair will lead on family engagement with the support of AAFDA, who are supporting Donna Williamson's family, and the MPS Family Liaison Officer who has engaged with Donna Williamson's friends.
29. Sensitively attempt to involve the family of YZ in the Review, once it is appropriate to do so in the context of on-going criminal proceedings. The Chair will lead on family engagement with the support of the Greenwich Council Adult Social Care Social Worker who is supporting YZ's family.
30. Invite YZ to participate in the review, following the completion of the criminal trial.
31. Co-ordinate family liaison in such a way to reduce emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
32. Coordinate with the IPCC investigation in relation to contact with family and friends to minimise duplication and distress to those involved.

**Media handling**

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

**Confidentiality**

35. 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.
36. All information discussed 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.

37. 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.
38. 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. Documents to be password protected.

### Disclosure

39. 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.
40. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
    b) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
        i) It is needed to prevent serious crime
        ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

## 9. Appendix 2: Retrospective DASH Risk Checklist for Donna Williamson

| **Current Situation**<br>The context and detail of what is happening is very important. The questions highlighted in bold are high risk factors. Tick the relevant box and **add comment** where necessary to expand. | YES<br>☑ | NO<br>☑ |
|---|---|---|
| 1. Has the current incident resulted in injury? (please state what and whether this is the first injury) | ☑ | |
| **2. Are you very frightened?**<br>Comment: | ☑ | |
| 3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)….. might do and to whom)<br>Kill: Self ☐ Children ☐ Other (please specify) ☐<br>Further injury and violence: Self ☐ Children ☐ Other (please specify) ☐<br>Other (please clarify): Self ☐ Children ☐ Other (please specify) ☐ | ☑ | |
| **4. Do you feel isolated from family/ friends i.e. does (name of abuser(s)…..) try to stop you from seeing friends/family/Dr or others?** | ☑ | |
| 5. Are you feeling depressed or having suicidal thoughts? | ☑ | |
| **6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?** | ☑ | |
| **7. Is there conflict over child contact?** (please state what) | | ☑ |
| **8. Does (…..) constantly text, call, contact, follow, stalk or harass you?** (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done) | ☑ | |
| **CHILDREN/DEPENDENTS** (If no children/dependants, please go to the next section) | YES | NO |
| **9. Are you currently pregnant or have you recently had a baby (in the past 18 months)?** | | ☑ |
| 10. Are there any children, step-children that aren't (…..) in the household? Or are there other dependants in the household (i.e. older relative)? | | ☑ |
| **11. Has (…..) ever hurt the children/dependants?** | | ☑ |
| 12. Has (…..) ever threatened to hurt or kill the children/dependants? | | ☑ |
| **DOMESTIC VIOLENCE HISTORY** | YES | NO |
| **13. Is the abuse happening more often?** | ☑ | |
| **14. Is the abuse getting worse?** | ☑ | |
| **15. Does (…….) try to control everything you do and/or are they excessively jealous?** (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider honour based violence and stalking and specify the behaviour) | ☑ | |
| **16. Has (…..) ever used weapons or objects to hurt you?** | ☑ | |
| **17. Has (…..) ever threatened to kill you or someone else and you believed them?** | ☑ | |
| **18. Has (…..) ever attempted to strangle/choke/suffocate/drown you?** | ☑ | |
| **19. Does (….) do or say things of a sexual nature that makes you feel bad or that physically hurt you or someone else?** (Please specify who and what) | ☑ | |
| **20. Is there any other person that has threatened you or that you are afraid of?** (If yes, consider extended family if honour based violence. Please specify who) | ☑ | |

| | | |
|---|---|---|
| 21. Do you know if (…..) has hurt anyone else ? (children/siblings/elderly relative/stranger, for example. Consider HBV. Please specify who and what)<br>Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐ | ☑ | |
| 22. Has (…..) ever mistreated an animal or the family pet? | Unknown | |
| **ABUSER(S)** | YES | NO |
| 23. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues? | ☑ | |
| **24. Has (…..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?** (Please specify what)<br>Drugs ☐ Alcohol ☐ Mental Health ☑ | ☑ | |
| **25. Has (…..) ever threatened or attempted suicide?** | ☑ | |
| 26. Has (…..) ever breached bail/an injunction and/or any agreement for when they can see you and/or the children? (Please specify what)<br>Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐<br>Forced Marriage Protection Order ☐ Other ☐ | ☑ | |
| 27. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify)<br>DV ☐ Sexual violence ☐ Other violence ☐ Other ☐ | ☑ | |
| **Other relevant information (from victim or officer) which may alter risk levels. Describe:**<br>victim's vulnerability - disability, mental health, alcohol misuse; abuser's alcohol misuse | ☑ | |
| Is there anything else you would like to add to this? | | |

## 10. Appendix 3: Description of Services

| Service | Explanation |
|---|---|
| CGL | Change, Grow Live is a national health and social care charity providing the commissioned services for drug and alcohol.<br>CGL New Direction deliver this in Lewisham.<br>CGL Aspire deliver this in Greenwich. |
| Crown Prosecution Service | The Crown Prosecution Service (CPS) is responsible for prosecuting criminal cases investigated by the police in England and Wales. |
| Her Centre | The Her Centre is a women only holistic service, we are the main Independent Domestic Violence Advocacy (IDVA) Service for Greenwich Borough, and have advocates in many specialisms, such as Sexual Violence (ISVA), BME IDVA, and 2 young women IDVA's who work with young women from ages 13-19 years. We initially deal with the many high risk cases that are referred to us, but as a holistic service, we also have a low risk adviser, and therapy services for counselling and support groups. |
| Housing for Women | Housing for Women run domestic violence and abuse services in Greenwich. |
| Lewisham & Greenwich NHS Trust | Lewisham & Greenwich NHS Trust was formed in October 2013 and consists of two acute hospitals, University Hospital Lewisham (UHL) and Queen Elizabeth Hospital Woolwich (QEH). This organisation provides acute medical services to the surrounding boroughs of Lewisham, Greenwich and Bexley. |
| London Ambulance Service NHS Trust (LAS) | Emergency ambulance service covering London. |
| London Borough of Lewisham Adult Social Care | Social Care and Advice and Information Team (SCAIT) is the single point of contact service for Adult Social Care (ASC). First point of contact for new referrals into ASC, or where cases are unallocated. Establish eligibility for further assessment and refer on to relevant social work / ASC service if assessment or on-going input required. Provide information and advice, referrals on to more appropriate agencies where no role for ASC. |
| London Borough of Lewisham Crime Enforcement & Regulation Service | The Crime, Enforcement and Regulation Service (CERs) deals with issues concerning Anti-social behaviour, Environmental Health, Licensing and Trading Standards. We are expected on occasion to respond to customer complaints affecting members of the public while carrying out phone duties. The CER Service sit alongside the VAWG Coordinator and the MARAC Coordinator under the same Manager. Whilst CER officers do not undertake casework on domestic abuse cases, where cases appear to have DA as an issue these are referred to the Athena Service and the Police, who will make referrals to the MARAC. CER officers may also make checks with the MARAC coordinator as to whether individuals are known to the MARAC. |
| London Borough of Lewisham Single Homeless Intervention and Prevention Service | The Single Homeless Intervention and Prevention Service is a Housing Options and Advice service for single people. Its primary functions are to assess cases of homelessness or potential homelessness, provide actions to prevent that homelessness, give advice on alternative options for finding a home, signpost clients to appropriate services, make assessments of suitability for commissioned and un-commissioned supported housing services, make referrals to these services and deal with statutory homeless applications. |
| Metropolitan Police Service | Metropolitan Police Service (MPS) is the police service covering all of London (except for the City of London). |

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| National Centre for Domestic Violence | The NCDV provides a free, fast emergency injunction service to survivors of domestic violence regardless of their financial circumstances, race, gender or sexual orientation. NCDV work in close partnership with the police, local firms of solicitors and other support agencies (e.g. Refuge, Women's Aid) to help survivors obtain protection. |
| National Probation Service | NPS is an agency within the National Offender Management Service tasked with advising courts, risk assessing offenders, preparing court reports and generating sentence proposals, supervising high risk and MAPPA offenders within the community. |
| Oxleas NHS Foundation Trust | Provide local NHS services in south London and Kent, including community health, mental health and learning disability services. |
| Refuge | Refuge is a national charity which provides a wide range of specialist domestic violence services to women and children experiencing domestic violence and other forms of violence and abuse. On any given day, our services support over 4,000 women, children and men.<br><br>Refuge operate the Athena service, which is funded by Lewisham Council to provide one-to-one confidential, non-judgmental, independent specialist support. The Athena service provides:<br>▪ A specialist independent gender-based violence advocacy (IGVA) team to support women and men who at are at risk of serious harm.<br>▪ A specialist service for 13-19 year old girls<br>▪ Group support.<br>▪ A peer support scheme to reduce isolation; build social networks and support women and men to regain control of their lives.<br>▪ Emergency refuge accommodation for women and children who fleeing domestic violence and for whom it is safe to live in the Lewisham.<br><br>The service is available to anyone living in Lewisham who has experienced or is at risk of gender-based violence and is one of the following:<br>▪ Women and girls aged over 13.<br>▪ Men aged 16 or older.<br>▪ Transgender and identifies as male, female, as another gender, or is questioning their gender identity. |
| Royal Borough of Greenwich Adult Social Care | Adults and older people who live in the Royal Borough of Greenwich can access a range of different services and support, from short-term assistance and rehabilitation, to ongoing support and risk prevention. |
| Royal Borough of Greenwich Housing Options and Support Service | Ways in which the Royal Borough of Greenwich can help prevent you from becoming homeless include:<br>▪ helping you to avoid being evicted by a private landlord<br>▪ negotiating with your lender if you're a home owner<br>▪ helping you stay in the family home until you find another place to live<br>▪ advising you on finding somewhere else to live.<br>The council has specialist teams to provide housing support for young people and housing support for people who are considered vulnerable, for example, people who have physical or mental ill health issues, a history of substance misuse, or have come out of prison or care.<br>If you're a private tenant or home owner at risk of becoming homeless, our Housing Aid Centre may be able to help.<br>The council has legal duties to provide accommodation to some, but not all, homeless people. If the council can't help you prevent homelessness, it will carry out a homeless assessment to establish if it has a duty to help you. |
| South London and Maudsley | South London and Maudsley NHS Foundation Trust (SLaM) provide mental health services for people living in Lewisham. |

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| NHS Foundation Trust | |
| Together for Mental Wellbeing | Within London, Together for Mental Wellbeing provides criminal justice mental health services within police, court and probation settings. We hold core contracts with NHS England for the delivery of our liaison & diversion services within police and courts and with the NPS (London division) for the delivery of a forensic mental health service across all London NPS offices. |
| Victim Support | Victim Support is the independent charity for victims and witnesses of crime in England and Wales.<br>In Lewisham, Victim Support offers emotional and practical support and information to domestic abuse victims/survivors who are assessed as being of standard risk levels; domestic abuse clients assessed as being at high and very high risk are referred, with consent, for specialist IDVA support, whilst also being referred to MARAC. The services provided by Victim Support are free, confidential, non-judgemental and based upon an empowerment model of support. |

## 11. Appendix 4: Glossary of Terms / Explanation of Acronyms

| Term / Acronym | Explanation / Definition |
|---|---|
| Multi-Agency Risk Assessment Conference (MARAC) | Multi-Agency Risk Assessment Conference (MARAC)<br>A risk management meeting where professionals share information on high and very high risk cases of domestic violence or abuse and put in place a risk management plan. The aim of the meeting is to address the safety of the victim, children and agency staff and to review and co-ordinate service provision in high risk domestic violence cases.<br>Coordinated locally; national guidelines provided by Safe Lives. |
| Independent Domestic Violence Advocate (IDVA) | Independent Domestic Violence Advocate or Advisor (IDVA)<br>Locally managed and determined in relation to service provision (e.g. risk thresholds and client groups) the national Safe Lives definition of an IDVA is[34]:<br>▪ "*The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.*<br>▪ *They are pro-active in implementing the plans, which address immediate safety, including practical steps to protect themselves and their children, as well as longer-term solutions. These plans will include actions from the MARAC as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short- to medium-term to put them on the path to long-term safety. They receive specialist accredited training and hold a nationally recognised qualification.*<br>▪ *Since they work with the highest risk cases, IDVAs are most effective as part of an IDVA service and within a multi-agency framework. The IDVA's role in all multi-agency settings is to keep the client's perspective and safety at the centre of proceedings.*"<br>It should be noted that many IDVA services do not only work with high risk cases. |
| DASH Risk Checklist | Domestic Abuse, Stalking and Harassment and 'Honour Based Violence' (DASH, 2009) Risk Assessment Checklist<br>From http://www.dashriskchecklist.co.uk/dash/:<br>▪ "*The DASH (2009) Model has been built on the existing good practice of the evidence based SPECSS+ Risk Identification, Assessment and Management Model. The SPECSS+ was previously Association of Chief Police Officers compliant and had been evaluated numerous times. Victim and practitioner focus groups have also been run to ensure the language and format worked as best it could.*<br>▪ *The risk factors included are evidence based and drawn from extensive research and analysis by leading academics in the field into domestic homicides, 'near misses' and lower level incidents.*"<br>It is designed to be completed with a victim of domestic abuse, by any professional in any agency. |

[34] http://www.safelives.org.uk/sites/default/files/resources/National%20definition%20of%20IDVA%20work%20FINAL.pdf

| | |
|---|---|
| | The outcomes of the Checklist (as determined by the number of 'yes' answers given by the victim, combined with the professional judgement of the professional) are: standard, medium or high risk. |
| Standard risk | As determined by the DASH Risk Checklist:<br>Current evidence does not indicate likelihood of causing serious harm |
| Medium risk | As determined by the DASH Risk Checklist:<br>There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. |
| High risk | As determined by the DASH Risk Checklist:<br>There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.<br>Risk of serious harm (Home Office 2002 and OASys 2006):<br>"*A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible*". |
| Operation Dauntless | Operation Dauntless is part of the MPS Continuous Improvement Plan for Domestic Violence. It comprises an Activity Tracker attached to a Tactical Plan to ensure the Metropolitan Police Service is monitoring activity in relation to Domestic Violence 'DV' / Domestic Abuse 'DA'. The plan calls for a 'whole borough' response to tackling 'DV' / 'DA' and performance is monitored from call handling through response teams, Community Safety Units (CSU's) and Neighbourhood Policing Teams (NPT) The borough Senior Leadership Team (SLT) 'DV' / 'DA' Champion will review the activity tracker fortnightly within the Tasking Group (TTCG) process; holding portfolio leads to account for performance. There are three strands; Total Victim Care (Enduring Risk), Offender Management and Emerging Risk. |
| Domestic Violence Protection Notice / Order (DVPN / DVPO) | Domestic Violence Protection Notice / Order<br>From:<br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575363/DVPO_guidance_FINAL_3.pdf<br>A DVPN is an emergency non-molestation and eviction notice which can be issued by the police, when attending to a domestic abuse incident, to a perpetrator. Because the DVPN is a police-issued notice, it is effective from the time of issue, thereby giving the victim the immediate support they require in such a situation. Within 48 hours of the DVPN being served on the perpetrator, an application by police to a magistrates' court for a DVPO must be heard. A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. Both the DVPN and DVPO contain a condition prohibiting the perpetrator from molesting the victim. |

## 12. Appendix 5: Action Plan for Overview Report Recommendations

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