The London Borough of Lewisham

DOMESTIC HOMICIDE REVIEW

Of

FF

Dave Mellish
April 2013

Index

London Borough of Lewisham
Domestic Homicide Review – FF

1.0 Executive Summary

1.1 On 14 June 2011 police attended the address of BB in Lewisham, following a report to police that BB had killed FF a week earlier. Officers looked round the house and nothing was found to arouse suspicion. The following day officers attended the property again to conduct a more detailed search. This resulted in the discovery of FF's body in a wheelie bin. At her trial in November 2012 at the Old Bailey, BB was found guilty of murder and sentenced to life imprisonment, with a recommendation that she serve a minimum of 17 years.

1.2 These circumstances led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the Safer Lewisham Partnership (Lewisham's Community Safety Partnership). The decision that this case met the criteria set out under 3.8 of the Statutory Guidance was conveyed to the Home Office on 29 June 2011. The initial meeting was held on 12 July 2011 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death (September 2011, October 2011 and March 2013). The panel reconvened in March 2013 after the sentencing of BB in November 2012.

1.3 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.4 The purpose of these reviews is to:

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

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

2.0 Terms of Reference

2.1 The full terms of reference were agreed at the first panel meeting on 12 July 2011 and are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

3.0 Methodology

3.1 The panel agreed to review a five year timeframe of 15 June 2006 to 15 June 2011 to examine the causes, impact and outcome of agency involvement with FF and BB. It also examined agency contact/involvement over the same period with EE (a child of BB) and MP (believed to be a child of BB and FF), both of whom were residing with BB at the time of the homicide.

3.2 The approach adopted was to seek chronologies and Individual Management Reviews (IMRs) from all organisations and agencies that had contact with FF or BB.

3.3 In addition to chronologies and IMRs provided by all organisations and agencies that had contact with FF or BB, further information and chronologies were requested from:

- Rochdale Community Safety Partnership as FF had previously resided in this area.
- Blackpool Community Safety Partnership as BB had previously resided in that area and was known to mental health services there.
- Dumfries and Galloway Constabulary, Scotland, as BB had previously lived there, had previous children from her first marriage adopted there and had convictions for serious offences of violence against her then husband and other crimes during her time there.

3.4 All agencies involved in the review were asked to provide their DV policies to review and match against actions taken.

3.5 Letters dated 13 October 2011 were sent to Rochdale Community Safety Partnership and Blackpool Community Safety Partnership, and a letter dated 14 October 2011 was sent to Dumfries and Galloway Constabulary, Scotland. A further letter dated 28 October 2011 was sent to the Rochdale Caldicott Guardian.

3.6 A response was not received from the Rochdale Calidcott Guardian, nor Rochdale Community Safety Partnership. Blackpool Community Safety Partnership responded on 28 October 2011 by confirming no information was held in relation to BB. Dumfries and Galloway Constabulary responded by providing conviction history between 1986 and 1993 of BB, while she resided there.

3.7 Once the IMRs had been provided panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

4.0 Composition of the DHR panel

4.1 The following were members of the DHR Panel:

- Metropolitan Police Service – Homicide Unit, Specialist Crime Review Group and Lewisham Police (Public Protection)

- South London and Maudsley (SLaM) Foundation Trust
- London Borough of Lewisham Community Services Directorate
- Lewisham Healthcare NHS Trust
- Lewisham Probation
- NHS South East London
- London Borough of Lewisham Children's Social Care
- London Borough of Lewisham Attendance and Welfare Service
- Victim Support
- Refuge
- Lewisham Joint Commissioning

4.2 A full list of panel members is contained in Appendix 2.

4.3 The Independent Chair of the DHR is Dave Mellish, a retired Chief Constable of Northumbria Police, and Chair of Oxleas NHS Trust. He has no connection with the Borough of Lewisham or any of the agencies involved in this case.

4.4 There were no parallel review processes taking place alongside this DHR. However, during this DHR process it was identified that BB had not formally been discharged by SLaM Foundation Trust following her failure to attend and maintain contact with the Consultant Psychiatrist in November 2009. Therefore she was still technically a patient of SLaM at the time of this homicide. On interview the Consultant Psychiatrist did explain that she had asked the team administrator to formally discharge BB. However, it appears from the clinical records that this administrative task was not completed on the Trust's electronic patient record. As such, this case was notified to NHS London once the above was discovered. However a decision was made at that time not to investigate through the HSG guidance as BB had not appeared to have had any contact with the Trust for 18 months prior to this incident.

5.0 The Facts

6.0 The death of FF

6.1 On 14 June 2011 BB told a friend that seven days earlier she had killed FF at her home. This friend contacted the police to inform them of this disclosure. Police attended her address in Forest Hill on 14 June 2011, however BB denied the comments and told officers they had argued about a week earlier and he had left. She invited officers to look round the house and nothing was found to arouse any suspicions.

6.2 On 15 June 2011 a DCI from Lewisham Public Protection Unit discussed the allegation with the officers and directed a further visit to the home address in order to conduct a more detailed search. This resulted in the discovery of FF's body in a wheelie bin. The wheelie bin had been sealed air tight with duct tape and had blankets placed over it.

6.3 The Pathologist details that it is entirely plausible that death resulted from the combined effects of intoxication (by Alprazolam) and obstruction of the upper airways (by plastic bag). However, given the absence of a bag, and the effects of decomposition, he considers that the pathological cause of death should be given as: *Unascertained.*

6.4 The toxicologist notes that Alprazolam is a benzodiazepine drug, which is reported to cause adverse effects such as drowsiness, light headedness, sedation, reduced alertness and loss of co ordination.

6.5 The Pathologist states that the changes of decomposition were consistent with a post mortem interval of approximately 11 days.

7.0 Information sharing

7.1 There were good examples of information sharing between the Health Visiting service and other agencies, specifically the GP and Mental Health services.

7.2 There were examples of inadequate information sharing between agencies and there were examples of poor recording of information shared between agencies with some information missing. There were difficulties in ascertaining information from other areas of the country due to a large amount of movement of both victim and perpetrator in the past. This also led to poor information sharing by agencies in the transition of services for all family members.

7.3 Communication between Health Visiting and SLaM showed a willingness to provide a joined up service but the infrastructure did not appear to support this. Many telephone calls were made by both services over a period of days without success. Communication between BB's psychiatrist and other professionals could have been better. Neither the Health Visitor nor the Social Worker were informed when the relationship with the psychiatrist broke down and the patient was discharged from her care. This was only discovered when BB showed the Health Visitor the letter from the psychiatrist at a planned Health Visiting home visit.

7.4 At the time of this homicide, there was no routine sharing of information between staff responsible for monitoring Elective Home Education (EHE; education otherwise) and other agencies to whom the family was known. As such, those staff were not aware of the GP referral to CSC, nor of the Section 47 investigations that were carried out with the family. A regular information sharing forum now takes place in relation to EHE cases. It is unlikely that any different course of action would have been taken had this information been available, however in alternative circumstances this could have been significant in terms of the Attendance and Welfare Service's (AWS) contact with the family.

7.5 Some adjustments in practice have already been made within AWS since this case began. Checks are now made with CSC, Health, SEN and Attendance and Welfare prior to the School Improvement Team carrying out home visits. Depending on what is known about the child's circumstances, the view may be that home education is not suitable. It may also be appropriate to use the CAF process to explore the child's needs more fully. A safeguarding group has also been set up, including representatives from CSC, Admissions and Attendance and Welfare which aims to highlight any cases causing concern.

8.0 Risk assessment and record keeping

8.1 Within SLaM there were identified recording gaps and a lack of use of IT case management systems for recording information on interventions and directing risk and needs assessments.

8.2 A number of other agencies had gaps in files and notes missing.

8.3 The review highlighted the need for robust and appropriate levels of recording and documentation to aid the process of care planning and effective clinical management of the care of service users, particularly within mental health services. The absence of this, as seen in this case, can contribute to a mirroring of the service user's chaotic and/or fixed presentation and focus as opposed to the production of a proper risk assessment, care plan and follow up.

9.0 Understanding the existence of DV with FF and previous partners

9.1 BB was well known to CSC, SLaM and Health (GP and Health Visiting) agencies. In particular, there is considerable information available to the Review Panel that over a period of years she had been involved in a number of alleged incidents of domestic violence, more often as a victim than a perpetrator, involving different partners. There was also information available to SLaM and CSC that BB had made threats to kill previous partners, however police were not made aware of this.

9.2 Health Visiting records report that BB had been in an abusive relationship prior to her relationship with FF. Records also appear to suggest a breakdown in BB and FF's relationship, including reference to physical violence. The Health Visitor provided information about couples counselling without further exploring the issue. Couples counselling is not appropriate where domestic violence and abuse is present within a relationship.

9.3 According to the IMR from SLaM, BB was seen as a fantasist whose repeated reports of homicidal thoughts and risk of harm to others were deemed to be overvalued ideas linked to her personality disorder. The SLaM review team noted the fact that their two staff members to whom BB reported the alleged incident of attacking and attempting to kill her ex husband, LE, with an iron bar only remembered it when the clinical records were read to them when they were interviewed. SLaM has acknowledged the requirement to report such an incident to police and the seriousness of such a lack of disclosure.

10.0 Culture of questioning

10.1 The IMRs from Health, SLaM and CSC show that staff involved with the family had never explicitly asked about domestic violence and abuse.

10.2 Given that BB consistently and regularly reported incidents that can be seen as indicators of domestic violence to clinical team members there was an opportunity for practitioners to respond sensitively to BB's needs as a victim and also a perpetrator. These opportunities were not taken as the clinical team reportedly did not believe that she would act on homicidal tendencies and threats of violence to her ex-partner; and appeared to doubt whether previous incidents that BB reported had actually happened.

11.0 Conclusions

11.1 Some of the information contained in this report was not known to agencies until the police investigation into the homicide. It is now known that BB had a propensity for violence, but on the information available at the time she was often regarded more as a victim. However, there was no specific information that could have been disclosed to services that can now be regarded as a trigger to this homicide.

11.2 Given all the circumstances of this case, therefore, the Domestic Homicide Review Panel was satisfied that FF's death at the hands of BB in June 2011 could not have been predicted or prevented. There was no information available to the agencies involved in this review process that indicated FF was likely to become a victim or was otherwise vulnerable. It is likely that if similar circumstances occurred, things would not have been different.

11.3 Nonetheless the Panel is of the view that there are lessons to be learnt in relation to this homicide by all the agencies involved in responding or supporting this family which, if implemented, would make the occurrence of a similar incident in Lewisham less likely.

12.0 Recommendations

12.1 The Review Panel acknowledges that services have been reconfigured and changes made to practice in some services since the time of this homicide. As such, work is already underway to meet some of these recommendations. However, they remain included for the purposes of completeness and monitoring.

12.2 The below recommendations will be shared with relevant bodies within the Safer Lewisham Partnership as well as the Lewisham Safeguarding Children's Board and the Safeguarding Vulnerable Adults Board in order to prevent domestic homicides from happening in the future.

12.3 Implementation of the recommendations will be overseen by the Domestic Homicide Review Task and Finish Group, a sub group of the SLP's Performance and Delivery Board.

12.3.1 The Safer Lewisham Partnership (SLP) should ensure they have in place up to date policies and procedures in relation to domestic violence, accompanied by comprehensive training programmes for staff across all agencies and all tiers including management.

12.3.2 All agencies must undertake a regular review of the policies mentioned above and carry out training audits to ensure that training in respect of male victims is embedded in the practice of all staff. The SLP to recommend that the LSCB and Safeguarding Adult Board should monitor the implementation of this recommendation.

12.3.3 Services involved in this DHR process, who are working with clients with dual or triple diagnosis, are made aware of referral routes and criteria for the appropriate organisation (including police) where a disclosure of domestic violence and abuse is made. All disclosures must be thoroughly investigated and communicated to the appropriate agencies. This requirement should be detailed within domestic violence and abuse policies.

12.3.4 Mental health teams to conduct an audit of their caseloads in ePJS in order to provide quantitative and qualitative assurance that risk assessment and care planning are in line with Trust expectations and that formal discharge procedures are adhered to and fully recorded and communicated.

12.3.5 Social Workers and Team Managers within CSC are to be reminded that difficulties with obtaining information from other local authorities should be escalated to senior managers.

London Borough of Lewisham
Domestic Homicide Review – FF

Overview Report

13.0 Introduction

13.1 On 14 June 2011 BB told a friend that seven days earlier she had killed FF (her male partner) at her home. This friend contacted the police to inform them of this disclosure. Police attended her address in Forest Hill on 14 June 2011, however BB denied the comments and told officers she had argued with FF about a week earlier and he had left. BB invited officers to look round the house and nothing was found to arouse any suspicions.

13.2 On 15 June 2011 a DCI from Lewisham Public Protection Unit discussed the allegation with the officers and directed a further visit to the home address in order to conduct a more detailed search. This resulted in the discovery of FF's body in a wheelie bin. The wheelie bin had been sealed air tight with duct tape and had blankets placed over it.

13.3 At the time of the discovery of the body, there were 2 children in the home, EE aged 11 and MP aged 2. BB was arrested on suspicion of murder along with KK, another individual who was present.

13.4 On 17 June 2011 BB appeared at Greenwich Magistrates Court charged with murder and was remanded in custody. At her trial in November 2012 at the Old Bailey she was found guilty of murder and sentenced to life imprisonment, with a recommendation that she serve a minimum of 17 years. KK, who was a friend of BB, was found guilty of assisting an offender but not guilty of murder.

13.5 Following the conclusion of the trial in November 2012 the following information was made available by the SIO in the case:

13.5.1 BB made an allegation of rape against KK which the court discounted.
13.5.2 BB tried to prove she was unfit for trial by way of mental disorder, which the court also discounted.
13.5.3 No adverse comments regarding agency involvement in this case were made during the course of the trial.

13.6 These circumstances led to the commencement of this Domestic Homicide Review (DHR) at the instigation of the Safer Lewisham Partnership (Lewisham's Community Safety Partnership). The decision that this case met the criteria set out under 3.8 of the Statutory Guidance was conveyed to the Home Office on 29 June 2011. The initial meeting was held on 12 July 2011 and there have been three subsequent meetings of the DHR panel to consider the circumstances of this death (September 2011, October 2011 and March 2013). The panel reconvened in March 2013 after the sentencing of BB in November 2012.

13.7 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

13.8 The purpose of these reviews is to:

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

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

14.0 Terms of Reference

14.1 The full terms of reference were agreed at the first panel meeting on 12 July 2011 and are included in Appendix 1. The essence of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

15.0 Methodology

15.1 The panel agreed to review a five year timeframe of 15 June 2006 to 15 June 2011 to examine the causes, impact and outcome of agency involvement with FF and BB. It also examined agency contact/involvement over the same period with EE (a child of BB) and MP (believed to be a child of BB and FF), both of whom were residing with BB at the time of the homicide.

15.2 The approach adopted was to seek chronologies and Individual Management Reviews (IMRs) from all organisations and agencies that had contact with FF or BB.

15.3 In addition to chronologies and IMRs provided by all organisations and agencies that had contact with FF or BB, further information and chronologies were requested from:

- Rochdale Community Safety Partnership as FF had previously resided in this area.
- Blackpool Community Safety Partnership as BB had previously resided in that area and was known to mental health services there.
- Dumfries and Galloway Constabulary, Scotland, as BB had previously lived there, had previous children from her first marriage adopted there and had convictions for serious offences of violence against her then husband and other crimes during her time there.

15.4 All agencies involved in the review were asked to provide their DV policies to review and match against actions taken.

15.5 Letters dated 13 October 2011 were sent to Rochdale Community Safety Partnership and Blackpool Community Safety Partnership, and a letter dated 14 October 2011 was sent to Dumfries and Galloway Constabulary, Scotland. A further letter dated 28 October 2011 was sent to the Rochdale Caldicott Guardian.

15.6 A response was not received from the Rochdale Calidcott Guardian, nor Rochdale Community Safety Partnership.

15.7 Blackpool Community Safety Partnership responded on 28 October 2011 by confirming no information was held in relation to BB.

15.8 Dumfries and Galloway Constabulary responded by providing conviction history between 1986 and 1993 of BB, while she resided there.

15.9 Once the IMRs had been provided panel members were invited to review them all individually and debate the contents at subsequent panel meetings. This became an iterative process where further questions and issues were then explored. This report is the product of that process.

16.0 Composition of the DHR Panel

16.1 The following were members of the DHR Panel:

- Metropolitan Police Service – Homicide Unit, Specialist Crime Review Group and Lewisham Police (Public Protection)
- South London and Maudsley (SLaM) Foundation Trust
- London Borough of Lewisham Community Services Directorate
- Lewisham Healthcare NHS Trust
- Lewisham Probation
- NHS South East London
- London Borough of Lewisham Children's Social Care
- London Borough of Lewisham Attendance and Welfare Service
- Victim Support
- Refuge
- Lewisham Joint Commissioning

16.2 A full list of panel members is contained in Appendix 2.

16.3 The Independent Chair of the DHR is Dave Mellish, a retired Chief Constable of Northumbria Police, and Chair of Oxleas NHS Trust. He has no connection with the Borough of Lewisham or any of the agencies involved in this case.

16.4 There were no parallel review processes taking place alongside this DHR. However, during this DHR process it was identified that BB had not formally been discharged by SLaM Foundation Trust following her failure to attend and maintain contact with the Consultant Psychiatrist in November 2009. Therefore she was still technically a patient of SLaM at the time of this homicide. On interview the Consultant Psychiatrist did explain that she had asked the team administrator to formally discharge BB. However, it appears from the clinical records that this administrative task was not completed on the Trust's electronic patient record. As such, this case was notified to NHS London once the above was discovered. However a decision was made at

that time not to investigate through the HSG guidance as BB had not appeared to have had any contact with the Trust for 18 months prior to this incident.

17.0 The Facts

17.1 The following sections summarise the information known to each agency involved about the victim, perpetrator and family.

17.2 Neither victim nor perpetrator were known to the MARAC, MAPPA or Domestic Violence Perpetrator Programme. However BB was known to Victim Support as a victim.

18.0 The death of FF

18.1 On 14 June 2011 BB told a friend that seven days earlier she had killed FF at her home. This friend contacted the police to inform them of this disclosure. Police attended her address in Forest Hill on 14 June 2011, however BB denied the comments and told officers they had argued about a week earlier and he had left. She invited officers to look round the house and nothing was found to arouse any suspicions.

18.2 On 15 June 2011 a DCI from Lewisham Public Protection Unit discussed the allegation with the officers and directed a further visit to the home address in order to conduct a more detailed search. This resulted in the discovery of FF's body in a wheelie bin. The wheelie bin had been sealed air tight with duct tape and had blankets placed over it.

18.3 The Pathologist details that it is entirely plausible that death resulted from the combined effects of intoxication (by Alprazolam) and obstruction of the upper airways (by plastic bag). However, given the absence of a bag, and the effects of decomposition, he considers that the pathological cause of death should be given as: *Unascertained.*

18.4 The toxicologist notes that Alprazolam is a benzodiazepine drug, which is reported to cause adverse effects such as drowsiness, light headedness, sedation, reduced alertness and loss of co ordination.

18.5 The Pathologist states that the changes of decomposition were consistent with a post mortem interval of approximately 11 days.

19.0 FF and contact with the statutory sector

19.1 FF had very little contact with any agency, and as such very little was known about him at the time of his death.

19.2 FF lived in Bromley and was previously in a relationship with BB. FF had previously lived with BB, but their relationship had become strained (some notes indicate due to FF sending money to his older children from a previous relationship). Although he visited regularly to see his son, at the time of his death FF did not live at the same address as BB. There are notes that suggest at one stage FF was living in his car.

19.3 FF was not known to Housing, Victim Support or SLaM (other than a brief mention in the medical records that he may have accompanied BB to one of her Consultant Psychiatrist appointments).

19.4 FF was not known to the Attendance and Welfare Service, other than mentioned as a friend of the family who had agreed to collect EE from school if the mother could not be contacted.

19.5 There is little recorded on FF in GP records. There is evidence of mental health problems and difficulties in a previous relationship. There had been little contact with primary care in the last 3 years. FF was registered at a different GP to BB and her children from 2009. It is noted that it is unlikely that GPs could have perceived him to be vulnerable and at risk of domestic violence.

19.6 There is limited information held by Children's Social Care on FF. In March 2009 BB was taken to A&E having been found drunk in the street. A&E contacted the police as BB disclosed having 2 children at home. The police visited the home and spoke to FF. He explained that BB did not normally drink and was suffering from post natal depression. FF was seen to be a responsible person and police viewed this as a one off incident. A duty social worker also spoke to FF who said that BB provided good care to the children and that this was a one off incident. FF indicated that he did not live with BB but stayed there most nights.

19.7 In April 2009, BB contacted her social worker and alleged that FF, her current partner, had assaulted her. BB stated that she did not want to report this as an incident of domestic violence to the police (although police records show that she had reported this incident to them), and was frightened and wanted to move to Bournemouth. However, during the core assessment BB indicated her relationship with FF was improving and that the incident of domestic violence was a one off. The core assessment concluded that there was no role for Children's Social Care and the case was closed.

19.8 In April 2009 a domestic violence incident between BB and FF was reported to police. It is alleged by BB that FF had barged in and pushed past her to get his belongings, and BB had ripped his shirt. Police saw FF's ripped shirt, and BB also showed them an old injury under her eye, however she had no recent injuries. FF informed police that he was trying to leave BB and said he could no longer live with her due to her violent temper and mental health. BB became aggressive towards officers, but was not arrested. There is no information about the children and no MERLIN entry was completed.

19.9 Lewisham Healthcare NHS Trust had a single recorded entry in March 2011 relating to FF's arrival at A&E with a finger injury. He was given sutures.

20.0 The perpetrator BB and early contact with the statutory sector

20.1 BB has 5 previous convictions including shoplifting (1986), vandalism and fraud (1989), deception (1992), extortion (1993) and criminal trespass with a firearm (1995) (threatening her mother during an argument at her mother's home). With the exception of the deception in 1992 all the above offences were committed in Dumfries, Scotland.

20.2 Police files show that BB has three children with her ex-partner, VC. These three children did not live with BB. Two children were in care in Scotland and in 1993, whilst BB was in prison, VC had custody of the third child, a son. He became the focus of a dispute between them in relation to his custody and care. Camden Social Services dealt with the care proceedings and he was taken into foster care (he is now 23 years of age). In the MPS Child Protection File there is a disclosure that there had been a history of domestic violence between BB and VC, with BB the apparent victim. It is unknown whether these matters were ever reported, or how they were dealt with. They were not MPS matters. The police files show further that in 1993 BB travelled from Dumfries to Hampstead with two males to try to obtain custody of her son. Not knowing where to find the boy, they kidnapped a close friend of VC and subjected him to a violent assault in order to discover his whereabouts. During the course of this the victim was assaulted with an iron bar for which the two men with BB were convicted.

20.3 In 1994 BB made telephone threats to kill VC. This case was discontinued at Hampstead Magistrates Court.

20.4 It is alleged that BB stabbed VC on two occasions; once in the chest and once in the hand. These incidents were not reported to police at the time and are believed to have taken place in Blackpool. This information only came to light as a result of the later homicide investigation when a statement was taken from VC.

20.5 In 1992 BB was sectioned at Blackpool Psychiatric Hospital for a week having homicidal thoughts in relation to VC. In 1994 she was admitted to Chrichton Royal Psychiatric Hospital, Dumfries, for emergency assessment. This information also came to the notice of police as a result of the homicide investigation and is not information held in MPS records, nor was it confirmed by Blackpool Community Safety Partnership who responded to an information sharing request by confirming that no information was held.

20.6 BB had been registered with 4 GP practices since 1996 in London. It is noted that she had significant mental health problems and needs, as well as a complex obstetric and gynaecological history.

20.7 There is no clear information as to when the family moved to Lewisham, although records indicate it was circa 1994. However the earliest contact with the statutory sector was in September 1999 when BB made a homeless application to Lewisham Council. She did this with a son, EE, and her husband at the time, LE. In 2001 a further application was made to join the Lewisham housing register. In 2004 the housing application was given a low medical priority, however in July 2005 records show BB presented as homeless due to landlord eviction. In this period, records show that BB had a dependent and was pregnant. The Homelessness application form shows BB stated “there is no history of violence from inside or outside the home”. In these same records it indicates BB was pregnant but lost her child shortly after birth. Records show that she identified that her son, EE, has learning difficulties and requested to be rehoused near Lewisham Bridge School for this reason.

21.0 The perpetrator BB period 2005 – 2011

21.1 The family first came to the notice of Children's Social Care in 2004, when EE attended Lewisham Bridge School. The Special Educational Needs Coordinator at the time expressed concerns to the Priory Manor Child Development Centre about EE's language and communication skills, as well as behavioural issues that required 1:1 supervision at home and at school. A developmental assessment was undertaken and this confirmed EE had speech and language delay and poor social and communication skills. In August 2005 the school informed the social worker that EE had been diagnosed with autism, and that he displayed challenging behaviour.

21.2 BB was first known to SLaM treatment services from 5 September 1995 to 7 May 1996, when seen by the Lewisham Dual Team (community substance misuse team) to attempt to cease her use of tranquilisers. It was reported that she achieved a drug free state on discharge, which was ultimately decided by BB's eventual failure to attend appointments.

21.3 In September 2005 BB was named as a suspect for making malicious telephone calls and texts to a female friend between 30 July and 18 September. The allegations involved threatening to cut out the victim's tongue and spread rumours that she was a murderer. The friend did not wish to pursue the allegation and in accordance with her wishes, BB was not spoken to by police. The friend was advised to change her mobile number.

21.4 Lewisham Healthcare NHS Trust records show their initial intervention with BB was on 4 August 2005 when she attended A&E having delivered a 15 week foetus and claiming her husband had put pills in her tea to cause the termination. She stated to A&E staff that she did not want any police involvement. Despite this, in September 2005 BB reported to police that she had been a victim of domestic violence and that her estranged husband, LE, had administered a noxious substance causing her to miscarry. She stated she was 15 weeks pregnant at the time. She was spoken to at length by the officer in the case (OIC). During this interview BB was much more concerned about her housing issues and with moving house, rather than on the criminal allegation, which she subsequently withdrew. The OIC referred this matter to Victim Support and to CSC in relation to the housing issue.

21.5 The referral made to Victim Support was flagged as a domestic violence incident, however BB's focus continued to be on housing. BB engaged in an office visit for support in October 2005. Victim Support encouraged BB to seek a GP referral for counselling, gave advice regarding housing, her safety and any future support.

21.6 Prior to the homicide GPs may have considered that BB was at greater risk of being a victim of domestic violence than as a perpetrator. However it is noted that there is evidence in GP records during this period that BB could become violent and records alluded to the fact that she had tried to stab VC (father of her first three children). There are records suggesting that BB believed her husband, LE, had caused her to miscarry in 2005 and she expressed significant anger.

21.7 There was a notification (MERLIN) received by Children's Social Care in September 2005 from the police where an alleged threat to kill was made by LE towards BB. In October 2005 a S47 Investigation (an assessment of risk

of significant harm to a child) was started. During the course of this investigation BB disclosed that LE had caused her to lose her baby through poisoning. BB stated that she had informed the police about the miscarriage, but Children's Social Care records do not explicitly state this. The CSC record suggests that the police and the social worker were of the view that the claims about the enforced miscarriage were "rooted in delusions related to BB's mental ill health". The CSC IMR indicated that the police, school and social worker had concerns about BB's mental health and emotional stability, although the assessment did not rule out the possibility of domestic violence from LE. The conclusion of the S47 investigation in October 2005 was that EE was not at risk.

21.8 In September 2005 BB was provided with emergency accommodation for one night and offered a temporary accommodation, which she accepted. In October 2005 BB reported to Housing Options to ask for alternative accommodation as a result of threats from her husband, LE. Records from Housing showed that contact was made to the police, however it is recorded that no contact was received back from police.

21.9 In December 2005 police attended BB's address where she had allegedly taken tablets in an attempt to kill herself. It was established that she had not taken the tablets but had written a note expressing a desire to take her own life. She was detained under S2 Mental Health Act following an assessment at the Ladywell Unit on 26 December 2005 due to suicidal ideation following her reported miscarriage due to alleged poisoning by her ex husband, LE. A MERLIN report had indicated that she was struggling with the care of EE, who she stated suffered from autism. EE was not at the address at this time, but it was noted that she appeared to have spent a great deal of money on baby clothes and that the home was spotless.

21.10 Following the above incident on 25 December 2005, police contacted the Emergency Duty Team within Children's Social Care to say that LE had contacted them as he was worried that BB was going to kill herself, threatening to take an overdose. The EDT report also states that BB had told police that she had hit LE across the back of the head with an iron bar and that she wished to kill him. She indicated that EE was in the flat when this occurred. Whilst CSC records show that BB had reported this incident to the police, the police have no record of it.

21.11 SLaM records show that BB had a volatile and acrimonious relationship with her ex husband, LE. She regularly discussed the reported poisoning that apparently caused the miscarriage. She also regularly discussed the fact that she would like revenge and would harm him. In January 2006 BB reports that she also informed SLaM staff that she had attacked LE with an iron bar with the intention of killing him. This disclosure was never shared with the police by SLaM staff.

21.12 An initial assessment was started by Children's Social Care in January 2006, and it was observed by the social worker that EE and his mother "were said to have had a warm bond".

21.13 For about five years after this admission BB utilised the following SLaM services; Lewisham Home Treatment Team (HTT), the Southbrook Road Community Mental Health Team (CMHT) and the outpatient Consultant Psychiatrist's clinic. BB's period of treatment is noted as being a continued

focus on medication management, her fluctuating engagement and attendance and continuous reported homicidal thoughts and intentions towards her ex-husband, LE, following the alleged poisoning. BB also continued to discuss the alleged miscarriage with professionals from Children's Social Care, GP and Health Visiting Services for a number of years after the alleged incident. It is noteworthy that no professional suggested or referred BB for counselling as a result of these repeated disclosures.

21.14 In December 2005 BB was diagnosed as suffering from a Moderate Depressive Episode, in 2006 was diagnosed with Reaction to Severe Stress and Adjustment and subsequently as having an emotionally unstable personality disorder. BB's community treatment contained periods of engagement and disengagement and missed appointments resulting in discharge and re-referral. Re-referrals were mainly as a result of Primary Care having concerns that BB's mental state was deteriorating and to request a review of medication and prescribing. Clinical records and staff interviews conducted by SLaM confirm that the mental health services did not find psychotic symptoms and viewed BB as having a personality disorder whose presentation and expression were over valued ideas crossed with fantasy. There was a consistently held recollection of BB as a small but fiery woman. Others described her as frosty but likeable and challenging but not particularly seen by them as a threat to others. In contrast, some commented that they were scared of her and not keen to visit her home.

21.15 In April 2006 BB reported a domestic violence / harassment incident against LE stating he was peering into her flat, hanging around and listening to her calls. No further action was taken and a referral was made to Victim Support, although Victim Support records show BB declined their help. Police notes from this incident indicate that BB stated she found it difficult to cope since leaving the Ladywell Unit. As a result of this incident police noted the escalation and the address was flagged so as to treat all future calls as urgent. There was a second police report of domestic violence the next day against LE. BB stated that she was seeking a divorce and was 11 weeks pregnant with LE's child. A MERLIN entry was completed for the unborn child.

21.16 In April 2006 BB contacted the Social Worker who had completed the initial assessment in January 2006 to say that she was 9 weeks pregnant and that LE was not happy about the pregnancy and wanted her to have an abortion. BB said she felt under threat from LE as she was worried he would make her miscarry the baby just as he had done in August 2005. The Social Worker who knew the family well from previous involvements carried out a home visit on 25 April 2006. BB played down her previous claims about the threats posed by LE and said that everything was alright and LE was no longer threatening her or the baby. The Social Worker concluded that there were no concerns regarding the care of EE and that the mental health services needed to stay involved. It was felt that Mental Health should be the lead agency and that there was no role for CSC.

21.17 On 26 May 2006, BB reported a third DV incident to police which had occurred three days earlier, where LE had attended her home and threatened her with a knife in the kitchen stating that he would kill her unborn baby. BB claimed he held her around the neck, pushed her against the wall, held the knife by her side and was whispering threats in her ear. She stated she was 17 weeks pregnant and was taking medication for depression and high dosage

sleeping pills. Had BB been 17 weeks pregnant at the time, the expected date of delivery (EDD) would have been 3 November 2006. Having made the allegation, BB declined to support police actions and went as far as stating she would move to Algeria if LE was arrested. In view of the serious nature of the allegation, police made numerous attempts to arrest LE even without the support of BB. Children's Social Care were notified of these allegations by police and a further S47 investigation was undertaken. It is not clear if information was requested from the police by CSC regarding LE and BB's previous history.

21.18 As a result of being unable to arrest LE, and the fact no further incidents had been reported, police officers made the decision to attend his home address with Children's Social Care in order to resolve the situation. On 29 July 2006, Police and Children's Social Care made a joint visit to LE's home. There was no answer and as the result of local enquiries, neighbours stated they had seen LE leave three weeks earlier carrying suitcases. The case was reviewed and closed taking into consideration BB's request that police not speak with LE and the fact that he appeared to have gone away.

21.19 BB stated that she was making private arrangements for ante-natal care and delivery and that it would be out of jurisdiction. BB refused to give any details of these arrangements. BB also failed to attend any appointments with the GP so that her pregnancy could be confirmed. The professionals who saw her during this time (the Social Worker, Team Manager, Psychiatrist, School SENCO, GP practice nurse) stated that BB looked pregnant to them and the size of her bump suggested she may be quite a bit further on than she was claiming. When BB was seen in August 2006 she no longer appeared pregnant.

21.20 During a joint home visit by the Consultant Psychiatrist and a Social Worker in June 2006 BB said that she might go abroad to have the baby or just take a train to another part of London to avoid her husband knowing about the baby.

21.21 BB gave different explanations about the outcome of this pregnancy with the EDD 3 November 2006. BB told the Social Worker that she had given birth at 27 weeks and that the baby was in a special care unit. Baby equipment, clothes, nappies etc were seen in her flat prior to the alleged birth.

21.22 The outcome of the Section 47 investigation which had been completed in June 2006 was that a pre-birth child protection conference should be convened. However given that there was no baby it was difficult to progress a pre-birth child protection conference.

21.23 When police visited BB on 18 August 2006 to find out about the missing baby, BB denied giving birth to a baby and said "of course there was no baby". The police though that BB was 'playing games' and they found no evidence of a baby in the flat.

21.24 A legal planning meeting was convened by the Social Worker on 21 August 2006 where information was shared that the police were going to close the case. A decision was made by CSC to employ a private detective to see if it could be established whether the baby that BB had claimed to have given birth to at 27 weeks existed and traced. The detective was unable to find any evidence of a baby born at 27 weeks. Extensive checks were also carried out by Health but no baby could be found.

21.25 The Core Assessment continued through the summer and was finally concluded in October 2006 after the private detective had completed his investigation. The case was closed by CSC on 3 October 2006.

21.26 In March 2007 BB wrote to Lewisham Police making an allegation that her husband, LE, poisoned her to induce a miscarriage. This was a repeat of the previous allegation made in 2005.

21.27 In July 2007 BB was offered an alternative temporary accommodation, which she accepted. There are issued letters regarding rent arrears on this property, and termination of housing benefit.

21.28 In December 2007 a referral was made to Children's Social Care Children with Disabilities Team by a GP requesting support for EE regarding his autism. However, this referral did not meet their threshold and there was no further involvement.

21.29 Between September 2004 and May 2006 EE attended Lewisham Bridge School. He had a 2 days fixed term exclusion for assaulting a member of staff in November 2005. He transferred to Rangefield school between June 2006 and July 2007. The Special Educational Needs Coordinator received a letter in January 2008 explaining that BB would be withdrawing EE from school to teach him at home. The letter was dated September 2007 and had gone astray.

21.30 In January 2008 the School Improvement Officer carried out an inspection at the family's home. Their view was that what BB was providing met the requirements for home education, and no follow up visit was required. The report outlined that EE had Asperger's Syndrome and that EE was doing well and some of his skills and knowledge were above the expectation for his age. A review date was set for March 2010, but this was not carried out.

21.31 Letters regarding EE's home schooling were sent in August 2008, August 2009 and August 2010. In August 2008 BB responded to the Local Authority in writing explaining that the family was waiting to be relocated out of London, with the intention of EE starting school in January 2009. There is no reply on record for the August 2009 letter, although there was no legal obligation to do so. In response to the August 2010 letter BB submitted an application for a place in a local primary school stating that she would like EE to be taught in a school environment.

21.32 In March 2008 BB attended A&E having had 2 positive pregnancy tests and bleeding. In October 2008 notes indicate that she is 26 weeks pregnant.

21.33 In September 2008 SLaM records show that BB informed her psychiatrist that she had contemplated giving herself and her unborn baby a lethal injection. She further stated that her relationship with the father of her unborn baby remained acrimonious and heated. A follow up appointment was arranged for 4 weeks time.

21.34 Health Visitor records in November 2008 show that BB informed the midwives that she had experienced domestic violence in previous relationships and had 4 children taken into care and adopted. She indicated she was now in a stable relationship, had a 9 year old son and had previous mental health

concerns. A referral in this light was made to Dr Parker, a Consultant Psychiatrist within SLaM.

21.35 In January 2009 BB delivered a baby boy at Lewisham Hospital. Midwifery notes are unavailable, however Children's Social Care records show that a midwife at Lewisham Hospital contacted them in relation to MP, who had just been born to BB. The midwife completed a CAF referral and was loaded on to the CSC electronic recording system as a "contact". This new contact was not linked to the old information held on the family and was created as a new entry as if it was a new case. This was an administrative error as sufficient information was provided by the midwife to link the contact with previous records. In response to this contact, the Social Worker contacted the psychiatrist and the midwife who visited BB and MP at home. No concerns were raised and therefore the CSC team manager did not progress the contact to a referral.

21.36 In February 2009 Health Visitor records indicate good interactions with BB and MP, and that BB was home tutoring EE and had a supportive partner. A Targeted Visit by the Heath Visitor in February 2009 was followed by a visit in March where advice was given about MP seen to be lying on his front in his cot and concerns about this leading to sudden infant death syndrome. This advice was given at each visit as BB continued to allow this to happen. Between May 2009 and March 2010 it is reported that "all milestones met and rapport between mother and child good".

21.37 In January 2009 an offer of permanent housing was made to an address in the south of the borough. The offer was accepted, however BB submitted medical evidence and asked for a review of the suitability of this address under Sec 202 Housing Act 1996, in relation to her son with autism and a requirement for an additional room for him.

21.38 In March 2009 BB was taken to A&E by London Ambulance Service having been found lying on the pavement, vomiting, agitated and restless. It is reported that BB does not remember going out, and said she had only drunk one beer. She was ejected from the hospital for being violent and abusive. A&E contacted the police as BB disclosed having 2 children at home. The police visited the home and spoke to FF. He explained that BB did not normally drink and was suffering from post natal depression. FF was seen to be a responsible person and police viewed this as a one off incident. A duty social worker also spoke to FF who said that BB provided good care to the children and that this was a one off incident. FF indicated that he did not live with BB but stayed there most nights.

21.39 There is no evidence that the Health Visitor was advised of the incident outlined above. During a planned Health Visitor appointment in April 2009 BB stated that following this incident Children's Social Care spoke to her psychiatrist and were reassured because she was engaging with mental health services and her psychiatrist "had no concerns re her mental health or parenting ability".

21.40 In April 2009, BB contacted her social worker and alleged that FF, her current partner, had assaulted her. BB stated that she did not want to report this as an incident of domestic violence to the police (although police records show that she had reported this incident to them), and was frightened and wanted to move to Bournemouth. However, during the core assessment BB indicated

her relationship with FF was improving and that the incident of domestic violence was a one off. The core assessment concluded that there was no role for Children's Social Care and the case was closed.

21.41 In April 2009 a domestic violence incident between BB and FF was reported to police. It is alleged by BB that FF had barged in and pushed past her to get his belongings, and BB had ripped his shirt. Police saw FF's ripped shirt, and BB also showed them an old injury under her eye, however she had no recent injuries. FF informed police that he was trying to leave BB and said he could no longer live with her due to her violent temper and mental health. BB became aggressive towards officers, but was not arrested. There is no information about the children and no MERLIN entry was completed.

21.42 In October 2009, patrolling police officers stopped KK in the street outside BB's house. He then alleged he had been assaulted by BB. BB alleged that KK had tried to rape her so she had assaulted him. Police noted that BB was volatile and appeared "either under the influence of drink or suffering from mild mental health issues". It is believed that KK had made several advances towards BB and was unhappy with her relationship with FF. KK is described as an "uncle" who visited a couple of times a week. The allegation was investigated. BB subsequently withdrew her allegations and the case was referred to and reviewed by the Crown Prosecution Service who advised no further action. At this time, police saw EE at the home and noted the home to be clean and tidy and there was a good amount of baby food in the kitchen cupboards. It is noted that officers considered EE to be at ease with his mother and neither children appeared to be at any risk. A MERLIN was completed and shared with Children's Social Care. The CSC Team Manager made a decision not to investigate this incident any further. The case was closed on 9 November 2009.

21.43 Health Visitor records show BB disclosed details of the above incident during a targeted home visit. Additional information regarding this incident, as disclosed by BB to the HV during this visit, state that the incident had taken place after BB had had a couple of glasses of wine and got angry, and that a physical fight occurred in front of her son EE.

21.44 BB reported details of the above incident to her GP in November 2009. The GP notes that CBT is required for anger management.

21.45 BB's third and final contact with Victim Support was in October 2009 following a referral from the police in relation to the above incident. The incident was not flagged as domestic violence as the suspect is deemed an acquaintance. 2 attempts were made to contact BB and a letter sent. It is noteworthy that the case was not flagged as a domestic violence incident. If the case was flagged as domestic violence, a letter would not have been sent.

21.46 From March 2009 onwards, BB made sporadic requests to her GP for diazepam. Between January and October 2010 BB had 9 contacts with her GP requesting diazepam, smoking cessation advice and regarding asthma. BB had no further contact with her GP after this time.

21.47 BB's last contact with SLaM was in April 2009 when she was seen by a Consultant Psychiatrist. Subsequently to this she ceased her contact in November 2009 following non attendance of appointments. It came to light during this DHR process that BB did not appear to have been formally

discharged by SLaM following her failure to attend and maintain contact with the Consultant Psychiatrist's Outpatient Clinic.

21.48 In March 2010 a decision was made to transfer BB's case to another Health Visitor. The reason for this decision is not clear. During an opportunistic visit by the new Health Visitor in June 2010 BB reported that she had recently found out via Facebook that her mum died in 2009 and no member of her family had contacted her. Also, a brother who she believed to be dead was in prison serving a sentence for murdering his partner. BB stated she had always believed her brother had died from a drug overdose. She was very angry and upset about the situation. BB reported that she was getting support from her current partner but appeared ambivalent about this at times.

21.49 In June 2010 LE reported to police being a victim of domestic violence from BB in relation to harassment over a period of 3 weeks. It is noted that BB had not been in contact with him for several weeks, but then upon contact allegedly asked him for £4000 to help her move to Leeds with her new partner (no name). It is noted that she then told him that she really needed it to dispose of a drug dealer, whom she had killed and stored in her freezer. LE did not take these claims seriously. BB was issued with a First Instance Harassment Warning. No further action would then be taken by police unless further incidents were reported.

21.50 Health Visitor records show that in July 2010 the case was discussed at a GP vulnerable family meeting, minutes of which cannot be sourced.

21.51 Following a match on Lewisham Homesearch in October 2010, BB was offered accommodation in Forest Hill (the address where the body of FF was discovered), which is owned by Hexagon Housing. Hexagon Housing had little involvement with BB as she only moved into the Hexagon Housing property in October 2010, and they had no contact with her after January 2011 when she contacted them regarding minor repair issues. BB did disclose that she had suffered with depression and suicidal thoughts and was under the care of a local medical centre. Information from Hexagon Housing shows that BB was capable of maintaining her tenancy and did not ask for support or assistance.

21.52 In November 2010, following a house move, BB's Health Visiting records were transferred to a new health centre. A family health needs assessment was undertaken and no current identified health needs noted. The episode of care was closed, and universal services offered.

21.53 BB declined a place for EE at Downderry School in September 2010, however a place was accepted for Kilmorie School, where EE attended between November 2010 and June 2011.

21.54 It is noteworthy that BB's involvement with agencies involved in this DHR process was significantly less over the final two years leading to the homicide in comparison to the previous years. The GP remained the only main contact, although this was due to physical health conditions.

22.0 FF and BB

22.1 The agencies involved in this review have very limited information about the relationship between FF and BB. There is no clear indication how long they had been in a relationship for prior to the homicide.

22.2 Information gathered by the police during the course of the homicide investigation revealed that in 2009 and 2010 FF was attempting to reconcile his relationship with BB, which helps explain why he frequently stayed at her address.

22.3 It appears that shortly after the alleged domestic violence incident in April 2009 FF moved out of BB's address and he was not living there at the time of the homicide.

23.0 Analysis

23.1 There is considerably more information about BB and spread over a longer period than is available for FF within the records of the statutory sector. As such, there are still gaps in information about the victim and perpetrator due to limited contact with those agencies approached as part of the DHR process and the fact that information was held by agencies outside of London.

23.2 This domestic homicide is unusual, or made more complex, to the extent that:

- The victim was the male partner in the relationship and was barely known to any agency;
- Both victim and perpetrator had spent the majority of their lives in other parts of the country and had only been in Lewisham for a few years;
- The perpetrator was known to a number of agencies to be suffering from a mental illness;
- Whilst there was much agency contact, particularly with the perpetrator, between 2006 and 2009, this contact had all but ceased during the two years leading up to the homicide.

23.3 It is also important to note that a good deal of information, particularly some now held by the police, only came to light as a result of the murder investigation and subsequent court case. Such information was not, therefore, readily available to any of the agencies during the period under review leading up to this domestic homicide.

24.0 Information sharing

24.1 There were good examples of information sharing between the Health Visiting service and other agencies, specifically the GP and Mental Health services.

24.2 There were examples of inadequate information sharing between agencies and there were examples of poor recording of information shared between agencies with some information missing. There were difficulties in ascertaining information from other areas of the country due to a large amount of movement of both victim and perpetrator in the past. This also led

to poor information sharing by agencies in the transition of services for all family members.

24.3 Communication between Health Visiting and SLaM showed a willingness to provide a joined up service but the infrastructure did not appear to support this. Many telephone calls were made by both services over a period of days without success. Communication between BB's psychiatrist and other professionals could have been better. Neither the Health Visitor nor the Social Worker were informed when the relationship with the psychiatrist broke down and the patient was discharged from her care. This was only discovered when BB showed the Health Visitor the letter from the psychiatrist at a planned Health Visiting home visit.

24.4 In 2009 police were called to a domestic violence incident between BB and FF, and another incident between BB and KK, which was not a domestic violence incident as he was seen as a friend of BB and not someone residing with her. In both instances, counter allegations of violence were made. Police made CSC aware, however the Health Visitor, who was in regular contact with the family during this period, was unaware of these incidents until BB disclosed them directly during a planned visit.

24.5 The fact that BB had been discharged from mental health services and was no longer receiving treatment from SLaM was not communicated to other interested agencies.

24.6 Where a school removes a child from their roll the Local Authority should be informed by the school about home education. In this case there was an inexplicable and unacceptable delay of almost four months before the Local Authority was informed. Although the school did not raise any concerns about home schooling in this case, the delay could have proved very significant in safeguarding terms. It is important that schools are reminded that they must inform the Local Authority in a timely fashion about any pupils whose parents have withdrawn them to educate them at home, and whether the school has any concerns about that arrangement. Where there are concerns, a Common Assessment Framework (CAF) should be completed and a Team Around the Child (TAC) meeting arranged.

24.7 At the time of this homicide, there was no routine sharing of information between staff responsible for monitoring Elective Home Education (EHE; education otherwise) and other agencies to whom the family was known. As such, those staff were not aware of the GP referral to CSC, nor of the Section 47 investigations that were carried out with the family. A regular information sharing forum now takes place in relation to EHE cases. It is unlikely that any different course of action would have been taken had this information been available, however in alternative circumstances this could have been significant in terms of the Attendance and Welfare Service's (AWS) contact with the family.

24.8 Some adjustments in practice have already been made within AWS since this case began. Checks are now made with CSC, Health, SEN and Attendance and Welfare prior to the School Improvement Team carrying out home visits. Depending on what is known about the child's circumstances, the view may be that home education is not suitable. It may also be appropriate to use the CAF process to explore the child's needs more fully. A safeguarding group

has also been set up, including representatives from CSC, Admissions and Attendance and Welfare which aims to highlight any cases causing concern.

25.0 Risk assessment and record keeping

25.1 Within SLaM there were identified recording gaps and a lack of use of IT case management systems for recording information on interventions and directing risk and needs assessments.

25.2 A number of other agencies had gaps in files and notes missing.

25.3 The review highlighted the need for robust and appropriate levels of recording and documentation to aid the process of care planning and effective clinical management of the care of service users, particularly within mental health services. The absence of this, as seen in this case, can contribute to a mirroring of the service user's chaotic and/or fixed presentation and focus as opposed to the production of a proper risk assessment, care plan and follow up.

25.4 The lack of proactive use of the electronic patient record system within mental health services contributed to a lack of effective care planning and clinical management in this case. When used proactively the system can aid appropriate risk assessment, care planning and documentation and can prompt consistent levels of action and follow up in the best interest of the safety and wellbeing of service users and others.

25.5 Following the alleged domestic violence incident between FF and BB in April 2009 no MERLIN report was completed by police. Although there was no mention of the children being present during the incident, there is sufficient information to have led an officer to complete a MERLIN report. The children's whereabouts were unknown at the time and in the absence of a MERLIN report there appears to have been no risk assessment made of their situation and being in a home where domestic violence had occurred. A MERLIN report should have been completed and would have ensured that the incident had been shared with CSC, however, an individual MERLIN report would not have triggered an investigation.

26.0 Understanding the existence of DV with FF and previous partners

26.1 BB was well known to CSC, SLaM and Health (GP and Health Visiting) agencies. In particular, there is considerable information available to the Review Panel that over a period of years she had been involved in a number of alleged incidents of domestic violence, more often as a victim than a perpetrator, involving different partners. There was also information available to SLaM and CSC that BB had made threats to kill previous partners, however police were not made aware of this.

26.2 Health Visiting records report that BB had been in an abusive relationship prior to her relationship with FF. Records also appear to suggest a breakdown in BB and FF's relationship, including reference to physical violence. The Health Visitor provided information about couples counselling without further exploring the issue. Couples counselling is not appropriate where domestic violence and abuse is present within a relationship.

26.3 According to the IMR from SLaM, BB was seen as a fantasist whose repeated reports of homicidal thoughts and risk of harm to others were deemed to be overvalued ideas linked to her personality disorder. The SLaM review team noted the fact that their two staff members to whom BB reported the alleged incident of attacking and attempting to kill her ex husband, LE, with an iron bar only remembered it when the clinical records were read to them when they were interviewed. SLaM has acknowledged the requirement to report such an incident to police and the seriousness of such a lack of disclosure.

27.0 Mental health

27.1 CSC, SLaM and the GP were aware that BB had a long history of mental illness. The SLaM IMR suggests that her mental illness was the over-riding factor in determining how seriously her statements and allegations were taken, how thoroughly these allegations were followed up and investigated and how well risk assessments were undertaken and communicated between agencies. However, BB's consistent expression throughout her four year period of treatment and the nature of the homicidal intentions, leads to a legitimate question of why there was no evidence of escalation and follow up.

27.2 None of the SLaM staff interviewed as part of this DHR process viewed BB as either a victim or perpetrator of domestic violence. They responded to questions by the review team regarding what BB had reported she had done and wanted to do with the commonly-held belief that these events had not happened and were more a feature of BB's perceived tendency to engage in "overstated ideas crossed with fantasy".

27.3 The review team noted from the clinical records that there was a very definite focus within the documentation of sessions on medication management and in particular on BB's dependence on diazepam. This appeared to remain a focal point for both BB and staff members throughout her period of treatment and it is notable that even at times when BB disclosed concerning and homicidal intensions and also reported incidents of inflicting physical harm on her ex-husband the records invariably revert immediately to refocus on the medication issues. Medication management is clearly an extremely important element to the treatment that HTT and CMHTs provide, but in this case BB's apparently heightened level of focus on medication appears to have been mirrored by the clinical team; possibly at the expense of ongoing risk assessment and follow up in relation to the threats that BB consistently made over this four year period.

28.0 Children's Social Care

28.1 In January 2009 CSC were informed by a midwife that although BB and her new baby MP were doing well, BB had stated that four of her children had previously been adopted. There is no evidence on file that a Social Worker had asked BB or her partners about these children. There should have been a concerted effort to follow up on this information relentlessly, until the information was confirmed or refuted. The failure to obtain information about children who had been removed and placed for adoption did not impact on the welfare of these children in this case. In another case, such information may well have done.

28.2 In 2010 an initial referral to CSC was made because the police had been called by KK who alleged BB had assaulted him. She counter alleged that he had tried to strangle her so that he could rape her. There were also allegations that KK had downloaded child pornography. After the police found no evidence of child pornography on KK's computer, BB saw no reason to stop KK visiting the family home. Once the Social Worker was satisfied that KK had not downloaded child pornography the case was closed. The risk of exposure to sexual and physical violence in the home from KK, who was a friend of the family, was not explored. The police IMR shows that the rape allegation was No Further Actioned (NFA) after further investigation and CPS advice. The fathers of the children were not interviewed and included in the core assessment in February 2010.

28.3 The administrative error in not linking the referral from the midwife in January 2009 to previous records was an oversight with potentially serious consequences. Fortunately in this case the children did not come to significant harm because of the administrative error. In another case the consequences might have been very different.

29.0 Police action

29.1 Information available to the Review Panel shows that there was one recorded incident of domestic violence between the victim and the suspect in April 2009. When police were called to the incident, counter-allegations were made by both parties. Records indicate that police did not believe BB's version of events (e.g. BB showed old bruising injuries claiming they had just occurred, whilst the officers considered they were "many days old"). A decision was made by police supervisors to take no further action regarding this incident. It is conjecture, but had greater attempts been made to ascertain the primary aggressor during this incident, FF may have been recognised as a potential victim and referred to Victim Support. He might then have had the opportunity to disclose any concerns regarding his own safety.

30.0 Support services

30.1 FF was not known to any support services.

30.2 BB had limited contact with Victim Support following an allegation of domestic violence between her and LE. The focus of this contact was on housing support, after which BB stated that she did not want further contact from Victim Support.

31.0 Culture of questioning

31.1 The IMRs from Health, SLaM and CSC show that staff involved with the family had never explicitly asked about domestic violence and abuse.

31.2 Given that BB consistently and regularly reported incidents that can be seen as indicators of domestic violence to clinical team members there was an opportunity for practitioners to respond sensitively to BB's needs as a victim

and also a perpetrator. These opportunities were not taken as the clinical team reportedly did not believe that she would act on homicidal tendencies and threats of violence to her ex-partner; and appeared to doubt whether previous incidents that BB reported had actually happened.

32.0 Policies and processes

32.1 With the exception of the police, agencies did not have updated procedures and policies in place regarding domestic violence and abuse. Where there were policies in place, not all agencies had training programmes to support them. As a result, practitioners were not always aware of these policies and did not comply with them in practice. Policies were not explicit in relation to the potential of the male partner becoming a victim of domestic violence and abuse.

33.0 Equality and diversity

33.1 The nine protected characteristics as defined by the Equality Act 2010 have all been considered within this review. They are; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

33.2 The panel did not feel that these issues had a material bearing on the circumstances of this case or the subsequent review, with the exception of the gender of the victim and the mental health of the perpetrator which have been fully discussed within the report.

34.0 Family contact

34.1 FF had very limited or no contact with either the statutory or voluntary sector organisations involved in this Review.

34.2 FF's family were contacted by the Chair of the DHR Panel and given the opportunity to contribute to the process. The family declined to do so.

34.3 The murder investigation revealed that FF's mother had concerns about her son's relationship with BB. There was no physical violence mentioned by the victim to his mother, though his mother encouraged FF to stay fully separated. Further evidence / information gathered by the Murder Team shows that there is nothing noted which would have caused FF's mother to make an allegation to the police.

35.0 Conclusions

35.1 Some of the information contained in this report was not known to agencies until the police investigation into the homicide. It is now known that BB had a propensity for violence, but on the information available at the time she was often regarded more as a victim. However, there was no specific information that could have been disclosed to services that can now be regarded as a trigger to this homicide.

35.2 Given all the circumstances of this case, therefore, the Domestic Homicide Review Panel was satisfied that FF's death at the hands of BB in June 2011 could not have been predicted or prevented. There was no information available to the agencies involved in this review process that indicated FF was likely to become a victim or was otherwise vulnerable. It is likely that if similar circumstances occurred, things would not have been different.

35.3 Nonetheless the Panel is of the view that there are lessons to be learnt in relation to this homicide by all the agencies involved in responding or supporting this family which, if implemented, would make the occurrence of a similar incident in Lewisham less likely.

36.0 Recommendations

36.1 The Review Panel acknowledges that services have been reconfigured and changes made to practice in some services since the time of this homicide. As such, work is already underway to meet some of these recommendations. However, they remain included for the purposes of completeness and monitoring.

36.2 The below recommendations will be shared with relevant bodies within the Safer Lewisham Partnership as well as the Lewisham Safeguarding Children's Board and the Safeguarding Vulnerable Adults Board in order to prevent domestic homicides from happening in the future.

36.3 Implementation of the recommendations will be overseen by the Domestic Homicide Review Task and Finish Group, a sub group of the SLP's Performance and Delivery Board.

36.3.1 The Safer Lewisham Partnership (SLP) should ensure they have in place up to date policies and procedures in relation to domestic violence, accompanied by comprehensive training programmes for staff across all agencies and all tiers including management.

36.3.2 All agencies must undertake a regular review of the policies mentioned above and carry out training audits to ensure that training in respect of male victims is embedded in the practice of all staff. The SLP to recommend that the LSCB and Safeguarding Adult Board should monitor the implementation of this recommendation.

36.3.3 Services involved in this DHR process, who are working with clients with dual or triple diagnosis, are made aware of referral routes and criteria for the appropriate organisation (including police) where a disclosure of domestic violence and abuse is made. All disclosures must be thoroughly investigated and communicated to the appropriate agencies. This requirement should be detailed within domestic violence and abuse policies.

36.3.4 Mental health teams to conduct an audit of their caseloads in ePJS in order to provide quantitative and qualitative assurance that risk assessment and care planning are in line with Trust expectations and that formal discharge procedures are adhered to and fully recorded and communicated.

36.3.5 Social Workers and Team Managers within CSC are to be reminded that difficulties with obtaining information from other local authorities should be escalated to senior managers.

Glossary of acronyms	
DHR	Domestic Homicide Review
SLP	Safer Lewisham Partnership
IMR	Individual Management Review
DV	Domestic Violence
SLaM	South London and Maudsley
HSG	Health Service Guidelines
GP	General Practitioner
VS	Victim Support
CSC	Children's Social Care
MPS	Metropolitan Police Service
OIC	Officer in the Case
EDT	Emergency Duty Team
HTT	Home Treatment Team
CMHT	Community Mental Health Team
HV	Health Visitor
EDD	Estimated Date of Delivery
CAF	Common Assessment Framework
CBT	Cognitive Behavioural Therapy
TAC	Team Around the Child
EHE	Elective Home Education
AWS	Attendance and Welfare Service
NFA	No Further Action
LSCB	Lewisham Safeguarding Children Board

Appendix 1

Domestic Homicide Review Terms of Reference for FF

1.0 Introduction

1.1 The Review will be coordinated independently by Dave Mellish. The membership of the panel will be supplemented by contributions by other invited professionals, as required.

1.2 The Review will be conducted within the 6 month timescale provided within the "Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011".

1.3 The Review will initially use the timeframe 15 July 2006 to 15 July 2011 to explore the individuals named below, their lives and the impact and outcome of the professional network's involvement with them throughout this period.

1.4 A first stage chronology to be done on all the following: BB, FF and KK and 2 children, EE and MP. SLaM will do a separate chronology 2005 to 2009, and other health services will provide a single chronology.

1.5 Officers of the Local Authority who are members of the Panel are there in their capacity as lead officers in relation to crime in the Council.

1.6 Once this first stage is completed then other information can be considered and timeframes agreed by the Chair.

1.7 The Review will address the conduct of agencies, individually and collectively, in the protection and support of the individuals named above. Agencies and professionals asked to submit reports or otherwise contribute to the review:

1.7.1 South London and Maudsley (SLaM)
1.7.2 Nursing
1.7.3 Hospital
1.7.4 GPs
1.7.5 Probation
1.7.6 Police
1.7.7 Hexagon Housing
1.7.8 Children's Social Care

1.8 Exploration of national homicide service involvement and information.

1.9 Neither the victim nor the perpetrator were known to the MARAC, MAPPA, Domestic Violence Perpetrator Programme, local victim support services or other specialist provision.

1.10 Where appropriate the Review Panel will obtain legal advice about any aspect of the review.

1.11 The Review will draw conclusions and make recommendations as necessary, Lewisham's Safer Lewisham Partnership (SLP), through the production of Individual Management Reviews and Overview Report.

2.0 Methodology

2.1 Sharing / obtaining information from other parts of the country.

2.2 Identifying information and intervention regarding the history of homicidal tendencies and what was known / done.

2.3 Identifying what action was taken re the increased drugs and alcohol in the past few years.

2.4 There are not any specific considerations around equality and diversity issues at this stage.

2.5 The perpetrator will not be contacted as part of this review at this stage, based on the ongoing criminal matter taking primacy.

2.6 This DHR will dovetail with the ongoing criminal investigation. Consideration is being given as to whether a Serious Case Review for the children will be undertaken. If this is done, this would run parallel to the DHR. It will be the responsibility of the Review Panel Chair to ensure contact is made with the Chair of any parallel process to consider combining the reviews.

2.7 The Homicide Team have a Single Point of Contact (SPOC) for the family, all information to go through that. Homicide Team will agree a communication plan with the family.

2.8 When meeting with friends, family members and others, the Review Panel should:

- Communicate through a designated advocate within the Homicide Team.
- Make a decision regarding the timing of contact with the family based on information from the advocate and taking account of other ongoing processes i.e. post mortems, criminal investigations.
- Ensure initial contact is made in person and deliver the relevant information leaflet.
- Ensure regular engagement and updates on progress through the advocate, including the timeline expected for publication.
- Explain clearly how the information disclosed will be used and whether this information will be published.
- Explain how their information has assisted the review and how it may help other domestic violence victims.
- Prior to sending the final review to the Home Office, a completed version of the review should be provided to the family. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.
- Maintain reasonable contact with the family, even if they decline involvement in the review process; it will be important to communicate through the designated advocate when the review is completed and when the review has been assessed and is ready for publication. They should also be informed about the potential

consequences of publication i.e. media attention and renewed interest in the homicide.

2.9 Disclosure is one of the most important issues in the criminal justice system and the application of proper and fair disclosure is a vital component of a fair criminal justice system. All disclosure issues must be discussed with the police SIO, the CPS and the HM Coroner's.

2.10 In this case, where the suspect is arrested and charged, the commissioning of the Overview Report should be held temporarily until the conclusion of the criminal case but agencies and interested parties should be notified of the requirement and be obliged to secure and records pertaining to the homicide against loss and interference. In these circumstances the Review Panel should ensure records are reviewed and a chronology drawn up to identify any immediate lessons to be learned (an immediate IMR). These should be brought to the attention of the relevant agency or agencies for action, secured for the subsequent Overview Report and forwarded to the disclosure officer for the criminal case. Any identified recommendations should be taken forward without delay.

2.11 Following the criminal proceedings the DHR should be concluded without delay.

2.12 Sharing / obtaining information from other parts of the country.

2.13 Identifying information and information regarding the history of homicidal tendencies – and what was known / done.

2.14 Identifying what action was taken re the increased drugs and alcohol use in the past few years.

3.0 Scope of the Review

3.1 The Review will :

3.1.1 Address how the agencies functioned individually and collectively in relation to the named individuals in relation to support, management and protection.

3.1.2 Identify issues relation to communication and information sharing between staff within agencies and between agencies.

3.1.3 Identify gaps in information and involvement.

3.1.4 Identify any specific triggers / signs of concern prior to the incident i.e. through mental health, social care and police.

3.1.5 Apply lessons learnt to improve service response in the future with a view to preventing further domestic homicides.

3.2 The Overview Report and Executive Summary will be suitable anonymised and made publically available.

3.3 IMRs will not be made publically available.

3.4 The Summary will be published unless there are compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen. The publication of the documents will be timed in accordance with the conclusion of any related court proceedings and other review processes.

3.5 The content of the Overview Report and Executive Summary will be suitably anonymised in order to protect the identity of the victim, perpetrator, relevant family members, staff and others and to comply with the Data Protection Act 1998.

4.0 Learning lessons and effective practice

4.1 DHRs are a vital source of information to inform national and local policy and practice. All agencies involved have a responsibility to identify and disseminate common themes and trends across review reports, and act on any lessons identified to improve practice and safeguard victims.

4.2 Consideration of what type and level of information needs to be disseminated, how and to whom, in the light of the review will be had by the Chair.

4.3 Subsequent learning will be disseminated to the local MARAC, local Domestic Violence Forum or similar, the Local Safeguarding Children's Board and commissioners of services. They will:

- Incorporate the learning into local and regional training programmes.
- The SLP should put in place a means of monitoring and auditing the actions against the recommendations and intended outcomes.
- Establish a culture of learning lessons by having a standing agenda item for DHRs on the meetings of CSP and Domestic Violence Forum and similar groups.

Appendix 2

Panel members and agencies represented

Agency	**Panel Member**
Metropolitan Police Service Homicide Unit	Damian Allain
South London and Maudsley NHS Trust	Matt Beavis
Local Authority – Community Services	Aileen Buckton
Metropolitan Police – Lewisham Borough Commander	Jeremy Burton
Local Authority – Joint Commissioning	Dee Carlin
Lewisham NHS Healthcare Trust	Kathy Harman
London Probation Trust	Louise Hubbard
NHS South East London	Jane Schofield
Children's Social Care	Ian Smith
Local Authority – Attendance and Welfare	John Russell
Local Authority – Crime Reduction	Geeta Subramaniam
Local Authority – Community Safety	Kellie Williams
Victim Support	Cora Green
Refuge	Melissa Altman
Independent Chair	Dave Mellish

Appendix 3

DHR 1 - Action Plan

All recommendations will be overseen by the Lewisham Community Safety Partnership supported by a Task and Finish sub group of that partnership.

Theme 1 – e.g. Local partnership					
Recommendation	**Action to take**	**Lead**	**Key milestones achieved in enacting recommendation**	**Target Date**	**Evidence – with Date of completion and outcome**
N/A					
Theme 2 – Processes					
The Safer Lewisham Partnership should ensure they have in place up to date policies and procedures in relation to domestic violence, accompanied by comprehensive training programmes for staff across all agencies and all tiers including management.	Lewisham Healthcare NHS trust to update their DV Policy	All agencies	DV Policy for Health completed	January 2013	March 2013
	LBL Housing Options Centre and all major Residential Social Landlords (RSL) in the borough to update their DV Policies.	CRS – Ade Solarin	DV Policy for Housing Options Centre completed	April 2013	May 2013
	CSC to update and complete Domestic Violence Policy and Procedure	CSC – Ian Smith	New DV policy to be reviewed by Senior Managers Team (SMT).	Sep 2013	
			Sign off by SMT	November 2013	
			Circulation to all social workers	December 2013	

			and team managers		
Mental health teams to conduct an audit of their caseloads in ePJS in order to provide quantitative and qualitative assurance that risk assessment and care planning are in line with Trust expectations and that formal discharge procedures are adhered to and fully recorded and communicated.		SLaM – Wanda Palmer	Local Commissioners to have oversight of the audited cases.	January 2014	
Social Workers and Team Managers within CSC are to be reminded that difficulties with obtaining information from other local authorities should be escalated to senior managers.		CSC Ian Smith	Workshops conducted by Practice Improvement Officers when IMR was completed by CSC.	May 2013	May 2013
Services involved in this DHR process, who are working with clients with dual or triple diagnosis, are made aware of referral routes and criteria for the appropriate organisation (including police) where a disclosure of domestic violence and abuse is made. All disclosures must be thoroughly investigated and	All relevant agencies to update their DV Policies to incorporate a section on dual or triple diagnosis	Lewisham Healthcare NHS Trust – Paul Hudson SLaM – Wanda Palmer Substance misuse – Fiona Kirkman		May 2014 May 2014 May 2014	

communicated to the appropriate agencies. This requirement should be detailed within domestic violence and abuse policies.	SLP to develop referral routes and criteria document and circulate to all agencies	CRS Ade Solarin		December 2013	September 2013
Theme 3 – Training					
All agencies must undertake a regular review of these policies and carry out training audits to ensure that training in respect of Male Victims is embedded in the practice of all staff. The LSCB and Adult Safeguarding Board should monitor the implementation of this recommendation.	ASC has circulated the LCSB training audit to all staff and collated responses. A meeting in arranged to discuss specific ASC training needs. For CSC, all training includes male victims	All agencies CSC – Ian Smith	Service Manager Quality Audits and checks of Core Assessments shows that appropriate attention is also paid to male victims	Training audit circulated May 13. Meeting with LSCB June13.	May 2013 June 2013