



**BRENT COMMUNITY SAFETY PARTNERSHIP  
DOMESTIC HOMICIDE REVIEW  
EXECUTIVE SUMMARY  
Report into the Death of Elaine**

**Independent Chair and Author of Report: Althea Cribb  
Associate, Standing Together Against Domestic Violence**



<b>1. Executive Summary .....</b>	<b>3</b>
1.1 Outline of the incident.....	3
1.2 Domestic Homicide Reviews .....	3
1.3 Terms of Reference .....	4
1.4 Independence.....	4
1.5 Parallel Reviews .....	5
1.6 Methodology.....	5
1.7 Contact with the family.....	7
1.8 Summary of the case.....	8
1.9 Issues raised by the review .....	12
1.10 Recommendations.....	15

# 1. Executive Summary

## 1.1 Outline of the incident

- 1.1.1 This Review concerns Elaine, the person who killed her (Elijah), and the significant witness to that homicide, Elaine's ex-partner, Michael. The circumstances of the homicide, and the events leading up to it, are unusual for a Domestic Homicide Review.
- 1.1.2 Elaine and Michael had been in a relationship for around three years up to shortly prior to the homicide, during which time Michael had been abusive to Elaine. Elijah had been a friend of Michael for over thirty years and latterly a friend of Elaine also.
- 1.1.3 According to Michael, four months prior to the date of the homicide, Elaine had disclosed that she had had a sexual encounter with Elijah. This disclosure apparently led to arguments and altercations between the three. One of these occurred three weeks prior to the homicide, in which Elijah threatened Michael with a weapon.
- 1.1.4 No record of abuse from Elijah to Elaine was disclosed during this Review, and the police had no record of any violence on his part.
- 1.1.5 On the date of the homicide, Elaine and Elijah attended Michael's home (it is assumed to remove Elaine's belongings, as she had been living with Michael). Michael was present at the time, and an argument ensued. The argument continued outside of Michael's home and was witnessed by many people.
- 1.1.6 During the altercation, Elijah stabbed Elaine, causing the fatal injury.
- 1.1.7 Elijah was found guilty of Elaine's murder and was sentenced to life, with a minimum tariff of twenty-two years before parole.

## 1.2 Domestic Homicide Reviews

- 1.2.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and are conducted in accordance with Home Office guidance.
- 1.2.2 The purpose of these reviews is to:
  - (a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
  - (b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- (c) Apply those lessons to service responses including changes to policies and procedures as appropriate.
  - (d) Prevent domestic homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.
- 1.2.3 This review process does not take the place of the criminal or coroners courts nor does it take the form of a disciplinary process.

### **1.3 Terms of Reference**

- 1.3.1 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.
- 1.3.2 The first meeting of the Review Panel was held on 18 December 2014. The Review Panel were asked to review events from May 2011 up to the homicide. Agencies were asked to summarise any contact they had had with Elaine, Elijah or Michael prior to May 2011.
- 1.3.3 The Panel agreed that, to get a full picture of Elaine, her life and her interaction with agencies, it was necessary to seek information about Michael. While not the perpetrator of the homicide, he presented an ongoing risk to Elaine and played a significant role in her life up to and including the day of her death. Information on Michael has however only been included where it specifically relates to Elaine and supports the Review's analysis and understanding of her situation.
- 1.3.4 Home Office guidance states that the Review should be completed within six months of the initial decision to establish one. This has taken longer than six months due to a delay in receiving some IMRs, and further information being sought once IMRs had been received. In addition, it was late in the Review process that Elijah responded to state he would be willing to be interviewed and this added a further delay in completion.

### **1.4 Independence**

- 1.4.1 The Chair of the Review was Anthony Wills, an associate of Standing Together Against Domestic Violence which is an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. Anthony has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on DV partnerships, 'In Search of Excellence'. He was also Chief Executive of Standing Together from 2006 to 2013. He has undertaken the Home Office accredited training for DHR Chairs and also worked as a police officer for 30 years, concluding his service as a Chief Superintendent. He has no

connection with the Brent Community Safety Partnership or the agencies involved in this review.

- 1.4.2 The Overview Report Writer was Althea Cribb, an associate DHR Chair with Standing Together Against Domestic Violence. Althea received training from Anthony Wills and has Chaired and completed two DHRs. Althea has over eight years' experience working in the domestic violence and abuse sector, currently as a consultant supporting local strategic partnerships on their strategy and response to domestic violence and abuse. Althea has no connection with the London Borough of Brent or any of the agencies involved in this case.
- 1.4.3 At the time that Elaine was referred to Brent MARAC, Standing Together provided the coordination and administration of the MARAC; at time of writing this report it is provided by Hestia<sup>1</sup>. This is a separate part of Standing Together's service delivery, distinct from the Associate DHR Chairs who have chaired and authored this Review. The Associate Chairs are not direct employees of Standing Together; are not based at the Standing Together offices and have had no direct line management/supervision experience of the MARAC team.
- 1.4.4 Brent Community Safety Partnership (CSP) recognised that Anthony Wills was the CEO of Standing Together at the time Elaine's case was referred to MARAC. However, Althea Cribb was appointed alongside him as the independent report author, she attended the Review Panel meetings and Brent were satisfied she provided sufficient oversight and independence.

## **1.5 Parallel Reviews**

- 1.5.1 There were no reviews conducted contemporaneously with this review.

## **1.6 Methodology**

- 1.6.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Elaine, Elijah and/or Michael. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved.
- 1.6.2 London Borough of Brent Adult Social Care reviewed their files and notified the DHR Review Panel that they had no involvement with Elaine, Elijah or Michael and therefore had no information for an IMR.
- 1.6.3 London Borough of Brent Children's Social Care confirmed that they held information relating to Elaine's child; the Panel agreed that, as the child had not

---

<sup>1</sup> At time of writing this report the coordination and administration of MARAC was provided by Hestia; however, at time of publication in 2018 it is provided by ADVANCE.

lived with Elaine during the period set out in the Terms of Reference, and to protect their confidentiality, an IMR would not be sought from Children's Social Care.

- 1.6.4 At a later stage in the review, the Panel requested specific information from Children's Social Care regarding whether there were any discussions at Child Protection Conferences, or during other engagement with Elaine and her family, concerning support or referrals for Elaine herself. This has been incorporated into the report.
- 1.6.5 A request was sent to the Crown Prosecution Service (CPS) in relation to the offences in which the police sought charging advice. Unfortunately no response was received; a recommendation has been added to this Report with regard to the CPS involvement.
- 1.6.6 The Review had difficulty in securing information from the GPs for Elaine, Elijah and Michael, and multiple letters, emails and phone calls were required. It was particularly challenging because in some cases the GPs did not know anything about DHRs, and so did not understand the process, the statutory nature of them, or what they were required to do. Thankfully information was received from Elaine's and Elijah's GPs, in the form of chronologies, but lacking the analysis required. The General Practice for Michael declined, citing patient confidentiality, as Michael was not the prime subject of the Review.
- 1.6.7 Information was received from the Housing Department that Elaine had stated she had visited Cricklewood Housing Concern, now called Ashford Place. Ashford Place was subsequently contacted on behalf of the Panel, requesting that they check their records; the information received was added to the Report.
- 1.6.8 Contact was also attempted with Elaine's solicitor, but this was unsuccessful.
- 1.6.9 All IMRs included chronologies of each agency's contacts with Elaine, Elijah and/or Michael. On the whole, the IMRs provided were comprehensive and the analysis supported the findings. Following comments, questions and suggestions some IMRs were redrafted and once complete were comprehensive and high quality. IMRs were received from:
  - (a) Metropolitan Police Service
  - (b) General Practice for Elaine (medical notes and additional information received)
  - (c) General Practice for Elijah (chronology received)
  - (d) Central and North West London NHS Foundation Trust (CNWL)
  - (e) Victim Support Brent

- (f) Imperial College NHS Trust (St Mary's Hospital)
  - (g) Hestia (IDVA provider)
  - (h) London Community Rehabilitation Company, formerly Probation
  - (i) London Borough of Brent Housing Needs Department
  - (j) London Borough of Brent Public Health Substance Misuse Commissioning – re: Addaction and CRI (chronologies received)
- 1.6.10 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs.
- 1.6.11 The Review Panel members and Chair were:
- (a) Anthony Wills, Standing Together, Chair
  - (b) Althea Cribb, Standing Together, Overview Report Writer
  - (c) Metropolitan Police Service (Specialist Crime Review Group)
  - (d) Metropolitan Police Service Brent
  - (e) London Community Rehabilitation Company
  - (f) NHS England
  - (g) Central and North West London NHS Foundation Trust
  - (h) Victim Support Brent
  - (i) Imperial College NHS Trust
  - (j) Hestia London Borough of Brent Housing Needs Department
  - (k) London Borough of Brent Public Health (substance misuse commissioning)
  - (l) London Borough of Brent Community Safety
  - (m) London Borough of Brent Adult Services
  - (n) Brent Clinical Commissioning Group
- 1.6.12 The Chair wishes to thank everyone who contributed their time, patience and cooperation to this review.

## **1.7 Contact with the family**

- 1.7.1 The independent Chair attempted to make contact with Michael via the police family liaison officer on two occasions, and subsequently by direct letter. Michael did not respond to any of these communications.

- 1.7.2 The independent Chair attempted to make contact with the ex-husband of Elaine, via the Victim Support Homicide Service, and he declined to be part of the review.
- 1.7.3 The independent Chair attempted to make contact with a friend of Elaine, and no answer was received.
- 1.7.4 The independent Chair attempted contact with Elijah three times, twice via the prison in which he is detained, and then by direct letter. A response was received following this direct letter, in which Elijah agreed to be interviewed in the prison in which he is held. The information received from this interview has been incorporated into the Report.

## **1.8 Summary of the case**

- 1.8.1 The Terms of Reference for this review asked agencies to scrutinise contact with Elaine, Elijah and Michael between May 2011 and the date of Elaine's death; and to summarise any significant contact prior to that.
- 1.8.2 Elaine and Michael had been in a relationship for around three years, up to shortly before the homicide. During this time Michael had been abusive to Elaine. Elijah and Michael had been friends for over thirty years, although in interview Elijah stated that he had been trying to end his friendship with Michael for some time. Elijah and Elaine became friends separate from Elaine and Elijah's relationships with Michael.
- 1.8.3 Elaine was 42 at the time of her death, and White British; the review showed that she had longstanding issues with alcohol and depression. Elaine had no family since her mother had died from cancer, in front of Elaine.
- 1.8.4 Elaine had been in a relationship with Andrew from 2002 to 2011, and they had a child. Elaine alleged abuse from Andrew. Since the end of the relationship, Elaine's alcohol use had led to the child being in the permanent custody of Andrew, although Elaine had some contact.
- 1.8.5 At the time of her death, it was not clear where Elaine was living: she had been living with Michael but was in the process of moving out. The review showed that Elaine had been without a stable home for some time; she disclosed being homeless at times, or staying with different friends.
- 1.8.6 Elijah was either 55 or 60 years old (according to different agency records) at the time he killed Elaine, and is Black British. Information was received from his General Practice, the Metropolitan Police Service and London Borough of Brent Housing Department.
- 1.8.7 The information received by the review demonstrated that Elijah had minimal contact with agencies, and little that added anything to the conclusions of the



review. The General Practice records indicated that in the 1990s Elijah attended for reasons relating to depression and alcohol use, and an earlier incident of self-harm that led to a permanent injury.

- 1.8.8 The Panel agreed that, to get a full picture of Elaine – her life and interaction with agencies – it was necessary to seek information relating to Michael. While not the perpetrator of the homicide, Michael presented an ongoing risk to Elaine. Information has only been included in the report where it specifically relates to Elaine and supports the review’s analysis and understanding of her situation.
- 1.8.9 Michael mentioned, and attended appointments (at Probation and CRI) with, Elaine on a number of occasions. He referred repeatedly to Elaine having received a cancer diagnosis – medical records do not indicate that this was the case. Both Probation and CRI were aware of domestic abuse from Michael to Elaine, and had opportunities to act on this via a referral to MARAC, which they did not take.
- 1.8.10 Elaine had contact with eight agencies in the timeframe for this review: the Metropolitan Police Service (MPS), her General Practice (GP), Addaction (alcohol support service), Independent Domestic Violence Advisor (IDVA) service, Victim Support, London Borough of Brent Housing Department, Imperial College NHS Trust and Central and North West London NHS Trust (CNWL). In addition she was referred to the Multi-Agency Risk Assessment Conference (MARAC).
- 1.8.11 **Contact relating to Police incidents (MPS, IDVA, MARAC and Victim Support)**
- 1.8.12 From approximately 2002 to March 2012, Elaine made a number of allegations of domestic abuse regarding Andrew, none of which led to convictions (Elaine withdrew all allegations). In addition there was an incident involving abuse from Elaine to Andrew, for which Elaine was prosecuted and found not guilty.
- 1.8.13 Following an incident in July 2011, Elaine was referred to Victim Support. Elaine declined support as she did not want to substantiate the allegation, as she “wishes to speak to social services regarding [contact with] her daughter.”
- 1.8.14 From January 2012 to May 2014 there were 14 incidents of domestic abuse from Michael towards Elaine. Michael was often arrested, but rarely charged; on many occasions no offences were recorded, or Elaine withdrew her statements. She was offered support following some of the incidents, however Elaine declined what was offered. In addition she was twice referred to Victim Support, who were unable to make contact with her on both occasions.
- 1.8.15 Michael was convicted twice for assaults on Elaine, in October 2013 and May 2014.

- 1.8.16 Following the sixth incident overall, and the second in 2013 (April), Elaine was referred to the Independent Domestic Violence Advocacy (IDVA) service<sup>2</sup>. This was the first of three referrals from the Police to the IDVA service, and Elaine's contact with them was sporadic. In the first instance her case was closed in October 2013 after Elaine told the IDVA that she was homeless, but not as a result of domestic abuse. A referral from the Police shortly after that was closed in March 2014 after the IDVA service had not been successful in reaching Elaine at all.
- 1.8.17 The third referral from Police to IDVA was made in May 2014; support was primarily around Elaine's need for a stable home, with which the Housing Department were unable to help her as she did not pass the priority need test. The last contact Elaine had with the IDVA was 21 May 2014.
- 1.8.18 The Police, IDVA and Addaction made MARAC referrals and Elaine was discussed on three occasions. Actions primarily related to agencies' struggles to maintain contact with Elaine. At the first meeting Addaction received an action to re-engage with Elaine to offer her support; they fed back to the MARAC Coordinator after the meeting that they had not attempted to contact Elaine, as her case had previously been closed with Elaine's agreement.
- 1.8.19 At that second meeting, when the Police shared that Elaine had been arrested and charged with assaulting Michael and a friend, the only action was for her to be referred to Minerva: a service that supports women who have committed crime, providing practical and emotional support and advocacy across a range of issues. (This referral was made, however Elaine did not attend.)
- 1.8.20 **Health based contact (GP, Imperial College NHS Trust and CNWL)**
- 1.8.21 Elaine had extensive contact with her GP within the Terms of Reference timeframe (25 appointments or telephone calls, with ten different GPs), and additional contact is likely in the years prior to that. She had regular appointments in relation to her alcohol use, and depression. She also attended with physical health complaints. In that time, there was no record of a disclosure from Elaine or an enquiry by one of the GPs regarding domestic abuse.
- 1.8.22 Elaine primarily attended her GP for what was recorded as reviews of her "Depressive Disorder" and "Alcohol – Problem Drinking". For the former, she was prescribed anti-depressants and on two occasions referred to IAPT<sup>3</sup>. For the

---

<sup>2</sup> Specialist domestic violence and abuse advocacy and support service for medium and high risk victims; in this case provided by Advance and then Hestia (see below).

<sup>3</sup> Improving Access to Psychological Therapies, IAPT, is a national programme (locally delivered and managed) supporting the NHS to get patients into counselling or other mental health support.

latter, the GPs repeatedly advised Elaine to stop drinking, and encouraged her to continue to attend Addaction.

1.8.23 The first referral (November 2011) was returned by IAPT, without contacting Elaine, suggesting that the GP advise Elaine to access counselling via Addaction, as that would be more appropriate given her problematic alcohol use. The second referral (September 2012) led to IAPT contacting Elaine in November 2012 for a telephone assessment. Elaine referred to “relationship difficulties”. Due to long waiting lists, Elaine was offered an appointment in March 2013; of four scheduled appointments, Elaine attended one and was therefore discharged back to her GP in April 2013.

1.8.24 At all her GP appointments, Elaine mentioned how the lack of contact with her child was having a negative impact on her. She was frequently noted as “not doing well”. Her prescription for anti-depressants was changed a number of times.

1.8.25 In addition to the above, the following were significant:

- (a) Following a GP appointment in September 2011 because she was pregnant, Elaine attended two months later (November) to request – and then receive – a termination. The reason she gave was that her “marital relation has broken down”. It was recorded that there was a “close friend present” but there were no details on who that was.
- (b) On two occasions Elaine attended having been injured: once with a broken collarbone and once with a black eye. There was no enquiry into how these occurred.
- (c) In May 2013 Elaine disclosed being homeless on the street, and that she was begging. No action in relation to her homelessness was recorded.
- (d) From August 2013 Elaine had extensive contact with her GP in relation to a physical complaint. She was referred in October 2013 to Imperial College NHS Trust for a procedure relating to this. At the pre-assessment clinic she was recorded as having attended with her “partner” but there is no information on who this was. Michael was recorded as Elaine’s next of kin. Subsequently Elaine was unable to undergo the procedure and she was discharged back to the GP.

1.8.26 A telephone conversation on 22 April 2014 discussing her anti-depressant prescription was Elaine’s last contact with her GP.

1.8.27 **Addaction**

- 1.8.28 Children’s Social Care Services referred Elaine to Addaction twice as part of the Child Protection Plan for Elaine’s child. Elaine received support from October 2011 to July 2012, and again from October 2012 to March 2013.
- 1.8.29 Elaine disclosed abuse from Andrew and Michael to the Support Worker, and also sought help with housing and contact with her daughter. Her attendance was sporadic and on each occasion, Elaine’s case was closed due to “lack of engagement”.

## **1.9 Issues raised by the review**

- 1.9.1 It is not possible to state that, had agencies acted differently, Elaine’s death would have been prevented. This is due to the unusual nature of this domestic homicide, in which the perpetrator posing the most significant risk to Elaine – Michael – was not the perpetrator of the homicide.
- 1.9.2 Elaine had a very troubled existence with a large and significant number of deeply worrying issues, and such extensive contact with services that it is possible to see where opportunities were missed to support her to lead a healthier, less chaotic life which could have taken her away from Michael, Elijah or any other person who could harm her.
- 1.9.3 Elaine had a duty of care to herself to address her many issues. However, in reality these issues were such that she was often unable to take care of herself or take the action that would have helped her. The onus was on services, perhaps collaboratively, to support Elaine to maintain engagement and to address her difficulties.
- 1.9.4 *Seeing the whole person*
- (a) Elaine’s alcohol use, mental health issues, experiences of loss and abuse, and housing situation meant that she was vulnerable<sup>4</sup> to experiences of abuse, harm and distress. However, few agencies were able to see all of these circumstances.
- (b) The Independent Domestic Violence Advocacy (IDVA) service and Elaine’s General Practice both missed opportunities to assess Elaine taking into account all of her varying needs.
- (c) Although there was the opportunity to facilitate support and safety for Elaine through the Multi-Agency Risk Assessment Conference (MARAC) process, the fact that not all agencies were part of the process, and that actions did not

---

<sup>4</sup> NB: this refers to Elaine’s general vulnerability, not a specific statutory definition of vulnerability for example as used by Housing, or Social Care.

seem to be aimed at minimising the risk she faced, effectively left Elaine still at high risk.

#### 1.9.5 *Single issue focus*

- (a) Elaine was rarely seen in the context of all of her needs, and in the service delivery there can be seen a focus on the (often single) issue for which Elaine had been referred.
- (b) St Mungo's research with homeless women, *Rebuilding Shattered Lives*, highlights how women can be attempting to cope with multiple issues, which are "reinforcing and interrelated", but that many services focus on one specific aspect of women's circumstances, failing to take into account their whole situation. In addition they often fail to communicate with each other, as seen with Elaine where there was minimal contact between the three services she was most engaged with (GP, Addaction, and IDVA).
- (c) The MARAC offered the ideal opportunity for joined up working with Elaine from these, but Addaction had already closed her case, the GP was not engaged and Elaine subsequently withdrew from the IDVA service.

#### 1.9.6 *Professional curiosity and creativity*

- (a) The MARAC process can facilitate a creative approach to supporting victims, in particular those who are difficult to engage. However it relies on agencies continuing that approach within their own service delivery.
- (b) The Panel agreed that the GP, and possibly others, could have considered seeking advice and information from the safeguarding adults service.
- (c) Any of the agencies working with Elaine could have recognised that what was being offered was not 'working' for Elaine. At what point should an alternative be sought to the standard response? No agency said "we've done all we can we'll leave her to it", but that in effect was what happened.

#### 1.9.7 *Victim disengagement*

- (a) For victims to disengage from services that are trying to support them is not unusual, particularly in circumstances such as Elaine's. It is possible that she found it difficult to keep appointments, or meet the contact requirements of some services, leading in some cases to her being discharged. Unfortunately, the very factors that led her in to services were also the ones that led her to find engagement a challenge.
- (b) What more could services have done to maintain her engagement while she was within their service? In particular this is relevant for the IDVA service: when IDVAs were first introduced their purpose was to offer 'unconditional' support to victims – to offer something other, and more, than mainstream

services. It is difficult to see this being offered to Elaine, who was not met face to face by the IDVA at any point of her engagement with the service.

- (c) Alcohol Concern have produced the 'Blue Light Project Guidance', which focuses on clients of alcohol support services who do not engage, or when assessed do not show initial willingness to change their drinking behaviour. One of the issues highlighted, in addition to the point made in (a) above, is that these clients often lack the belief that they can change. It is therefore imperative for services to demonstrate their belief in their clients, and when cases are closed due to lack of engagement, this can send the message to clients that the service does not believe they can change.
- (d) This point must of course be balanced against the service's requirement to meet the needs of often very large numbers of clients; they are unlikely to have the time to follow up every non-attendance and cannot afford to spend valuable treatment time trying to engage someone who is not attending. However, this 'belief' in clients should be explored.

#### 1.9.8 *Agency assumptions regarding other services and processes*

- (a) There were a number of instances of contact with Elaine where it appeared that the service was making an assumption on the support she was getting. This interpretation is based on the lack of action from that service in response to issues presented by Elaine.
- (b) Elaine disclosed to her GP that she was homeless and begging, and no action was taken: did the GP assume she was getting support for this elsewhere?
- (c) Elaine talked to her GP and to Addaction about her feelings regarding the loss of contact with her daughter. Neither service is recorded as having found out from Elaine whether she was getting support in this process, perhaps assuming that Children's Social Care would provide this support. On the other side of this relationship, did Children's Social Care assume that a referral to Addaction for Elaine to address her alcohol issues was sufficient?
- (d) Addaction referred Elaine to the MARAC despite having already closed her case: did they assume that a referral was enough and that their role was subsequently over? That through the referral, Elaine would automatically get support?
- (e) Addaction, IAPT, the IDVA and the GP appear to have assumed that Elaine was making a deliberate, informed, choice to engage or not, and that there was nothing they could do about it. While no service could have taken responsibility for all of Elaine's issues, there was a lack of focus on – or proactive response to – her general wellbeing.

### 1.9.9 *Child loss and contact*

(a) One of the most significant recurring issues for Elaine in her interaction with services was contact with her child, which (appears to have) ended in 2011. In addition to the assumption outlined above regarding support for Elaine in relation to this, it must also be noted that for Children's Social Care the exclusive focus appears to have been Elaine's alcohol use. Also, the second referral to Addaction appears to have been concerned solely with testing, not also with support. Child contact was the biggest factor for Elaine at the time she was engaging – however, it was the issue for which she received the least support.

## **1.10 Recommendations**

### 1.10.1 Recommendation 1

The recommendations below to be completed on behalf of the Brent Community Safety Partnership (CSP) who are accountable for their completion, utilising the template action plan provided in the Overview Report. Initial reports on progress for individual agency action plans (from IMRs, which should already have commenced) and the Overview Report action plan should be made to the Brent CSP within six months of the review being approved by the CSP.

### 1.10.2 Recommendation 2

The Home Office to ask the Metropolitan Police Service to review all DHR IMR recommendations (going back as far as is reasonable, e.g. two years) to identify lessons that may need to be addressed across the Service and not just in local areas.

### 1.10.3 Recommendation 3

Brent Police, Victim Support and the Community Safety Partnership to conduct a review (e.g. dip sample) to understand the extent of the problem of missing or inaccurate contact details for victims, and to identify actions to address this.

### 1.10.4 Recommendation 4

The MARAC Steering Group, with support from the Violence Against Women and Girls Delivery Group, to agree a way forward for involving local GPs in the MARAC, with reference to good practice elsewhere; to report to the Delivery Group on progress.

### 1.10.5 Recommendation 5

The Violence against Women and Girls Delivery Group to review what support is available, and offered, to mothers who are victims of domestic abuse and are within the child protection process, where there is a risk that they will lose

contact with their child/ren. To then act to ensure that support is offered (through appropriate referrals) in relation to their needs and risks; and to ensure that all agencies, regardless of their primary focus, are aware of the needs of women in this situation (using this case as an example, once published).

#### 1.10.6 Recommendation 6

CNWL to report to the Violence Against Women and Girls Delivery Group on their relationship with the MARAC. Report to include any training they have undertaken, or outlining what training will be accessed if none has been received; and what processes are in place (or planned) to ensure a MARAC marker or flag is used on their database.

Staff needs to ensure that everything they write in patients notes is backed up with a complete explanation. Training in clear documentation with outcomes required.

Clinical Supervision is vital when dealing with difficult cases or challenging cases, therefore protected time should be given. This may mean re-prioritizing work load.

A dedicated question or prompt regarding Domestic Abuse and current partnerships should be on assessment form, particularly if there has been any type of violence towards others identified in the past.

To ensure that Domestic Abuse awareness training is available for all staff, at a level

#### 1.10.7 Recommendation 6

Addaction to report to the Violence Against Women and Girls Delivery Group on their relationship with the MARAC, with reference to the points made in this case. Report to include any training they have undertaken, or outlining what training will be accessed if none has been received; and what processes are in place (or planned) to ensure a MARAC marker or flag is used on their database.

#### 1.10.8 Recommendation 7

The General Practice for Elaine (with support from NHS England) to develop a domestic abuse policy and procedure for all staff, along with accessing domestic abuse training, all of which includes the development of proactive enquiry around domestic abuse with all women and particularly those presenting with mental health issues, alcohol/drug issues and following separation. To report to the Violence Against Women and Girls Delivery Group on progress.



#### 1.10.9 Recommendation 8

The General Practice for Elaine (with support from NHS England) to ensure that pathways are in place for patients who attend reporting homelessness and advise the Violence Against Women and Girls Delivery Group on progress.

#### 1.10.10 Recommendation 9

The learning and practice referenced in Recommendations 7 and 8 to be provided to all General Practices in the Clinical Commissioning Group area, with NHS England support.

#### 1.10.11 Recommendation 10

Review Chair to write to the Home Office, General Medical Council and the Medical Defence Union with a recommendation that they work together to issue guidance for GPs on engaging with DHRs – covering what their responsibility and role is, consent and confidentiality within the review process.

#### 1.10.12 Recommendation 11

Public Health commissioners of drug and alcohol services to review the St Mungo's Rebuilding Shattered Lives report, and the Alcohol Concern Blue Light Project guidance, and report to the Community Safety Partnership on how practice with women with multiple and complex needs should change, and how to improve engagement with clients who find it difficult to engage.

#### 1.10.13 Recommendation 12

Hestia and the IDVA service commissioner to report to the Violence Against Women and Girls Delivery Group at least every six months on progress with addressing the high caseloads noted in this review, highlighting any risks to high risk victims and how these are being addressed. This report should also include an assessment of the performance of the new substance misuse IDVAs.

#### 1.10.14 Recommendation 13

The Violence Against Women and Girls Delivery Group to conduct a review, with Hestia and their referring agencies, to understand the process when contact cannot be made with victims referred into the IDVA service. This should include:

- the process followed by the IDVA service
- the process followed by the referring agency when they are informed by the IDVA service that contact has not been achieved

The review to include what multi-agency action is taken to ensure safe outcomes for victims. Outcome of review and actions required as a result to be presented to the Delivery Group and CSP.

#### 1.10.15 Recommendation 14

The MARAC Chair, coordination service (Hestia) and Steering Group to agree a system of monitoring the completion of agreed actions, so that issues can be identified – such as that outlined in this report – and high risk victims are managed as effectively as possible. For this work also to ensure that, where possible, actions are made in relation to the perpetrator as a means of making the victim safe. Progress to be presented to the Delivery Group.

#### 1.10.16 Recommendation 15

MARAC Steering Group to review at least ten cases in which the victim has been arrested / accused of using violence or abuse, to ensure that the MARAC Chair and members retained focus on the primary high risk victim in the case. Outcome of review and actions required as a result to be presented to the Delivery Group and CSP.

#### 1.10.17 Recommendation 16

The MARAC Steering Group to audit MARAC case files to ensure that victims' housing situations, particularly homelessness, are being identified within the MARAC meeting and that appropriate actions are being taken. Outcome of review and actions required as a result to be presented to the Delivery Group and CSP.

#### 1.10.18 Recommendation 17

Review Chair to write to the London Chief Crown Prosecutor outlining concerns about the lack of prosecutions that may have been possible in this case, contrary to CPS policy (this concern also exists in other areas of London following Standing Together's review work); and requesting that further efforts are made to ensure that the CPS's violence against women and girls policies are more consistently implemented at operational level.

#### 1.10.19 Recommendation 18

Brent Violence against Women and Girls Delivery Group to review its effectiveness, including its structure, links to other strategic bodies and whether membership from relevant agencies is at the appropriate level. The Delivery Group should also consider within that review whether it is able to deliver the recommendations contained within this report. Report to be provided to the CSP.