



**BRENT COMMUNITY SAFETY PARTNERSHIP
DOMESTIC HOMICIDE REVIEW**

Report into the Death of Elaine

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



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DHR Brent, Elaine

Overview Report

1. Introduction

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 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.
- 1.1.3 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.
- 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 full terms of reference are included at 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.
- 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.¹This 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 that impacted upon 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 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.

- 1.6.2 London Borough of Brent Adult Social Care reviewed their files and notified the 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 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. They were also asked to elaborate on what changes (specifically in Elaine) may have brought about changes to contact arrangements with her child, as this seemed to change over time. The limited factual information that was supplied 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. This was the case even when the GP was directly involved with the perpetrator or victim. 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
 - (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
 - (k) London Borough of Brent Housing Needs Department
 - (l) London Borough of Brent Public Health (substance misuse commissioning)
 - (m) London Borough of Brent Community Safety
 - (n) London Borough of Brent Adult Services
 - (o) 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 family / friends / perpetrator

- 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 letters. 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.

2. The Facts

2.1 Outline of the incident

- 2.1.1 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.
- 2.1.2 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.
- 2.1.3 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, including at least one alleged assault by Elijah on Michael and Elaine (none of which were reported to the Police). Neighbours reported to police after the homicide that altercations between the three were regular occurrences. No record of abuse from Elijah to Elaine was disclosed during the review.
- 2.1.4 On the date of the homicide, Elaine and Elijah attended Michael's premises (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.
- 2.1.5 During the altercation, Elijah pulled a two-foot sword from inside his waistband and stabbed Elaine in the chest, causing the fatal injury.
- 2.1.6 Elijah was found guilty of Elaine's murder and was sentenced to life, with a minimum tariff of twenty-two years before parole.

2.2 Information relating to Elaine

- 2.2.1 Elaine was 42 years old at the time of her death.
- 2.2.2 During the review it became apparent that she had a serious and enduring problem with alcohol misuse.
- 2.2.3 Elaine's mother died, in front of Elaine, from cancer, and as a result Elaine had no family, having never known her father. According to the IMR from CNWL, this took place when Elaine was 23. However when she started receiving a service from Addaction, Elaine disclosed that she had experienced problems with alcohol and depression from the time when her mother had died, when Elaine was 17.

- 2.2.4 Elaine was in a relationship with Andrew from 2002 to 2011, and the couple had a child. Police records from this time – in which Elaine alleged domestic abuse offences by Andrew, though none ended in conviction – variously describe Andrew as ‘partner’ and ‘ex-partner’, meaning that the date of their final separation is not clear. Further Police records suggest that this occurred in July 2011, at which point Andrew took custody of the child. However, in November 2011 in explaining her request for a pregnancy termination, Elaine stated that her marriage had broken down.
- 2.2.5 Information received by the review suggests that the child lived most of the time with Elaine’s ex-husband, although it appears that there may have been times when she had contact. The Police IMR shows that Andrew took custody of the child in July 2011, following an incident in which Elaine, while caring for the child, had been drunk and hit by a bus (sustaining minor injuries). Elaine’s distress at being separated from her child is a recurring theme in her contact with a number of agencies.
- 2.2.6 Elaine lived at a number of addresses in the three years from the separation to the time of her death, and it was difficult to ascertain whether any of them were her own. Most were the homes of (male) friends or partners, and on a number of occasions she disclosed sleeping rough.
- 2.2.7 Medical records show that Elaine struggled for many years with depression, for which she was treated with anti-depressants, also receiving referrals for counselling. She also had issues with her physical health.
- 2.2.8 Throughout the course of the review, it remained difficult to put together a picture of who Elaine was. While understandable, it was unfortunate for the review that her ex-husband, Michael and friend felt unable to contribute. We were able to get some sense of Elaine as a person from the interview with Elijah, and where possible this has been incorporated into the report.

2.3 Metropolitan Police Service

- 2.3.1 In 1996, prior to the time period indicated in the Terms of Reference, Elaine was fined, and disqualified from driving, having been convicted of driving a motor vehicle with excess alcohol.
- 2.3.2 Within, and prior, to the Terms of Reference time period, the Metropolitan Police Service (MPS) records show that there had been a number of domestic incidents reported in which Elaine alleged abuse by her (ex-)husband/partner Andrew, as well as one where Elaine was prosecuted (and found not guilty at court) of assaulting him. These appeared to start in 2002 and the last was in March 2012 when Elaine alleged receiving abusive text messages, but subsequently withdrew her allegation.

- 2.3.3 In July 2011 Elaine was the victim of common assault from a female at her child's school. Elaine did not wish to substantiate her allegation or support further police action, and the case received No Further Action.
- 2.3.4 On 3 September 2013 Elaine was arrested for stealing food from a newsagents and issued with a Fixed Penalty Notice. The police record stated she was 'in company with male'; this person was not one of the subjects of this review.
- 2.3.5 Setting aside the above, Elaine was primarily known to the police as a victim of domestic abuse from Michael: there were fourteen recorded domestic incidents between Elaine and Michael in the three-year time period covered by this review.
- 2.3.6 The first incident reported by Elaine regarding Michael was on 1 January 2012. Elaine stated Michael had assaulted her, however as she denied they were in a relationship it was not flagged as domestic abuse. Elaine did not wish to support an allegation and the case received No Further Action.
- 2.3.7 In 2012 there were four incidents involving Michael in February, June, October and December, where Elaine or a neighbour called the police, and each time Elaine declined to support any prosecution. On two occasions Michael was arrested, and in one the case was referred to the Crown Prosecution Service (CPS). All cases resulted in no further action or involved no offences.
- 2.3.8 After the first incident, the IMR notes that Elaine "declined a MARAC referral", suggesting that the officer involved did not understand the Multi-Agency Risk Assessment Conference (MARAC)² process, where a referral can be made without the consent of the victim, if the risk is identified as sufficiently high.
- 2.3.9 Following the second incident the attending police officer completed a Domestic Abuse Stalking Harassment and Honour-Based Abuse (ACPO-CAADA DASH) risk identification checklist with Elaine, and she was assessed as standard risk. It is not clear if any action was taken as a result of this assessment.
- 2.3.10 The IMR notes that there is no evidence of history checks being completed for these offences.
- 2.3.11 In 2013 there were eight incidents between Elaine and Michael reported to the police:
- (a) 18 March: Elaine provided a statement and supported the prosecution; despite this the CPS judged there to be no realistic prospect of conviction. Elaine was offered support but declined, saying she would seek GP assistance in relation to her alcohol issues.

² A multi-agency forum made up of key local organisations – statutory and voluntary sector – for the purpose of information sharing, and safety planning, for high-risk victims. More information available at: <http://www.safelives.org.uk/practice-support/resources-marac-meetings>
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- (b) 4 April: Elaine did not support an allegation; Michael was arrested, and the case put to the CPS who advised no further action. Elaine was referred to the Independent Domestic Violence Advocacy (IDVA) service³.
 - (c) 5 May: Police received an abandoned call from Michael's address. When they attended, Michael said he wanted Elaine out of his flat, and she left; no offences were disclosed, and a domestic abuse support services leaflet was provided to Michael.
 - (d) 22 May: Police received an abandoned call from Michael's address, in which a female was heard saying "stop hitting me". No offences were disclosed and the record shows that both refused to answer DASH questions. A Community Safety Unit Officer contacted Elaine afterwards to offer support information, and Elaine declined.
 - (e) 20 June: An allegation of assault was made against Elaine by Michael and a female friend, for which Elaine was prosecuted, and found not guilty at court as no evidence was offered.
 - (f) 26 October: a Policy Community Support Officer witnessed Michael grab Elaine by the throat. Elaine provided a statement; Michael was convicted and in February 2014 was sentenced to one month in prison. (Michael was imprisoned from February to May 2014 due to a sentence for other offences.) From the date of this offence until going to prison he had bail conditions not to contact Elaine. A MARAC referral was made, and the case discussed at the MARAC meeting on 13 November 2011 (see below).
 - (g) 24 November: Police attended Michael's flat, a female believed to be Elaine gave false names, and no offences were recorded. Elaine later denied to a Community Safety Unit Officer that she was involved.
- 2.3.12 On 7 May 2014 Elaine called the police stating Michael had assaulted her (this was five days after Michael had been released from prison following his sentence for the incident on 26 October 2013). Michael was arrested and charged, and remanded in custody. Elaine supported the prosecution. Michael pleaded guilty in May 2014 and was sentenced to eight weeks in prison, suspended for 12 months.
- 2.3.13 On 27 May 2014 a neighbour called Police to Michael's flat as they heard screaming. Police found Elaine hiding under a bed. She stated she was hiding, as she knew of Michael's bail conditions following the incident of 7 May. No arrest was made, as, despite this being a breach of Michael's bail conditions – it was recorded – it was Elaine who had attended Michael's flat. Elaine was

³ Specialist domestic violence and abuse support service for medium and high risk victims; in this case provided by Advance / Hestia (see below)
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warned that if she attended again she could be arrested for a potential breach of the peace.

2.4 Independent Domestic Violence Advocacy Service (Advance / Hestia)

- 2.4.1 Throughout the time that Elaine was a client of the Independent Domestic Violence Advocacy (IDVA) Service – April 2013 to May 2014 – the service was delivered by the charity Advance. Shortly before this DHR commenced the IDVA service had been re-commissioned and the new provider, Hestia, therefore compiled the IMR, with the support of Advance.
- 2.4.2 The IMR outlines that the IDVA attempted to engage with Elaine on a number of occasions, having received referrals from the Police, the first of which followed the incident of 4 April 2013. The referral was received by the IDVA service on the following day, and contact was made with Elaine immediately.
- 2.4.3 Safety planning was provided to Elaine. Elaine requested support to seek refuge accommodation, and a number of refuges were contacted over the subsequent days. Elaine was offered a space at a refuge out of London, which she declined as it was “too far away”. The IDVA continued to seek provision, however Elaine did not respond to the contacts made.
- 2.4.4 From this point on the IDVA was not successful in contacting Elaine, and as a result made a ‘professional judgement’ referral to the MARAC⁴. This was heard on 1 May 2013, and the action for the IDVA was to feed back the outcome of the meeting to Elaine. Contact was achieved two weeks later, and Elaine disclosed she was now sleeping rough “at a friend’s” and she was advised to present herself at the Homeless Person’s Unit (London Borough of Brent).
- 2.4.5 There was an unsuccessful attempt to contact Elaine on 30 May 2013, and another, successful, contact made on 4 July 2013. During this contact Elaine stated she had been assaulted by Michael again (19 June 2013) but had not reported this to the police. The record stated that she was advised again to contact the Homeless Person’s Unit, and support was provided.
- 2.4.6 On 8 July 2013 the IDVA made a referral to the MARAC based on the repeat incident⁵ disclosed by Elaine and also on professional judgement due to Elaine’s vulnerabilities, particularly alcohol addiction and homelessness. The MARAC

⁴ Referrals to MARAC are usually based on the DASH Risk Identification Checklist, with victims being referred if they score a certain number of ticks on the checklist. However, professionals are encouraged to also use their professional judgement to assess whether a victim is at high risk and should therefore be referred to the MARAC.

⁵ Definition of ‘repeat’: a case that has been referred to a MARAC, and at some point in the next 12 months (from the date of the last referral) a further incident is identified. Any agency may identify this further incident (regardless of whether it has been reported to the police). A further incident includes any one of the following types of behaviour, which, if reported to the police, would constitute criminal behaviour: Violence or threats of violence to the victim (including threats against property); or, a pattern of stalking or harassment; or, rape or sexual abuse.

meeting took place on 24 July; at the meeting the police shared that Elaine had been accused of attacking Michael (20 June 2013), and as a result the action for the IDVA was to refer Elaine 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 on 14 August, however Elaine did not attend.

- 2.4.7 On 17 October the IDVA attempted contact again, to discuss the Minerva referral and to “complete closing call”. Contact was achieved on 23 October: Elaine was still homeless but “not as a result of domestic violence”. There was no police action or pending criminal justice processes, and Elaine was signposted to Shelter and the case was closed.
- 2.4.8 The IDVA service re-opened the case on 31 October 2013 due to a new MARAC referral from the Police (on the basis of repeat incident and escalation, following the incident of 26 October). The IDVA attempted contact that day, and then on 5 November, 3 December, 20 December, 17 January and 22 January 2014. The case was closed on the 14 March with contact not having been achieved. The MARAC meeting was held on 13 November (see below), with an action for the IDVA service to update Elaine on the outcome of the meeting, which was not achieved due to the inability to reach her.
- 2.4.9 On 12 May 2014, the case was re-opened again by the IDVA service due to a referral from the Police, following the assault by Michael on 7 May 2014. Elaine was contacted the same day. A risk assessment was completed, and a referral made to MARAC (due to score of 16 meeting MARAC high risk threshold). The record stated that safety planning advice was provided to Elaine, and she was encouraged to approach housing.
- 2.4.10 On 14 May 2014 it was noted that Elaine was provided with emotional support, as she called with concerns that, following the assault of 7 May, Michael was calling her from prison, and that she would need to attend court on 16 May as Michael had told her he would plead not guilty.
- 2.4.11 On 16 May 2014 the IDVA spent time chasing the Housing Department (Elaine having attended on 13 May). Elaine had been advised she did not have priority need, but due to the domestic abuse she may be provided with emergency accommodation. The IDVA noted that Elaine was reluctant to do that, and would stay with a friend and approach housing on the Monday, 19 May. The IDVA made phone contact on that day, and Elaine confirmed she was doing this.
- 2.4.12 On 21 May the IDVA made contact with Elaine and she was advised of the MARAC referral. Elaine stated she had been to housing and would be placed in B&B until suitable accommodation was found. The IDVA was unable to contact Elaine on 22 May and this was the last time contact was attempted. (NB the final MARAC meeting took place after Elaine’s death.)

2.5 Multi-Agency Risk Assessment Conference (MARAC)

- 2.5.1 The Police Detective Inspector for the Community Safety Unit chairs the MARAC in Brent. At the time that Elaine was referred, Standing Together Against Domestic Violence⁶ provided the coordination and administration; it is now provided by Hestia.
- 2.5.2 Elaine was referred to the MARAC on four separate occasions, and three discussions were held: 1 May 2013, 24 July 2013 and 13 November 2013. Elaine died before the fourth meeting took place on 2 June 2014.
- 2.5.3 The first referral was from the IDVA service based on professional judgement; in addition there was a referral from Addaction, also based on professional judgement. The next three referrals were from Advance and/or the Police, following repeat incidents reported to them by Elaine.
- 2.5.4 All referrals involved Michael as the perpetrator.
- 2.5.5 First meeting: information was shared by the IDVA service, Police, Addaction, Probation and Child and Family Services. There were actions set out in relation to Elaine's child, and one for Addaction to work with CRI to re-engage Elaine in services. Addaction fed back to the MARAC Coordinator that Elaine's key worker had "closed her file as a mutually agreed planned exit as [Elaine] stated she did not want to engage. With this in mind they will not refer for re-engagement."
- 2.5.6 Second meeting: New information was shared by the IDVA with regard to the alleged assault reported to them by Elaine (19 June 2013), and also that Elaine had been sleeping rough. The police provided information relating to an incident where Elaine assaulted Michael and a woman (20 June 2013). As a result of this, Elaine was referred to Minerva (see above). This was the only new action. An action was given for the IDVA service to feedback to Elaine on the meeting, which they were unable to do, as they could not reach her.
- 2.5.7 Third meeting: no new information was shared from most agencies, as Elaine was not engaging with them; information was provided by the Police that, following an incident of abuse by Michael on 26 October 2013, and bail conditions that he must not contact Elaine, she was staying at the home of a male friend. The meeting heard that the male friend was also a MARAC repeat perpetrator, and there was concern that he had been served with an eviction notice, which made Elaine's residence with him problematic. An action was given to the Police to raise the issue of Elaine's living with the male friend but it is not clear what the outcome of this action was.
- 2.5.8 An action was given for the IDVA service to feedback to Elaine on the meeting, which they were unable to do, as they could not reach her. There were no other actions.

⁶ This is a separate part of Standing Together's service delivery, distinct from the Associate DHR Chairs.
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2.6 London Borough of Brent Housing Needs Department

- 2.6.1 Brent Housing Needs Department's first contact with Elaine came when she applied to join Brent's Housing Register (waiting list) for social housing in October 2008. Due to the shortage of social housing available average waiting times for family sized accommodation was, and is, many years. The approach address given was Andrew's, although this approach occurs three years prior to their separation.
- 2.6.2 On 30 November 2012 she submitted a change of circumstance form in relation to the housing register. The form stated Elaine had mental health (depression) and alcohol dependence vulnerabilities brought on by living conditions, with the following quote from Elaine: "I am sharing a studio flat with a male friend." It stated that she had a support worker at Addaction.
- 2.6.3 In January 2013 Elaine submitted a change of circumstance form that removed her child from her housing register application; she was informed that as a result, she may not satisfy the priority need test as defined by housing legislation. At this time she also changed her approach address to Michael's address.
- 2.6.4 At that time she also informed the council that she was street homeless, and was advised to visit a Single Homeless Surgery at Cricklewood Homeless Concern (now Ashford Place). Ashford Place checked their records and had no record of Elaine attending. However, they did state that LB Brent ran a housing advice service there at that time and it may be possible that Elaine attended that. Ashford Place did not keep records of attendance at those surgeries.
- 2.6.5 On 7 May 2014 Elaine attended to make a homelessness application. She stated she had lost her last settled accommodation with a 'friend', giving Elijah's address, due to her drinking problem. She also stated that she had mental health problems, and was issued with a medical assessment form. A letter was recorded on the Housing system from Elijah, stating that Elaine was a good friend of his but that she could no longer live with him.
- 2.6.6 Elaine signed the section on the Brent Rehousing Form that stated: "There are medical factors which may affect the type of accommodation offered to me or my household. I have been issued with a medical assessment form to complete" and "I am not at risk of violence in any specific areas".
- 2.6.7 On 12 May 2014 the Housing Department also received a letter from the IDVA service in support of Elaine, outlining that she was fleeing Michael's address, and the risk assessment showed her to be at high risk of domestic violence.
- 2.6.8 Elaine attended Housing again on 13 May 2014 with the completed forms.
- 2.6.9 The application was rejected as no priority was identified. The Housing Department emailed the IDVA service to inform them of this, and to advise Elaine to seek emergency accommodation.

- 2.6.10 On 16 May 2014 Elaine re-approached Housing, and was seen by a Housing caseworker. Copies of all documents were taken, and Elaine was advised to attend the next day for further assessment and possible placement in temporary accommodation.
- 2.6.11 Elaine attended the next day (17 May) and was told the caseworker was fully booked and could not meet her; Elaine left, and the IDVA emailed Housing to state that Elaine was upset, and to ask what the next action would be.
- 2.6.12 On 21 May 2014 Elaine returned to Housing. Emergency accommodation was authorised for seven days, and there was a discussion on the prospect of Elaine securing accommodation through a private landlord.
- 2.6.13 On 13 June 2014 this second homeless application was rejected as 'Not Priority'. A letter confirming this decision was issued and posted to Elaine, and a £150 Single Homeless Voucher also issued to Elaine to assist her to secure alternative accommodation in the private rental sector (PRS). Unfortunately by this time Elaine had died.

2.7 Victim Support

- 2.7.1 Elaine was referred to Victim Support on five occasions through the automated referral system from the Metropolitan Police Service.
- 2.7.2 Victim Support spoke with Elaine following the referral made when she reported being a victim of harassment from her ex-partner (Andrew), on 8 July 2011. Elaine declined further support in this initial call and in a subsequent one a week later. Elaine also declined support when contacted following the referral for an incident on 27 July 2011 (in which Elaine was allegedly assaulted by a neighbour).
- 2.7.3 On 1 January 2012 (following a referral for the incident in which Michael allegedly assaulted Elaine) Victim Support were unable to reach Elaine on the phone. As the suspect was detailed as a 'friend' (and so not domestic abuse), a letter was sent.
- 2.7.4 For the two further referrals, both following alleged assault by Michael (25 December 2012 and 4 April 2013) Victim Support were unable to reach Elaine. On the first occasion the number was incorrect, and there was an unsuccessful attempt to contact the Police to gain a correct number. On the second, there was no answer after a number of attempts, and so the Police were informed.

2.8 General Practice (GP)

- 2.8.1 Elaine had extensive contact with her GP within the Terms of Reference timeframe, and it 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.

- 2.8.2 Between May 2011 and May 2014 (three years), Elaine had twenty-five appointments or telephone calls with the General Practice (most often with a Doctor or occasionally a nurse). She did not attend (with no reason given) on eight further occasions; on two separate occasions prescriptions were destroyed after Elaine did not collect them (one for contraception and one for anti-depressants). In this time she saw ten different doctors.
- 2.8.3 The first significant event in the timeline is when Elaine attended the GP stating she was pregnant, on 13 September 2011. The pregnancy was recorded as 'gravidia 4', which meant it was her fourth pregnancy. A previous miscarriage was also noted. The GP recorded that Elaine "has been more emotional therefore keep with antidepressants".
- 2.8.4 Less than two months later, on 4 November 2011, Elaine attended to request a termination of pregnancy. She was at that time thirteen weeks pregnant. The GP recorded that Elaine was "very low, very tearful" and there was a "close friend present" – with no further details. The GP recorded that Elaine "definitely wants to terminate this pregnancy – very stressed as marital relation has broken down".
- 2.8.5 At this appointment the GP also recorded a 'review' of Elaine's diagnosis and treatment for "depressive disorder". It was noted that Elaine's child had been taken into the custody of her ex-husband, and that Elaine was working with Addaction (she was apparently drinking 4-5 cans of beer per day) and "feels very down and depressed, poor sleep, paroxetine [anti-depressant] not working". A new anti-depressant was prescribed (Mirtazapine), and a referral made to IAPT⁷.
- 2.8.6 Three days later a note was added to the GP's system that IAPT had telephoned to inform the GP they would be sending a letter returning the referral, "saying that Addaction is best place for patient to get counselling help while drinking" and that they had "checked with Addaction and they provide counselling".
- 2.8.7 On 9 November 2011 a note was added to the GP's system that Elaine was "seen in casualty". This was discussed in the appointment (below) on 11 November; there is no record of any enquiry being made as to how the injury occurred.
- 2.8.8 On 11 November 2011 Elaine attended for a 'review' following her previous appointment requesting a termination. She confirmed that the termination took place the day before. The following was recorded by the GP:
- (a) "low depressed and still alcohol smell, not having access to [child], SS [social services] involved, also doing better re alcohol reduction, relation[ship]"

⁷ 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.

destroyed by partner according to her - admits heavy drinker, broken collar bone yesterday seen on hospital already for this and has sling/support”

- (b) “in tears here, presentable though, says needs to get her life back so can fight to get access to [child] (at moment with father)”
- (c) “had TOP [termination of pregnancy] yesterday, lost script/medicine with bag yesterday, long chat re MUST ADDRESS THE ALCOHOL ISSUE VIA ADDACTION, THEY HAVE CONFIRMED WILL PROVIDE COUNSELLING TOO, METRONIDAZOLE [antibiotic] SHOULD NOT BE TAKEN WITH ALCOHOL AS SERIOUS SIDE EFFECTS INTERACTION, CALL back/go to hospital if any new concerns” [NB: capitals in original]
- 2.8.9 On 18 November 2011 a letter from the Perinatal Psychiatric Team was added to the system informing the GP that, following a midwife referral to the Team, Elaine had cancelled her appointment stating she was no longer pregnant.
- 2.8.10 Elaine attended the surgery again in February 2012, when she had discussions with the Surgery Nurse and GP about long lasting contraception. She also discussed her ‘alcohol problem drinking’ and stated she was having counselling at Addaction. At the end of February she reported that her mood was better on the new anti-depressant (Mirtazapine, first recorded as being prescribed 4 November 2011, repeat prescription made at the February appointment), and that there was “no alcohol intake”.
- 2.8.11 Elaine next attended for another ‘alcohol problem drinking review’ on 2 May 2012. She was recorded as “doing well, learning courses of IT with Learn Direct ... SEEING [CHILD] TWICE A WEEK, has stopped going to Addaction as was not happy with their procedure, trying herself to cut down alcohol (although still drinking 20units of lager/d!) ... warn that still above limit and really need to work hard to stop drinking”. Elaine was prescribed Lorazepam, a treatment for anxiety disorders; this was the only time she was prescribed this medication.
- 2.8.12 At the next ‘alcohol problem drinking review’ on 29 June 2012, Elaine informed the GP that she was due to enter rehab for a twelve-week programme. The GP gave Elaine a further prescription for Mirtazapine.
- 2.8.13 During a phone call on 6 September, Elaine informed the GP that the rehab had not been “particularly successful”. Elaine also asked for counselling again during this phone call, and attended the surgery the next day for a full appointment with the GP.
- 2.8.14 This appointment (7 September) was recorded as “Low mood – first”, rather than as a review of the “depressive disorder” noted above. Elaine was recorded as saying “for a year feel bad – needs counselling ... history she says that – she is missing her [child] who now lives with father – and drinks a bit more than normal”. The GP referred Elaine to IAPT, and gave her a prescription for Fluoxetine (also known as Prozac), a different anti-depressant. There is no

record as to why the prescription was changed, or whether this was prescribed in place of, or in addition to, the Mirtazapine. It is not clear from the notes whether the GP she saw at this appointment was aware of her alcohol use or depression, as reported in previous appointments.

- 2.8.15 On 12 November 2012 Elaine attended with a mouth ulcer and was given treatment. Elaine attended a follow up appointment for this on 14 November and it was noted that Elaine “feels low run down but denies clinical depression no thoughts plans self-harm or harming others”. At this appointment, there was also a review of her “depressive disorder”, where it was noted that she had “low mood and run down lately; well done abstinent of alcohol recently as strong advice medication not good with alcohol”. A repeat prescription was given of the anti-depressant Fluoxetine.
- 2.8.16 Elaine telephoned the surgery on 22 January 2013 to report she had a black eye, and was given an appointment. The GP she then saw (different to the one she spoke to on the phone) recorded the appointment as “Low mood – new” (for the second time) and noted that Elaine had fallen over and got a black eye, and also had a sore throat, was unable to sleep and was stressed. It was noted that Elaine was “due for counselling”, and she was advised to “stop the Fluoxetine and take Mirtazapine as this helps with sleeping well”. Mirtazapine is prescribed. There is no record of the GP enquiring further as to how the black eye had occurred.
- 2.8.17 A week later (29 January) Elaine called the surgery and reported she did not like the Mirtazapine, and requested Prozac (Fluoxetine), and this was prescribed.
- 2.8.18 In February 2013 she attended the surgery to see the nurse, who carried out a routine smear test, with the results posted to Elaine two weeks later.
- 2.8.19 Elaine attended again on 31 May 2013, for reviews of her “depressive disorder” and “alcohol problem drinking”. Within the “depressive disorder” record it was only noted that a new statement had been issued that Elaine was not fit for work, with a diagnosis of depression.
- 2.8.20 Within the “alcohol problem drinking” record, the following was noted: “came for sick note; has meeting with social worker this afternoon; homeless, living on street, begging for money; hopefully today will have something will be sorted out for her accommodation, still drinking, having counselling and attending Addaction as well; miss her [child] who is 7 now and living with ... dad; feels very low and down; taking Prozac 20 mg, asking if can be changed as does not seem to working ... unkempt, smell of alcohol, tearful”. The dose of Fluoxetine was increased.
- 2.8.21 On 2 July 2013 a GP attempted to call Elaine, and there was no answer.
- 2.8.22 On 5 August 2013 Elaine attended an appointment recorded as “Polymenorrhoea – first” (this is the name given when a woman menstruates

more frequently than the average). At this appointment Elaine stated that both her mother and aunt had had ovarian cancer. A number of referrals were made for tests, and the majority of the records in the three months following this were related to those referrals and tests, up to October 2013 when a referral was made to Imperial College NHS Trust (see further information below).

- 2.8.23 The condition was discussed briefly when Elaine attended for a different complaint on 11 October 2013, recorded as “Spots – first”.
- 2.8.24 Elaine’s “depressive disorder” was reviewed with her again on 19 November 2013, with the following recorded: “Long history of depression – used to be on mirtazapine and prefers as it helped with sleep (patient believes it was changed to Fluoxetine by Dr and not at her request and denies any previous problems with mirtazapine). No longer finds fluoxetine helpful for her mood.” Mirtazapine was prescribed. At this appointment there was also a record for “Acne vulgaris – first”, at which the diagnosis and treatment provided at the previous appointment (11 October) was discussed.
- 2.8.25 On 17 January 2014 Elaine was seen by the GP for an “alcohol problem drinking” review. The record states “tired tearful – had detox appointment 14 February and also gynae[cological] OPD [outpatient department] booked for menorrhagia – not doing well”.
- 2.8.26 On 11 April 2014 the GP received a letter from the Consultant Gynaecologist that Elaine had not attended for the procedure for which she had been referred, and when spoken with by the Nurse Practitioner, had declined to attend any further appointments. (See information from Imperial College NHS Trust below). There is no record of any follow up in response to this letter.
- 2.8.27 On 22 April 2014 Elaine telephoned the surgery to ask for medication, stating that she was “weaning off from Fluoxetine, as wants to go back to Mirtazapine”. Fluoxetine was prescribed.
- 2.8.28 This was the last time Elaine had contact with the surgery.

2.9 Imperial College NHS Trust

- 2.9.1 Imperial College’s involvement with Elaine related to a referral received from Elaine’s GP on 15 October 2013, for Elaine to undergo a routine gynaecological procedure (Hysteroscopy and Endometrial Biopsy). This was in response to the Polymenorrhoea Elaine reported to her GP in August 2013 (see above).
- 2.9.2 Elaine attended an appointment with the Nurse in the Pre-Assessment Clinic on 4 December 2013. Elaine was recorded in the notes as having attended with her partner, and that both smelled strongly of alcohol. It was also noted that Elaine was tearful and emotional at the appointment. The name of the ‘partner’ was not recorded.

- 2.9.3 Elaine stated that she had no relatives (except her child) and that her next of kin was Michael, who she referred to as 'a good friend'.
- 2.9.4 The box for 'history of depression' was ticked in the notes; also that Elaine reported drinking between four and six pints per day.
- 2.9.5 The IMR states that there was no record of any domestic abuse/violence or evidence that this was discussed or considered during the appointment.
- 2.9.6 On 11 February 2014 Elaine attended the Day Surgery Unit for the planned procedure. However, as she had no one to take her home, it was not appropriate for her to have a general anaesthetic (this is standard Hospital procedure). The procedure was attempted under local anaesthetic but Elaine was unable to tolerate it and the procedure was abandoned. A letter was sent to Elaine's GP to inform them of this.
- 2.9.7 The procedure was rescheduled for 25 February 2014, and Elaine did not attend. It was scheduled again for 11 March 2014, and again Elaine did not attend. Following this a Nurse spoke to Elaine, who declined to come in for the procedure. A letter was sent (11 April) to Elaine's GP with this information.
- 2.9.8 There was no further contact with Elaine.
- 2.9.9 Further to the information provided by CNWL (see below) regarding Elaine's referral to the Perinatal Psychiatry Team, Imperial tried to find records of Elaine attending midwifery services (as the referral came from a midwife). Unfortunately no records were found.

2.10 Central and North West London NHS Trust (CNWL)

- 2.10.1 CNWL's initial contact with Elaine fell outside of the Terms of Reference time period, in 1996 (when Elaine was 24). It related to a referral from her GP to the mental health service requesting counselling for Elaine. It referred to a supportive boyfriend, 'A'. It also mentioned that Elaine's mother had collapsed and died in front of her the previous year that they had been very close and Elaine had no other family (she had never met her father).
- 2.10.2 On her assessment form, Elaine stated that over the previous 18 months, her confidence had dropped, she felt she had changed and had become nervous and quiet. She referred to being prescribed anti-depressants by the GP; and said she wanted to gain a sense of wellbeing.
- 2.10.3 At her first appointment, Elaine stated she had had a difficult life with her mother, who was an alcoholic with several other problems (these are not noted specifically), and Elaine helped her a lot of the time.
- 2.10.4 At the second appointment it was noted that she seemed much better, and was willing to find a job.

- 2.10.5 Elaine attended one further appointment, where she informed the psychologist that she had ‘started to face life’ and had improved a great deal; also that she had found an ‘assertiveness course’.
- 2.10.6 After failing to attend the next two appointments, Elaine was discharged and a letter sent to her GP. The letter stated that Elaine had “unresolved bereavement issues and could not face work or life in general, although the assertiveness course helped Elaine recover quite quickly”.
- 2.10.7 CNWL’s next contact with Elaine was November 2011, with a letter from the Locum Consultant in Perinatal Psychiatry at St Mary’s Hospital to Elaine’s GP, stating that Elaine’s midwife had referred her to the Perinatal Psychiatry Outpatient Clinic for an assessment of her mood. An appointment had been offered, but Elaine had cancelled this stating that she was no longer pregnant (see information from GP section above with regard to Elaine’s pregnancy and termination in 2011).
- 2.10.8 Elaine’s GP referred her to the IAPT service on 4 November 2011. Elaine was not seen or spoken to on this occasion: the referral was screened and it was deemed that problem drinking was her primary problem, and the service therefore advised her GP to refer Elaine to Addaction to address this; it was also confirmed that Elaine could access counselling via Addaction.
- 2.10.9 A different GP referred Elaine to IAPT again on 7 September 2012. Although the screening identified that Elaine was still drinking and engaged with Addaction, she was allocated for an assessment. This took place via telephone on 15 November 2012 (Elaine having missed the previously arranged appointment on 6 November). During this assessment Elaine disclosed family and relationship difficulties for which she wanted psychological help; she also mentioned her child as a protective factor, although Elaine stated she only saw the child twice a week following social services intervention.
- 2.10.10 Elaine was offered counselling sessions, however due to a long waiting list the appointments were not made until March 2013 (four months after the assessment). Of the four appointments made, Elaine attended one. The counsellor therefore discharged her back to her GP, informing them that they felt Elaine’s drinking might be the cause of her missed sessions. There was no further contact.

2.11 Addaction

- 2.11.1 Elaine was first referred to Addaction in October 2011 by Children’s Social Care.
- 2.11.2 At her first appointment on 10 October 2011 Elaine was recorded as having stated that:
- (a) She had an issue with alcohol, and had started to use alcohol when she was around 17 years old, when her mother died to whom she had been very close.

Elaine also states that it was at that time she was first prescribed anti-depressants, which she was still taking.

- (b) She had no housing problems, no legal issues, and no mental or physical issues. (There is no note of a query in relation to this and her disclosure that she takes anti-depressants.)
 - (c) She was drinking around 20 cans a week, and drinks because she is bored.
 - (d) She had a five-year-old child who lived with her; but that the child had a Child Protection Plan with social services and there is a “child protection case against her” that she would find the result of shortly, after social services (following a number of incidents / reports) had “taken her daughter away”.
- 2.11.3 Two days after this initial appointment, the Support Worker spoke with the allocated Social Worker and was provided with further information on the incidents that led to their involvement, contradicting some of what Elaine stated.
- 2.11.4 Elaine missed her second appointment, and attended the next, on 25 October 2011. Elaine disclosed that her child had been removed from her, and put into the care of the child’s father; and that she felt the Social Worker was “very rude to her”. Elaine also stated that she felt the child’s father did not provide a safe home for the child, and also that he had been abusive to Elaine in the past in front of the child.
- 2.11.5 When Elaine attended the next day for ‘alcohol group’ she reported having been asked to attend the Police Station due to a report from someone at the school that they had seen Elaine hitting her child, which Elaine denied. The Support Worker gave Elaine the number for a solicitor, and she arranged a meeting.
- 2.11.6 When she next attended on 1 November 2011, Elaine reported having been arrested for the incident referred to above. Elaine also stated that she “didn’t know what was going on with her access rights”. On the same day the Social Worker called the Support Worker to find out how often Elaine had attended, as there were discrepancies with what Elaine had reported to the Police: she had told them she had attended Addaction “five times last week” which was not the case. The Social Worker asked the Support Worker to keep in touch.
- 2.11.7 On 2 November 2011 Elaine attended the group session and the record stated she was upset that “her daughter had been taken away by social services”.
- 2.11.8 On 9 November 2011 Elaine called to state she would not be at the group session because she had slipped and broken her collarbone. She also stated that she had had a termination on the Monday.
- 2.11.9 On 14 November 2011 Elaine attended her keywork session, and stated that she was still concerned with regard to the situation with her daughter; that she had had a termination the previous Monday and was not feeling well, and that her doctor had stopped her anti-depressants and she was experiencing withdrawal.

- 2.11.10 A week later on 22 November 2011 Elaine attended and stated that she was “doing quite well” and was happy as the Police were not pursuing charges against her. She reported that a new Social Worker had been allocated and that she “feels she is kept out of the loop”. The Support Worker agreed to follow up with social care to identify the new Worker; this was done, with a record of this on the system for 30 November 2011, but the content of the update is not recorded.
- 2.11.11 On 6 December 2011 Elaine spoke with a different Support Worker about her concerns over her property, as she was worried about an eviction notice. The Support Worker helped Elaine to set up an appointment with PCHA (Housing Association). The next day Elaine was very upset about this at the group session and was asked to leave until she could calm down.
- 2.11.12 For the following group session on 14 December 2011 the record states that Elaine worked well and seemed calmer.
- 2.11.13 The Support Worker spoke with Elaine on 28 December 2011, and Elaine stated that she had a good solicitor, and that she was “ready now to stop and has had enough of drinking”.
- 2.11.14 It was noted on 4 January 2012 that Elaine had worked well in the group again, and again there is a record of Elaine feeling good about her solicitor who had managed to gain her some access to her daughter. She also referred to concerns over utility bill debts, which the Support Worker offered to help identify. However on 11 January 2012 Elaine attended the group session again concerned about being evicted as her landlord was visiting her flat.
- 2.11.15 At her next appointment on 16 January 2012 Elaine is noted as looking well and being optimistic about the future. This was reiterated on 23 January 2012 when Elaine stated she was “doing really well” and discussed starting some voluntary work. The Support Worker noted, “All in all Elaine is feeling very positive”.
- 2.11.16 On 1 February 2012 Elaine was again noted as being in “good spirits”; she was due to start voluntary work, and was waiting for counselling sessions to begin at EACH (alcohol and drug advice and counselling service).
- 2.11.17 On 20 February 2012 Elaine told the Support Worker that she was upset as she had only seen her daughter for a short time the previous week, and that with her solicitor she was going to write to social services. She also mentioned a concern over being evicted, though she wasn’t sure what was happening. On 27 February 2012 she is recorded as stating she was not going to be evicted, and that “things are good with her [child]”.
- 2.11.18 On 5 March 2012 the Support Worker received an email from the Social Worker providing information on an incident in which Elaine called the police after she had been assaulted by Michael. The Social Worker asked the Support Worker to

confirm if Elaine had been having regular alcohol breathalyser tests and informed them of the new Social Worker's contact details.

- 2.11.19 On the same day, Elaine attended her session with the Support Worker. She is recorded as having been upset, and showed the Support Worker abusive text messages on her phone from "her partner". Elaine stated "that she didn't get to see her [child] over the weekend. Elaine states what else she has to do, as she is engaging at Addaction, is attending EACH and has started her voluntary work. Elaine stated that she felt everyone is against her and that her partner has got everyone wrapped round his finger. Elaine also stated that she is glad [previous Social Worker] has gone as she seemed to turn a blind eye on her partner's behaviour." Although this refers to a 'partner' it is not clear to whom this refers, as it would have most likely been Andrew, her ex-partner, involved with social services. The Support Worker spoke with the new Social Worker to find out what was happening and was promised an update, however if this was received it was not recorded.
- 2.11.20 On 10 March 2012 Elaine called to rearrange her key work session. She was in the park with her daughter and stated she was doing well.
- 2.11.21 On 20 March 2012 Elaine saw the Support Worker and stated "her partner assaulted her outside the school, teachers saw everything" [As above, it is not clear who the 'partner' was]. This did not appear to have been reported to the Police. Elaine stated that she was "ok now but is really getting down as no-one is listening to her". Said that she had spoken to the Social Worker about getting a schedule of access to see her child.
- 2.11.22 During her session on 27 March 2012 Elaine received a text message and phone call from "her partner" (as recorded), Andrew. The Support Worker spoke with Andrew, who stated that Elaine was "a liar" and referred to Michael as Elaine's boyfriend and stated that Michael had "spat in [child's] face".
- 2.11.23 Elaine called the Support Worker on 30 March 2012 and stated that the Social Worker had "said that he has had enough of this case". The Support Worker noted that Elaine seemed to blame her drinking on her "partner's mental abuse". Elaine stated she "isn't going to get her daughter back and doesn't want to attend Addaction anymore." The Support Worker stated that it was her choice to attend, and that Elaine would need to come in to sign some paper work, and would have to speak to their manager about closing her case. Elaine was upset and emotional on the phone and the Support Worker suggested that she think about it over the weekend and let the Support Worker know what she wanted to do.
- 2.11.24 During the next contact on 2 April 2012 Elaine apologised for her behaviour and stated she was willing to be tested every day. She also reported having sent an access order to Andrew and was waiting for the reply.
- 2.11.25 On 3 April 2012 Elaine stated that the "whole situation is getting to her".

- 2.11.26 On 26 April Elaine reported “struggling a bit” but was “enjoying” attending EACH and was going to mediation through the solicitor. She also mentioned that there was a new Social Worker for the case.
- 2.11.27 On 4 May 2012 the Support Worker spoke with Elaine’s solicitor, who reported that Elaine was “not in a good way” and was drinking.
- 2.11.28 The Support Worker was next able to speak to Elaine on 11 June 2012, after two unsuccessful attempts in May. She stated that she was doing fine and had access to her daughter; that there was a conference the next day and that she may be taken off the child protection plan. Elaine stated that she had mediation but her partner did not turn up and that there was another Social Worker that the Support Worker was not aware of. Elaine stated that she was drinking but had reduced considerably. Elaine stated that she had stopped attending EACH because “all they talked about was death, and Elaine didn’t want to go over past issues she had with her mum and dad.” The Support Worker gave an update to social services.
- 2.11.29 The Support Worker tried a further three times to contact Elaine and was unable to reach her until 23 July 2012, when Elaine was discharged. It is not clear what the prompt for case closure was. On this day the Support Worker spoke to Elaine who stated that she was “only drinking 2 days a week, and is consuming 4 cans of Stella on each occasion. Elaine stated she was looking for a flat as housing benefit would be cutting her allowance. Elaine also stated that she is seeing her daughter, and had told social services that she didn’t mind getting tested at Addaction. The Support Worker told Elaine that “she has not engaged since April and that [the Support Worker] has not heard anything from “them [social services]”. The notes stated that Elaine “agreed that she doesn’t need support at the moment”, and the Support Worker told Elaine she was welcome to return to the service any time.
- 2.11.30 Elaine was re-referred to the service in October 2012. The referral was from social services, requesting that Elaine be tested (the frequency of tests is not given in the record).
- 2.11.31 At her (negative) test on 8 October 2012 Elaine discussed that she was concerned about her housing, and that she had viewed a property that was unsuitable.
- 2.11.32 On 11 October 2012 Elaine attended for testing, the results were negative. Elaine also spoke with START Plus⁸ to discuss her housing situation.

⁸ START Plus is the central referral team co-ordinating access to over 3,600 units of supported housing, floating support and moves on to independent accommodation in the London Borough of Brent, the service is specifically for those with additional needs such as drug and alcohol use
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- 2.11.33 The records from START Plus show the following: an Enquiry Form was completed by a START Plus officer based at Addaction. This was as part of a Housing Advice Surgery held weekly for clients receiving support from the drug and alcohol services. Elaine's Support Needs were identified as "alcohol issues" and she also made enquiries about benefits/housing and advocacy. Elaine was noted to be sofa surfing. Elaine was given advice and information about securing accommodation in the private rented sector. Elaine was not referred for accommodation based or floating support services and therefore a case was never opened. There was no further interaction with START Plus.
- 2.11.34 Elaine did not attend her next testing appointment (18 October 2012). She stated she had to see someone about housing.
- 2.11.35 Elaine attended for testing on 22 October 2012; no result is given in the notes. Elaine was recorded as having stated that she was looking to move to Watford but it fell through, as the landlord wanted £400. Elaine was recorded as having called START Plus who tried to negotiate but it was unsuccessful (however there is no record with START Plus that this took place).
- 2.11.36 The Support Worker attempted to call Elaine on 29 October 2012 as she had missed her test, but couldn't reach her.
- 2.11.37 Elaine attended for a test on 2 November 2012, the results were negative.
- 2.11.38 The test on 20 November 2012 was negative.
- 2.11.39 On 14 January 2013 the Support Worker received an email from the Social Worker asking about the drug and alcohol testing, and stating this should be twice weekly but does not appear to be taking place this often, The Social Worker informed the Support Worker that in the next case conference the case would be transferred to another Local Authority. The Support Worker replied with details of Elaine's attendance: that she had not engaged in key work sessions since 27 November (NB there are no notes relating to that session); and that she had only been tested twice since that date, on 4 and 11 December.
- 2.11.40 The Support Worker stated that Elaine had been very difficult to engage, and did not attend appointments. The Support Worker stated that Elaine had a key-work session arranged that Elaine had said she would attend. On 18 January 2013 the Social Worker emailed Addaction worker to find out if Elaine had attended but there is no record of a response (nor is there a record of Elaine attending an appointment on the day mentioned).
- 2.11.41 Elaine attended for her first key-work session with this Support Worker on 28 January 2013. Elaine mentioned not having a stable place to live, and that she had been without her own place since September 2012. At this appointment the Support Worker noted that Elaine was "insistent" she was only drinking every fortnight and that she "can handle it". Elaine referred to her child being transferred to another Local Authority and that she was meeting with the new

Social Services, to find out what they expect of her with regard to testing and any other requirements, and would let the Support Worker know.

- 2.11.42 The next contact recorded with Elaine is on 13 March 2013, when the Support Worker called Elaine. The record states that Elaine was very upset and in tears, saying “she is fed up with being homeless and was on her way to Ashford Road to see about housing - she says she has been sleeping rough for the last three days”. It was noted that Elaine was supposed to meet the Support Worker that morning but Elaine did not attend, and that they were supposed to attend the core group meeting for social services but the Support Worker did not attend as she did not have the address. This record is not clear in relation to who did not attend what.
- 2.11.43 On 19 March 2013 the Support Worker noted on the system “Elaine has not been engaging with any level of consistency – she has repeatedly missed appointments and not turned up for pre-arranged meetings with her keyworker. The Support Worker has spoken with the Manager and we agreed that we should discharge her and Support Worker spoke with Elaine this morning, who agreed she is not ready to engage but understands that we are more than happy to see her again should she wish to access treatment and engage properly in the future”. Her case is then closed.
- 2.11.44 This was relayed to the Social Worker on 27 March 2013 in an email. “I spoke with [Elaine] and she said she did not wish to continue to see (not see) Addaction at present – she said she wishes to concentrate on finding housing first and foremost – I made it quite clear that [Elaine] is more than welcome to come back and see us whenever she feels she can commit to treatment here. [Elaine] has always maintained to me that she has no issue with drink or drugs and all her tests have been negative. Until she feels ready to ask for help and engage there really is not a great deal we can do. [Elaine] is liked by the staff here and knows she can come back if she wishes. We will have to wait and see.”
- 2.11.45 The MARAC records show that an Addaction worker referred Elaine to MARAC on 18 April 2013, after her case had been closed. This was prompted by the Worker’s contact with Elaine’s ex-husband/partner Andrew, where information was disclosed about Michael’s abuse towards Elaine. There is no record on the Addaction system regarding this referral.

2.12 Information from Family / Friends (Elaine)

- 2.12.1 Unfortunately those contacted either declined to be part of the review, or did not respond (please see paragraph 2.7 above for details of what attempts were made).

2.13 Information relating to Elijah

- 2.13.1 At the time of Elaine's homicide, Elijah was either 55 or 60 years old (the former from his GP records, the latter from Police records). He is Black British.
- 2.13.2 Other than the information from the General Practice below, the only information available in relation to Elijah was from the Police and Housing. Housing records showed that he had been provided with a secure tenancy (social housing) in 1995 following a homelessness application. He was still residing in that property when the homicide occurred.
- 2.13.3 The Police information showed that Elijah had on two occasions been arrested and either cautioned or given a Penalty Notice for minor shoplifting offences (2012 and 2014). On one occasion in 2007 he had been given a Penalty Notice for disorderly behaviour or threatening/abusive/insulting words likely to cause harassment alarm or distress.

2.14 General Practice (GP) for Elijah

- 2.14.1 A chronology was received from Elijah's GP. This showed that Elijah had not attended the GP for two and a half years prior to the offence, and all of his attendances for many years prior to this had been for routine medical complaints.
- 2.14.2 Elijah was registered with his GP for over 40 years, and there was a period in the mid- to late-1990s when Elijah was attending for reasons related to depression and alcoholism (where it was noted he was attending Alcoholics Anonymous); there was a record of a deliberate overdose in 1998.
- 2.14.3 There was also a record from 1981 of a closed fracture caused by a self-harm incident in which Elijah jumped from a height.

2.15 Information from the Perpetrator

- 2.15.1 The perpetrator was interviewed in the prison in which he is held.
- 2.15.2 Elijah confirmed that he and Elaine had been friends since she started her relationship with Michael. Elijah stated that he had been friends with Michael for a long time, but that he had been trying to end that friendship due to Michael's violence when drinking.
- 2.15.3 Elijah and Elaine became good friends and would spend time together away from Michael. Elaine often sought help from Elijah, in particular staying with him when Michael was abusive.
- 2.15.4 Elaine was "a bit of a drinker" according to Elijah, and he said that she seemed unable to control her drinking. This was exacerbated by the fact that she was nearly always around other drinkers – Michael and others. Elijah also felt that her problems had been going on for a long time.
- 2.15.5 Elijah made the point that a significant issue for Elaine was that she didn't have anywhere of her own to stay, and so she had to stay with Michael. This annoyed

- Elijah, he said, because he often tried to help Elaine to leave but she would always go back.
- 2.15.6 One of the ways in which Elijah said that he tried to help Elaine, was to try to get her to stop drinking, particularly when she was due to have contact with her child. He also stated that he had helped Elaine to get a new mobile phone, to make contact with her child easier.
 - 2.15.7 In addition, Elijah stated that he would help Elaine to make appointments, and offer to go with her; but that when the appointment came she would not turn up, and he “knew” she was out drinking instead.
 - 2.15.8 Elijah called Elaine “insecure”, and said he thought this was because of the abuse she experienced from Michael. He witnessed verbal abuse from Michael towards Elaine, but not physical violence; Elijah felt that Michael “held back” from that as he knew that Elijah would intervene.
 - 2.15.9 Asked what he felt could have made a difference to Elaine’s life, Elijah said that someone would have had to take her “forcefully” to appointments, or go with her. She needed a partner who would support her, and she didn’t have that. The only other friends Elijah was aware of were also drinkers, or using drugs.
 - 2.15.10 Elijah was clear that Elaine and he were only friends; he confirmed that they had on one occasion had sex, but that they had agreed this was a mistake and remained friends after this. He called his murder of Elaine an “accident”, that he didn’t know why he had done it. He mentioned further that Elaine had in fact told him not to take the weapon.
 - 2.15.11 Although they were friends and not intimate partners, Elijah did refer to Elaine being possibly “scared” of him on the day of the homicide, before they went together to Michael’s home. Elijah stated that he believed that, on this occasion, Elaine had given him Tramadol to make him pass out because she was worried about his anger; and that this was something Elaine had mentioned giving to Michael when she felt he was going to be violent. Elijah didn’t think she had done this before with him.
 - 2.15.12 Overall the feedback from Elijah fitted with what was already known from the review: that Elaine had experienced extensive abuse from Michael; that she had a persistent problem with alcohol use that she was unable to change on her own – or at times even with help – and that her lack of contact with her daughter, and lack of stable home, had ongoing and significant impacts on her life.

2.16 Information relating to Michael

- 2.16.1 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.

2.17 London Community Rehabilitation Company (CRC, formerly Probation)

- 2.17.1 The London CRC had extensive contact with Michael, none with Elijah and a small amount with Elaine. However, during their contact with Michael there were many references to Elaine; these are outlined below.
- 2.17.2 From June 2011 to February 2012 Michael was within the supervision of an Offender Manager, as he had received a Suspended Sentence Order with an Unpaid Work Requirement of 200 hours. This was for two offences of harassment against two ex-partners. Although their relationship would have started at this time, no information relating to Elaine was noted.
- 2.17.3 In June 2013 Michael was given a Suspended Sentence Order with requirement for 12-months supervision by an Offender Manager and to comply with 25 days of Alcohol Treatment, provided by CRI, and a 16-week curfew. This was for offences of racially aggravated common assault against three individuals (non-domestic). Overall he engaged, but inconsistently, and often under the influence of alcohol.
- 2.17.4 In this period, information relating to Elaine first appeared during his initial appointment with Probation after receiving the sentence (19 August 2013). Michael stated that he was seeing someone called Helen; however at his next appointment, 10 days later, he stated that he was single.
- 2.17.5 On 16 October 2013, Michael attended Probation with Elaine. At this appointment, he implied that his current drinking was triggered by concern for Elaine, who – he stated – had been diagnosed with bowel cancer. Although there are no medical records suggesting that Elaine ever had a cancer diagnosis, this disclosure occurs at the same time that Elaine has been referred to the Hospital by the GP for polypenorrhoea related problems. This was reiterated on a number of occasions. During this order, Michael was arrested for assault of Elaine (23 October 2013) and given bail conditions not to contact her; four days later he attended Probation with Elaine for an appointment. A short time later he disclosed that Elaine was not living with him, due to the bail conditions.
- 2.17.6 On 22 January 2014 Michael informed Probation that at his trial for assault of Elaine, she was “vocal in court when giving evidence and was supporting him”.
- 2.17.7 In February 2014, following the activation of the suspended sentence order, Michael was in prison and spoke to the Prison Probation Officer, expressing his concern over his partner Elaine's ill health due to cancer, and having to attend hospital appointments. He wished to apply for early release on Home Detention Curfew (electronic tag) but was advised that due to previous offences he was ineligible.

2.18 CRI (Drug and Alcohol Support Service)

- 2.18.1 Michael's contact with CRI started in August 2013 following his sentence in June 2013 ordering him to undertake alcohol treatment order. Therefore the majority of information provided by CRI coincides with or replicates that from Probation. This includes his disclosures that his partner had been diagnosed with bowel cancer.
- 2.18.2 It was clear from the start of his engagement with CRI that staff were aware of his history of domestic abuse against Elaine – in the first record it was noted that he was unable to attend another setting as his partner was receiving a service there, and “there was a history of DV”.
- 2.18.3 On 28 October 2013 Michael attended CRI and reported that he had been attacked by two males, one of who was “his partners ex-partner”. It is not clear who this individual was. He also disclosed that on the day after this incident, he had been arrested for assaulting Elaine: he stated that she had assaulted him and he had retaliated, and it was this that was witnessed by the police. CRI were aware that Michael should not have contact with Elaine following this.
- 2.18.4 On 7 November 2013 a referral was recorded for Michael to attend alcohol groups at Addaction.
- 2.18.5 On 29 January 2014 Michael informed the CRI worker that he had been in contact with Elaine. He also stated that he was angry with her “ex-partner” although it is not clear who this was; also that he was feeling suicidal. It was recorded that “Michael wanted to disclose information that he did not want shared outside the one to one.” Michael was reminded of the confidentiality policy and no further disclosures were recorded.
- 2.18.6 Two days later the CRI worker emailed the Probation officer with concerns over Michael, his drinking, seizures, and thoughts of suicide. The email also mentioned that the worker believed Michael was seeing Elaine, which he shouldn't be within his bail conditions, and that “when Michael drinks alcohol he becomes violent and aggressive”.
- 2.18.7 Michael's case was closed following his custodial sentence on 18 February 2014, and the CRI worker emailed the prison with information about Michael's treatment.

2.19 Information from Michael

- 2.19.1 Unfortunately Michael did not respond to invitations to be involved in the review (please see paragraph 2.7 above for details of what attempts were made).

3. Analysis

3.1 Domestic Violence Definition

3.1.1 The government definition of domestic violence and abuse is:

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

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

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

3.1.2 Within the definition given above, Elaine was clearly a victim of domestic abuse from Michael; and also possibly from Andrew (although there were no convictions, Elaine did make disclosures to Addaction and the Police).

3.1.3 It is also clear that Elaine was struggling with multiple issues: homelessness and unstable housing arrangements, loss of contact with her daughter, the death of her mother (following a difficult relationship framed by her mother's alcohol use) and absence of any other family, mental ill health, alcohol use and domestic abuse.

3.1.4 Unfortunately, her circumstances were not unique, as shown in the St Mungo's research *Rebuilding Shattered Lives*⁹:

“Sadly, women's homelessness often occurs after prolonged experiences of trauma, including physical, sexual and emotional abuse, frequently within the home. It often follows from and results in a cycle of mental ill health and substance use, and a myriad of other problems. Many homeless women are left grieving for lost childhoods and lost children.” (p3)

3.1.5 What makes this Domestic Homicide Review unusual is that the perpetrator posing the most significant risk to Elaine – Michael – was not the perpetrator of the homicide. In fact there was no information received within this review that indicated that Elaine had experienced any abuse from Elijah. The limited

⁹ http://rebuildingshatteredlives.org/wp-content/uploads/2014/03/Rebuilding-Shattered-Lives_Final-Report.pdf
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information available with regard to Elijah did not add anything to support the analysis of this review or indicate that Elijah was a domestic abuse perpetrator.

- 3.1.6 Including some information about Michael has helped ensure that this review has gathered as much information about Elaine as possible. This has been particularly important, as the only contribution from anyone who knew Elaine personally was the perpetrator of the homicide, Elijah.

3.2 Metropolitan Police Service (MPS)

- 3.2.1 The MPS IMR highlights that the frequency of domestic abuse incidents (in which Elaine was abused by Michael) was not identified. When Elaine was risk assessed (19 June 2012), she should not have been assessed as standard, and a MARAC referral should have been considered, particularly after the 4th and 5th incidents in a 12-month period (from 2012 onwards). The IMR also highlights how in some of the incidents the history of Elaine and Michael was not researched on the system, and supervisors did not pick this up.
- 3.2.2 Good practice can be seen in how proactive officers were in arresting Michael, particularly in those incidences when Elaine declined to make statements or support allegations. It is unfortunate that these cases were not able to proceed – even in one case where Elaine made a statement – however the CPS consistently judged there to be insufficient evidence, or insufficient likelihood of conviction.
- 3.2.3 The review contacted CPS for further information but unfortunately no response was received; this leaves outstanding the following questions:
- (a) The rationale for the decisions not to charge.
 - (b) Whether these decisions followed CPS policy/procedure for domestic abuse cases.
 - (c) Whether restraining orders were considered on those occasions that Michael did reach court.
- 3.2.4 It was noted in Panel discussions that the Specialist Domestic Violence Court (SDVC)¹⁰ was not running in Brent at the time of Michael's offences against Elaine, but that it is now operating again, and this is welcome. The absence of an SDVC highlights the fact that restraining orders do not appear to have been applied for to protect Elaine following Michael's convictions of assault against her.
- 3.2.5 The IMR identifies that the MARAC flag on the Police CRIS system was not utilised, despite MARAC referrals being made.

¹⁰ http://www.ccrm.org.uk/index.php?option=com_content&view=article&id=196&Itemid=261

- 3.2.6 The Police IMR identifies two recommendations to address the lessons learned:
- (a) Recommendation to Brent Senior Leadership Team (SLT) to “develop and deliver a training package for primary and secondary investigators and supervisors to ensure understanding and compliance with domestic abuse policies and procedures” including DASH and MARAC.
 - (b) Recommendation to Brent SLT to perform dip-sampling of Domestic Abuse CRIS reports to ensure initial investigators are robustly supervised to ensure thorough five year checks are completed; and that the Police MARAC representative is appropriately adding the MARAC flag to CRIS.
- 3.2.7 The Chair and Report Writer note however that these are similar recommendations to those made in DHRs elsewhere in London, and hence a recommendation is made in this Report for the MPS to review all recommendations for local areas to identify lessons that may need to be London-wide.
- 3.2.8 The incident of 5 May 2013 was the seventh involving Michael and Elaine; in all of the previous six, Elaine was identified as the victim and Michael the perpetrator. There were no offences on this occasion, and Michael stated he wanted Elaine to leave his flat. The Police are recorded as having given a domestic abuse services leaflet to Michael.
- 3.2.9 Although in this case Michael was asking Elaine to leave, this did not make Elaine the perpetrator and Michael the victim, and this may have been highlighted if the history check had been done. In responding only to this incident, without taking previous incidents – and the dynamics of domestic abuse, in which perpetrators often accuse victims in order to intimidate them and maintain control – into account, officers have ultimately supported the perpetrator as if he were the victim, and left Elaine with no offer of support.
- 3.2.10 The incident of 22 May 2013 refers to both Elaine and Michael refusing to answer DASH questions, which should not have occurred. The DASH is a risk identification checklist for victims of domestic abuse, and should only have been completed with Elaine. On attending the incident it was essential for the officers to identify which person at the scene was the perpetrator and which the victim. This can be difficult or impossible in some incidents, however in this case officers were attending following a 999 call from a female, who was heard saying “stop hitting me”, which – along with the history check – could have enabled them to correctly identify Elaine as the victim and Michael as the perpetrator.
- 3.2.11 Following the incident of 20 June 2013, in which Elaine was accused of assault against Michael and a female friend, the case went to court and no evidence was offered. It can be assumed that the case went forward to trial due to the fact that the female friend had provided a statement, although she perhaps did not then attend the trial (hence no evidence being offered). This raises the question of what was different about this case, as opposed to the other incidents in which

Elaine made a statement against Michael, and the CPS deemed that it should not go through for prosecution.

- 3.2.12 Research suggests that, where women are perceived as domestic abuse perpetrators, they can be treated more harshly within the justice system than men perceived as perpetrators. For example, Hester (2012) showed that women are more likely to be arrested following a domestic incident in which they were judged to be the perpetrator.¹¹

3.3 Independent Domestic Violence Advocacy (IDVA) Service

- 3.3.1 The IDVA service provided to Elaine seemed to be sporadic, but at times showed good practice in support of Elaine's needs. The IDVA was proactive in trying to find Elaine a refuge space, and in supporting Elaine's applications to the Housing Department. The IDVA also referred Elaine to MARAC on three occasions, two of which were based on the Advocate's professional judgement of the risks Elaine faced.
- 3.3.2 There were gaps in this service, for example the IMR highlights that there appear to have been no attempts to contact Elaine from 30 May until 4 July 2013, which was a very long gap. It is also unclear what attempts were made to find an alternative number for Elaine when contact was unsuccessful, most importantly following the referral on 31 October 2013, when the case was subsequently heard at MARAC, then closed by the IDVA service, without any contact having been made. Nor is it clear what liaison there was with the Police to ensure Elaine's safety at a time when she was consistently judged to be high risk and contact could not be achieved. The current IDVA service provider has assured the panel that they keep in contact with the police to identify contact details and refer back where necessary; it will be important to explore what outcomes this 'referring back' leads to for high risk victims.
- 3.3.3 The IDVA made a repeat referral to the MARAC following disclosure by Elaine of an assault by Michael; however, when at the MARAC meeting (24 July 2013) the police shared that Elaine had been arrested for an alleged assault on Michael and another woman, the only action for the IDVA service was to refer Elaine to Minerva – there were no actions relating to Elaine as an ongoing victim of domestic abuse. A recommendation is made below on this.
- 3.3.4 Following the 31 October 2013 referral from the Police, the attempts at contact were spaced out, and the case was closed two months after the last attempted contact. The case was closed despite no engagement from Elaine, and it is not clear whether this was reported back to the Police as original referrer, or an

¹¹ Hester, M. 'Portrayal of Women as Intimate Partner Domestic Violence Perpetrators' *Violence Against Women* published online 20 September 2012
<http://vaw.sagepub.com/content/early/2012/09/19/1077801212461428>

alternative number / contact route sought. Hestia have confirmed their current process is to try a number of different times of day to make contact, to seek alternative numbers and to go back to the original referrer if contact cannot be achieved. As above (4.3.2), we must ask what the outcomes are for high risk victims.

- 3.3.5 The IMR states that at the time Elaine was referred to the service, very high caseloads were common (around 70 per IDVA; Safe Lives recommended case load is 25-30), and that this may explain why contact with victims could be infrequent, as in this case. It also states that case management was not happening routinely, possibly explaining the delay in cases being closed. The IMR highlights that the IDVA did not work as effectively with Addaction or CRI as she could have, and there were no referrals or reference made to support for Elaine's alcohol misuse. This report notes that two substance misuse IDVAs are currently being put in place to work across substance misuse services.
- 3.3.6 Overall the impression is of a stretched service, that nevertheless was able to offer support to Elaine on her practical issues, and some telephone emotional support – but that was unable to give the time to go beyond this to fully explore with Elaine what she needed to give her the courage and confidence to make positive changes to her life (that could have given her the strength to move away from Michael).
- 3.3.7 It must be noted that, since this time the service provider has changed. The new provider, Hestia, have supported the review by providing information, relevant to the specifics of this case, about how the service is delivered now.
- 3.3.8 IDVA support continues to be primarily provided over the telephone, except in cases where the referral is received from the Police and the victim is still on the premises, in which case a face-to-face meeting takes place. Face-to-face support is also provided at court.
- 3.3.9 Hestia state that telephone contact is effective in relation to initial contact; but that it does present challenges in ensuring a good relationship is developed between the IDVA and the victim. If the victim requires more complex support, then a meeting will be arranged; this is for very few cases.
- 3.3.10 Hestia have informed the Panel that a new post of 'Senior IDVA' will be looking at alternative methods for delivering the service. In the light of this case, where telephone contact was problematic, and someone as vulnerable as Elaine perhaps required more in-depth work, this step is welcome.
- 3.3.11 While case management has improved, and cases are being closed more efficiently, unfortunately the caseload remains high at around 60 per IDVA; this is very high compared with the Safe Lives (formerly CAADA) recommended caseload of 25-30.

- 3.3.12 The Brent Domestic Abuse Screening Process was introduced in January 2015, in which an IDVA reviews all domestic abuse reports to the police to ensure that risk is identified accurately, and to work on contacting victims at an earlier stage – i.e. before they get to be high risk – to provide support. While this is clearly a welcome introduction of good practice, it also has the potential to put strain on an already stretched IDVA service.
- 3.3.13 These issues were discussed at a Panel meeting, and it was clear that the provider and commissioner are addressing caseloads, referral routes and the closure of cases. Work is also progressing to ensure that pathways are in place and all local services are utilised appropriately for victims. It is important to note however that while caseloads continue to be so high, an element of risk continues to be in place for victims who may not be having their needs met, or reaching safety, as promptly as possible.

3.4 Multi-Agency Risk Assessment Conference (MARAC)

- 3.4.1 An IMR was not requested covering the MARAC (provider no longer in place), however the Chair and Report Writer reviewed the referrals and minutes of the meetings, and the MARAC Chair (at the time of Elaine's case being heard) attended a Panel meeting, and agreed to review the Overview Report to support any analysis, lessons learned and recommendations relating to the MARAC. At the time Elaine was referred, Standing Together Against Domestic Violence coordinated the MARAC, however Hestia now provides this service.
- 3.4.2 At the first MARAC meeting (May 2013), there were two actions relating to Elaine: one for the IDVA to feedback the outcome of the meeting, and one for Addaction to try to re-engage her. This was good practice, and showed that the MARAC meeting attendees were trying to think creatively about different ways to engage Elaine in services. The update from the IDVA stated that they fed back to Elaine. However, Addaction updated that Elaine's case had been closed and so re-engagement would not be attempted.
- 3.4.3 Addaction had previously closed Elaine's case in line with their procedure, as Elaine no longer wanted the service. However the fact that, subsequent to the MARAC, they did not pursue further contact with Elaine could be seen as contrary to the purpose of the MARAC, which is to act proactively to prioritise the safety of high risk victims. A MARAC action should mean a client is prioritised, with serious consideration to re-opening a case when asked. This is addressed in the Addaction section below.
- 3.4.4 It is standard practice for all MARACs that cases are not discussed again, unless a repeat referral is made. Addaction's decision to not attempt contact was updated to the MARAC Coordinator but no further action would have been taken.
- 3.4.5 The assumption underlying the MARAC process is that if the process is followed correctly and all actions are done then the victim should no longer be high risk.

- 3.4.6 In this case, the key action relating to engaging Elaine in services was not completed. It is therefore unclear what was achieved by this meeting in terms of reducing the risk faced by Elaine, and increasing her safety. A recommendation is made below to address this.
- 3.4.7 From this meeting onwards minimal or no contact was possible with Elaine by the IDVA service, until she re-engaged with them in May 2014. Despite this there was an action at each of the next two meetings for the IDVA to "Feedback MARAC actions to the V/S [victim/survivor]". The update on the notes is that this was "not possible as V/S not engaging with services". As stated above with regard to the IDVA service, it is not clear what action was taken to seek alternative ways to contact or engage with Elaine.
- 3.4.8 At the second and third MARAC meetings information was shared with regard to Elaine's living arrangements. At the second meeting the IDVA service shared that Elaine was sleeping rough, but there were no actions and it is not clear whether there was any discussion on this issue. At the third meeting the discussion concerned her staying with another known domestic abuse perpetrator, and an action was given to the police to alert the officer in the case; however it is not clear what this could have or did achieve, and there were no other actions in relation to Elaine's living situation. A recommendation is made to address this.
- 3.4.9 The IDVA service referred Elaine for the second time (24 July 2013 meeting) due to a repeat incident she reported to them (that had not been reported to the police). At the meeting the police shared information about Elaine's arrest for assault on Michael (and a female friend), and there was no further discussion of Elaine as the primary victim, appearing to dismiss the information shared by the IDVA service. This is addressed in a recommendation below.
- 3.4.10 In each set of minutes there is no reference to her mental health issues, for example the fact that she was engaging with her GP regularly and being prescribed anti-depressants. Although CNWL were engaged with the MARAC at that time, at the time of the first MARAC referral, Elaine had already been discharged from IAPT. As there was no engagement with the GP, and (we assume) Elaine did not disclose this information to anyone, a key part of her circumstances was missing. The absence of GPs from the MARAC is addressed in a recommendation below.
- 3.4.11 There is no record on the referral forms or minutes of Elaine's wishes. As a result it is not possible to get a sense of what Elaine needed (either in her own view, or in the views of the professionals) to increase her safety. It is hard, looking at the minutes and following the discussion at the Panel meeting, to see how any of the actions would have reduced the risk she faced. It raises the question of whether, having shared information and set out actions, the MARAC Chair and attendees felt that they were reducing the risk faced by Elaine. It was noted in the Safe Lives assessment in October 2014 that the victim's voice "remained clear

throughout the meeting” and so it is hoped that this situation has improved for all victims.

- 3.4.12 It must also be noted that there were no actions with regard to Michael as the perpetrator of the abuse against Elaine, and the one judged to be posing significant risk to her. The primary focus of MARAC meetings is rightly on the victim/survivor, however actions relating to the perpetrator can be reasonably expected, wherever possible, with the aim of reducing the risk they pose to the victim/survivor. This point was also made in the Safe Lives assessment of the MARAC.

3.5 London Borough of Brent Housing Needs Service

- 3.5.1 On the two occasions Elaine was assessed by Housing Needs a vulnerability assessment was performed and Elaine failed the priority need test, as set out in legislation.
- 3.5.2 The Housing Department representative to the Panel was helpful in attempting to set out what assessment process Elaine’s application would have gone through to try to establish whether she could be judged as ‘vulnerable’ and therefore in priority need. He stated:
- “The critical test of vulnerability for applicants is whether, when homeless, the applicant would be less able to fend for himself than an ordinary homeless person so that he would be likely to suffer injury or detriment, in circumstances where a less vulnerable person would be able to cope without harmful effects (R. v Camden LBC Ex. p Pereira).”
- 3.5.3 Elaine had mental health needs and an alcohol dependency problem, and was fleeing domestic abuse/violence. She had no family, and was struggling with the loss of contact with her daughter. She did not have a home of her own – rather ‘sofa surfed’ or was street homeless.
- 3.5.4 The Panel therefore suggested that Elaine should – even just in hindsight – be seen as ‘vulnerable’ in this context. However, it is now clear that the need of homeless people in Brent is such that – unfortunately – Elaine’s case is not uncommon, and that there would have had to be additional, exceptional circumstances, for the threshold to be met.
- 3.5.5 Elaine was offered help and advice, and at one point emergency accommodation, which unfortunately she was unable to take up. This last took place in the days before she died, however it raises the question that, had she lived (or even earlier in her interaction with services), could she have been referred (e.g. by the Housing or IDVA service) to an agency specifically for support around housing?

3.6 Victim Support

- 3.6.1 The IMR, and Panel discussion, showed that contact with Elaine was attempted promptly following referrals. It is also clear that appropriate repeated attempts

were made, and efforts were also made to find alternative contact information, or to inform the Police (as referrer) of the service's inability to reach her.

- 3.6.2 There was discussion at the Panel over Victim Support's inability to contact victims following Police referral (either due to incorrect, or absence of, contact details) highlighting that this occurs in a high number of cases. It was agreed that it was good practice for Victim Support to report back to the Police where this is the case; however there were also questions over the efficacy of the referral and feedback system if there continues to be a problem with contact details.
- 3.6.3 A recommendation is therefore made in this report for the Police and Victim Support, and the Community Safety Partnership, to conduct an audit to understand the extent of the problem, and identify actions to address this.

3.7 General Practice (GP)

- 3.7.1 This analysis primarily concerns Elaine's GP; while information was supplied by Elijah's GP, it contained no information that required analysis.
- 3.7.2 Elaine had extensive contact with her General Practice. In addition to eight missed appointments Elaine had 25 contacts – on average attending once a month over the three years.
- 3.7.3 Elaine's attendance peaked in 2012 and 2013, with 19 contacts. In 2014 this dropped off significantly, and in the five months prior to her death only made contact twice.
- 3.7.4 In the time she was in contact, Elaine saw ten different GPs. While this can be seen as normal for a busy Practice, the impact can be seen in the records of appointments. Many appointments – with different doctors – are recorded as "Depressive Disorder Review". However in two instances, both with the same GP but one who Elaine had not seen before, the discussions are labelled "Low Mood – New" and "Low Mood (first)". The notes do not make clear whether the GP on this occasion was aware of Elaine's history.
- 3.7.5 Elaine was given a different prescription at that appointment, and it is not clear why. Given Elaine's recurrent depression and alcohol issue, it would have more effectively met her needs and been efficient practice to ensure she saw the same GP each time; or at least to ensure her history and previous medication was thoroughly researched. There are times where she has a telephone conversation with one doctor, and is then given an emergency appointment for that day with a different doctor. Again, with many appointments already booked in this is likely to be normal practice; however it must be taken into account Elaine's vulnerable circumstances encompassing homelessness, loss of her child, mental ill health and alcohol use – plus the domestic abuse that the GPs did not appear to be aware of.
- 3.7.6 There is no record in any of the notes of any enquiry about, or disclosure of, domestic abuse. The focus for all the doctors Elaine sees was: her alcohol use;

- medication for her depression; or the physical medical complaint she attended with.
- 3.7.7 Despite the inconsistency of the doctors Elaine saw, she appeared to be open with each one on her situation and what she needed. Elaine is recorded as ‘not doing well’ or ‘feeling low’ at nearly every appointment. The information provided by Addaction states that Elaine disclosed taking anti-depressants since she was in her late teens – which, by 2014, meant she had been on this medication for over twenty years. And yet, she was still having issues with medication ‘not working’, and repeatedly asked for counselling. It is therefore pertinent to ask, at what point in her treatment must an alternative be considered, or a more in-depth discussion held with her on the issues that persisted? What follow up was done to ensure that Elaine got through to IAPT and was accessing counselling?
- 3.7.8 Elaine disclosed to doctors that she was missing her daughter, that she wasn’t sleeping well, was stressed, and at one point stated she was homeless and begging in the street. She also attended having broken her collarbone, and with a black eye. There is no record of exploration or enquiry into how these occurred, and no action appears to have been taken in response to these issues other than a reiteration of her need to ‘address her alcohol intake’ and repeat prescriptions for different anti-depressants.
- 3.7.9 When Elaine attended to request the termination, it was recorded that she had a “close friend present”. No other information was recorded – whether the friend was male or female, or what their relationship to Elaine was. In the light of the information gathered for this review, this presented an opportunity to explore more with Elaine her living situation, and allow her space to disclose the domestic abuse that Addaction and police reports show Elaine was disclosing at that time as occurring from her ex-partner Andrew.
- 3.7.10 There is a general lack of follow up with Elaine following, for example, missed appointments and prescriptions not collected; and most notably when the letter was received from the Hospital stating that Elaine had not attended and subsequently declined the procedure for which one of the GPs had referred her.
- 3.7.11 An IMR was not received from the GP; only the medical notes were provided. A list of questions was sent to the Practice, and further information sought via email and telephone calls.
- 3.7.12 Further information was provided in relation to how the practice feels it “can contribute to a safe environment for victims of domestic violence”.
- 3.7.13 The information states that the Practice has a protocol/policy for domestic violence (in accordance with RCGP guidelines) and that staff and doctors attend training every year.
- 3.7.14 With regard to specialist services, the response states that the Practice can contact “Brent Adult Safeguarding” and “Brent Social Services”. It is assumed

that the latter refers to Children's Social Care. No domestic abuse specialist services are mentioned, but the Practice states that they would contact adult or child safeguarding for advice, in addition to calling the police if there is an immediate threat to a patient.

- 3.7.15 The Practice highlights the following areas for improvement:
- (a) More training needed for both health care professionals and staff to identify potential victims of domestic violence
 - (b) Vulnerable patients like those with mental health problems, drug and alcohol abuse should be provided easy access and same day appointments. Their proper follow up should be arranged.
 - (c) Effective collaboration need with other agencies as well and all information should be shared.
 - (d) All victims /potential victims should have emergency contact number and information.
- 3.7.16 All of the information provided by the Practice suggests a robust and comprehensive response to victims of domestic abuse. However, this did not translate into an effective response to Elaine – there was no enquiry regarding her relationships or domestic abuse, and opportunities were missed to offer support or referral to specialist agencies. A recommendation is therefore made in this Report for the Practice to engage with the Brent CCG (and NHS England where appropriate) to ensure that the above are acted upon, that training is sought and provided, and that the Practice's policy is reviewed in the light of the learning from this case and amended if required.

3.8 Imperial College NHS Trust

- 3.8.1 The IMR from Imperial College clearly sets out the lessons learned from this case, and makes recommendations that will address these.
- 3.8.2 The Hospital followed standard process in relation to Elaine's procedure, and there was good practice by the nurse in speaking to Elaine to try to get her to attend for her procedure.
- 3.8.3 However, the IMR highlights that the initial assessment with the nurse in December 2013 was an opportunity to ask Elaine about the health issues, detailed in the referral from the GP, in relation to alcohol use and depression.
- 3.8.4 The IMR also makes clear that the nurse should have noted the details of the person with whom Elaine attended.
- 3.8.5 There is also a recommendation in relation to the fact that the nurse should have picked up on Elaine's mention of her child, and acted in response to this, combined with Elaine's apparently heavy alcohol use, to consider a safeguarding referral.

- 3.8.6 The recommendations specifically cover: for the assessment to contain more comprehensive information about social/safeguarding issues, including domestic abuse; for routine enquiry on domestic abuse to be introduced; for women to be seen alone during pre-assessment appointments; for joint training to take place on child and adult safeguarding, so that issues for adults are not seen in isolation from issues for (their) children.
- 3.8.7 It has been noted by Imperial College that this last issue has also been picked up by the local LSCB, so Imperial's actions will not take place in isolation.

3.9 Central and North West London NHS Trust (CNWL)

- 3.9.1 CNWL's first contact with Elaine was outside of the Terms of Reference time frame, and far in the past compared with the period under review. It is noted by the IMR author however that Elaine was discharged from the psychology service after not attending appointments, which is standard practice, and was referred back to her GP, which was – and is – the appropriate course of action.
- 3.9.2 The IMR also notes that it was appropriate for the Perinatal Psychiatry team to refer Elaine back to her GP following her appointment cancellation. Following a discussion at a Panel meeting it was clear that, as Elaine's need was identified as being around 'mood', this is 'low level' and would reasonably be expected to be managed in primary care.
- 3.9.3 Nevertheless, the CNWL IMR identifies some key learning around domestic abuse/violence and MARAC awareness and response, as well as supervision and appraisal. Recommendations are made to address these: training in clear documentation; protected time for clinical supervision; routine enquiry for domestic abuse/violence and current partnerships; domestic abuse/violence awareness training.
- 3.9.4 The further information received during the review regarding Elaine's interaction with IAPT notes that all referrals, apart from a very small number that are clearly inappropriate, are now dealt with through a 30-45 minute phone call with the client. This is a welcome change given the rejection of Elaine's referral from her GP in November 2011, due to her "problem drinking". While the IAPT service – and others – may have viewed Elaine's drinking as her 'primary problem', this was not necessarily Elaine's view – as shown within her subsequent assessment by IAPT following the second referral made in September 2012.
- 3.9.5 The significant delay between referral (September 2012), assessment (November 2012) and counselling appointments (March 2013) is noted in the CNWL analysis, where the explanation is that there were long waiting lists and a problem with under staffing at the time Elaine accessed the service. It is impossible to know exactly what impact this delay had on Elaine, however it must be highlighted that she went from requesting counselling, and engaging with the service, to not attending appointments in that time (and subsequently did not request counselling from her GP again).

- 3.9.6 In the assessment carried out in September 2012, Elaine referred to family and relationship difficulties. There is no evidence of further exploration on this, for example whether the 'relationship difficulties' were in fact the abuse Elaine was experiencing from Michael. It is to be hoped that the counsellor, in Elaine's one appointment, did pick this up with her but it is not possible to know this.
- 3.9.7 The original recommendations made by CNWL in their IMR should also be applied to IAPT.

3.10 Addaction

- 3.10.1 From Elaine's first appointment with Addaction in October 2011, Elaine's most significant concern was having contact with her daughter (she was referred by Children's Social Care in relation to child protection discussions). This dominated the appointments she had – both group sessions and individual key-work sessions – and appeared to be the driving force behind her engagement with the service. At times in fact it seemed that she was only attending Addaction because it was required by social services as part of the Child Protection Plan and contact arrangements.
- 3.10.2 This is often a situation for women like Elaine. St Mungo's *Rebuilding Shattered Lives* project and subsequent report "heard again and again how devastating this separation [from children] is for women, yet they are often expected to cope with this loss with little or no emotional support."¹² The report shows how domestic abuse, drug and alcohol use, mental health, homelessness and other issues such as loss of children are "reinforcing and interrelated" for women, preventing them from being able to engage fully in the help that is offered on a specific issue¹³.
- 3.10.3 In January 2012 the positive impact of contact with her daughter could be seen, where Elaine was feeling optimistic, embarking on voluntary work and keen to engage with Addaction. This quickly changed at the end of March 2012 when she was noted as feeling she was not being listened to, was kept "out of the loop" with regard to social services and struggled to see "what more [she] could do".
- 3.10.4 At her first appointment, Elaine disclosed to the Support Worker that she had been prescribed anti-depressants by the GP for as long as she had been experiencing a problem with alcohol; however on this same record, it was noted that Elaine had "no mental or physical issues". This suggests either insufficient record keeping or an absence of exploration with Elaine with regard to her disclosure of mental ill health.

¹² St Mungo's *Rebuilding Shattered Lives*, 2014, p15 (see footnote 11 for full reference)

¹³ *ibid*, p19

- 3.10.5 Elaine disclosed abuse to the Support Worker from her ex-partner, Andrew. The Support Worker is also witness to a phone altercation between Elaine and Andrew. The Social Worker at one point informs the Support Worker of a domestic incident (5 March 2012, allegation also against Andrew). However at no point was there evidence of a discussion regarding, or a referral to, support services for Elaine around domestic abuse (for Addaction or Children's Social Care). The email from the Social Worker only asks for information about the testing of Elaine; there was no reference to support for Elaine herself following the incident or in relation to anything else.
- 3.10.6 There is no record in the system of the MARAC referral that was made (18 April 2013), which means that, had a repeat incident been disclosed, or further concerns raised, there was no way for another worker to identify Elaine as a high risk victim or make a repeat MARAC referral. The referral was also made after the case had been closed on 19 March 2013.
- 3.10.7 The MARAC meeting agreed an action for Addaction to reattempt contact (they had not attended): however, because Elaine had accepted the case closure, the service did not try to engage her again. This calls into question the reason for the original referral from Addaction, and their understanding and expectations of the MARAC process: the purpose of the MARAC is to act proactively to prioritise the safety of high risk victims, and this MARAC action should have meant prioritising Elaine, with serious consideration to re-opening her case.
- 3.10.8 The Worker who made the referral has now left the service, however she was contacted and the following feedback from Addaction is noted:
- (a) "[The Worker] was working with Elaine's ex partner Andrew and she believes that she made the referral based on information of DV perpetrated by Elaine's then current partner, claims being made by Andrew, her ex partner and father of their child."
- (b) "Addaction will make a referral to MARAC if the service user is currently working with us or if they have recently been discharged from services should we feel this is in the best interest of the service user. Elaine was known to a number of staff at Addaction, including [the Worker who made the referral] who stepped in and worked with her whilst there was a change of keyworker.
- If a member of staff hears or reports DV the matter is discussed in hand over, or in team meetings and / or in supervision. If the matter is felt that it needs to be raised as a MARAC or safeguarding referral then we currently have a robust procedure in place to make sure that a decision is made and acted upon following our procedure.
- [Of concern] with this matter is that [the Worker] neglected to write up the MARAC referral in Elaine's or Andrew's case notes as an entry."

- 3.10.9 It is the view of the independent Report Writer that Addaction should review their policy in relation to MARAC referrals where cases have been closed; in this case there was an opportunity to re-engage with Elaine, and to offer her support in the absence of her accepting support from elsewhere. If there is ongoing domestic abuse risk to a client or former client, then greater consideration should be given, in dialogue with the IDVA or other service supporting the victim, to re-opening the case. A recommendation on this is made below.
- 3.10.10 On both occasions when Elaine was discharged from the service, it is clear that the decision came from the service, based on their perception of Elaine's behaviour – i.e. her lack of engagement. In the notes for first discharge, in July 2012, it is not clear what had triggered the decision. With the second discharge, there is no record of exploration with Elaine over the fact that she had not had a stable home since before being referred to the service in October 2012. Nor is there any evidence of understanding of the impact this would have on her ability to engage with the service.
- 3.10.11 Elaine appears to have presented as a 'change resistant' drinker, and was at best ambivalent about addressing her drinking. Rather than focusing on Elaine's motivation, willingness to engage, or her ability to keep to scheduled appointments, an alternative focus could have been on Elaine's vulnerability and the risk she faced – from Andrew, Michael and from others in the future. An intervention which prioritised her risk and vulnerability rather than motivation could have led to a different attitude in the service's engagement with Elaine, focused on her needs and what her perspective was in accessing services. The organisation and commitment demanded of Elaine could not reasonably have been expected of someone in her situation. If the service was not in a position to pursue her in this way – understandably given their high case load – then this unmet need should have been communicated, for example to Public Health and/or the Clinical Commissioning Group.

3.11 London Community Rehabilitation Company (CRC), formerly Probation

- 3.11.1 As outlined above, information relating to Michael has only been included for what it adds to our understanding of Elaine and her life. However, in looking into Michael's interaction with Probation, the CRC IMR does outline some areas of good practice and lessons to be learned, which are addressed through appropriate recommendations.
- 3.11.2 One gap in practice identified is that, following the assault of Elaine by Michael on 26 October 2013, Michael disclosed to the Offender Manager that he was breaching his bail conditions by being in contact with Elaine. Good practice would have been for the Offender Manager to refer Elaine to MARAC on receipt of this information. The IMR notes that the Offender Manager identified that Michael was minimising his abuse towards Elaine, but took no action. A recommendation is made in the IMR concerning this.

- 3.11.3 The IMR concludes that Michael's alcohol dependency and related illnesses were the sole focus of Probation throughout his time within their supervision, and that as a result the risk he posed to Elaine was not picked up, or acted upon, as it should have been.
- 3.11.4 The recommendations identified in the IMR are: to highlight to frontline staff the risk issues of service users presenting both domestic abuse and substance misuse issues, to ensure that both risk issues are addressed and neither one neglected; to emphasise to frontline staff the importance of making MARAC referrals and liaising with MARAC Co-ordinator for advice; and for senior management to ensure that appropriate Supervision is provided for all Offender Managers, with a particular focus on those holding domestic abuse cases.

3.12 CRI

- 3.12.1 CRI's interaction with Michael coincided with his contact with Probation, as his engagement with CRI was part of his order. There was evidence of effective inter-agency working between CRI and Probation.
- 3.12.2 CRI were clearly aware of Michael's history of abuse against Elaine, as it was recorded in the first contact that he could not attend another setting as Elaine was receiving a service. Despite this, three months into his treatment he was referred to an alcohol group at just that setting. It is concerning that the information regarding Elaine was not taken into account in relation to this referral.
- 3.12.3 Michael also disclosed to the CRI worker that he had seen Elaine, contravening his bail conditions. In the first disclosure it was clear that the police were already aware of the breach; in the second, the worker informed the Probation Officer. However this sharing of information was not done in a way that implied any action should be taken – the email was somewhat informal and it is not clear what the CRI worker expected to happen as a result; i.e. whether they expected Probation to act on the information.
- 3.12.4 In this same email, the CRI worker shared with Probation a number of concerns about Michael, the worker having seen him the day before. These concerns included Michael's drinking, health, having seizures and the fact that he had suicidal thoughts. The email also referenced that Michael was "angry at his partners ex-partner", wanted to disclose something but didn't, and "becomes angry and aggressive" when drinking.
- 3.12.5 However, this email gave no indication of any action taken on these concerns, nor did it ask the probation officer to take any action. Given the combination of Michael's drinking, his anger and aggression at those times, his suicidal thoughts and the fact that CRI knew he was abusive to Elaine, it would have been good practice to act on these concerns. For example a referral could have been made to MARAC for Elaine so that concerns could be shared and actions taken to safeguard her.

- 3.12.6 CRI have confirmed to the review that they are engaged with the MARAC, and in a case such as this would have expected the worker to make a referral for Elaine given Michael's disclosures and the worker's concerns.

3.13 Diversity

3.13.1 Age

Elaine was 42, Michael of a similar age and Elijah 60. No information was presented within the IMRs, or shared in Panel meetings, suggesting that their age in any way impacted on the services they were provided with.

Their ages are significant due to the fact that they reflected alcohol and mental ill-health issues – particularly for Elaine – that had been going on for an extended period of time, and this may have impacted on their help seeking.

Elaine's GP and Addaction could have given consideration to the physical impact of Elaine's long-term alcohol use. Impacts can include poor sleeping, poor diet, general ill health and liver disease and in some extreme cases alcohol related brain damage¹⁴. All of these would make it hard for her to demonstrate motivation to make changes.

3.13.2 Gender

Being female is a risk factor for being a victim of domestic abuse, making this characteristic relevant for this case, Elaine having been a victim of domestic abuse from Michael, and possibly also from Andrew. This factor was not always recognised by agencies supporting Elaine: in particular at the MARAC, where at the second meeting Elaine was discussed as the perpetrator despite her situation as primary victim from Michael. In addition had the GP taken into account the significant risk Elaine faced, proactive questioning could have taken place enabling Elaine to disclose and potentially get further support.

St Mungo's Rebuilding Shattered Lives¹⁵ research shows that women's help seeking around homelessness, alcohol use, mental ill health and other issues can be different to men's, and complicated by the multiple factors they may be dealing with. This was certainly the case with Elaine; however it is not clear the extent to which Elaine's gender was taken into account, in particular the specific difficulties for a woman faced with losing contact with her child.

Research¹⁶ also suggests that women also face different difficulties in seeking help for an alcohol problem, the following of which are relevant to Elaine:

¹⁴http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/08/Health-impacts-factsheet-November-2010.pdf & <https://www.nice.org.uk/Guidance/CG100>

¹⁵ http://rebuildingshatteredlives.org/wp-content/uploads/2014/03/Rebuilding-Shattered-Lives_Final-Report.pdf

¹⁶ http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2014/12/Women-factsheet.pdf

- “the stigma attached to admitting the problem appears to be greater for women and women are affected by family pressure not to admit to the problem
- mis-diagnosis of the problem, as women often attribute their drinking problems to underlying causes, e.g. bereavement, and tend to seek help from agencies that fail to identify the alcohol problem
- fear of the consequences of making the problem public, e.g. loss of child custody”

These issues should be addressed within the response to recommendation 11.

3.13.3 *Race*

Elaine and Michael were White British, Elijah Black British. No information was presented within the IMRs, or shared in Panel meetings, suggesting that their race in any way impacted on the services they were provided with.

3.13.4 *Religion and belief; disability; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity*

No information was presented within the review to indicate these were issues.

4. Conclusions and Recommendations

4.1 Preventability

- 4.1.1 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. In fact there was no information received within this review that indicated that Elaine had experienced any abuse from Elijah.
- 4.1.2 Despite this conclusion, this report notes that Elaine had a very troubled existence with a large and significant number of deeply worrying issues, and such extensive contact with services – her GP, the IDVA service, Housing, Addaction, the Police – 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.
- 4.1.3 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. This was echoed in the interview with Elijah, making clear it was not just agencies she struggled to get support from, but also friends. The onus should have been on services, perhaps collaboratively, to support Elaine to maintain engagement and to address her difficulties. Instead, the pattern – from the contact with CNWL in the 1990s to the Terms of Reference time period – was of Elaine's engagement, then non-attendance and subsequent discharge, from a range of services.

4.2 Issues raised by the review

4.2.1 *Seeing the whole person*

- (a) Elaine's alcohol use, mental health issues, experiences of loss and abuse, and housing situation meant that she was vulnerable¹⁷ to experiences of abuse, harm and distress. However, few agencies were able to see all of these circumstances.
- (b) This was with the exception of the Independent Domestic Violence Advocacy (IDVA) service, and Elaine's General Practice, both of which had opportunities to assess Elaine taking into account all of her varying needs. However, the GP was not apparently aware of the incidents of domestic abuse reported to the police and IDVA service; and it is not clear the extent to which the IDVA service was aware of Elaine's mental health needs. Proactive enquiry by both

¹⁷ NB: this refers to Elaine's general vulnerability, not a specific statutory definition of vulnerability for example as used by Housing, or Social Care.

may have revealed the full picture. The IDVA in particular can reasonably be expected to have fully explored with Elaine all of her needs.

- (c) There was also the opportunity to facilitate support and safety for Elaine through the Multi-Agency Risk Assessment Conference (MARAC) process. However, not all agencies appeared to be part of the process at that time, in particular Elaine's General Practice. In addition, Addaction's referral was made after they had closed her case, and they then did not attend the meeting nor carry out their action. All of this effectively left Elaine still at high risk.
- (d) The Coordinated Community Response Model outlines the responsibilities of all agencies in responding to domestic abuse, and the MARAC is a case-specific representation of this Model. However, it is essential that all agencies are present, and commit to ensuring their practice is focused on the needs of that particular victim, at times over and above agency process.

4.2.2 *Single issue focus*

- (a) Elaine accessed a great deal of support via her GP, the IDVA service, and also engaged with Addaction, the Police and to a lesser extent IAPT and Housing. Rarely was she seen in the context of all of her needs (as outlined above), and what can be seen in the service delivery was a focus on the (often single) issue for which Elaine had been referred to them. For example, the IDVA closed Elaine's case despite her homelessness, as this was "not caused by domestic violence"; the General Practice likewise took no action in relation to Elaine's disclosure of homelessness. While each agency understandably retains a focus on the service it is required to deliver, in this case it led to a lack of support for Elaine.
- (b) Elaine's GP had information about most of Elaine's needs (except domestic abuse), but the focus was on her alcohol use, depression, or the presenting medical need on that day. On two occasions she presented with injuries (a broken collar bone and a black eye) and there is no record of enquiry over how these came about, specifically no record of enquiry about domestic abuse/violence.
- (c) 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", including histories of domestic and other abuse, drug and alcohol misuse, mental health issues, and loss of children due to child protection processes.
- (d) The research highlights that many services, focused on one specific aspect of women's circumstances, fail to take into account their whole situation. For example, it highlights that mainstream mental health services – such as IAPT – are not equipped to respond to such complex cases. For Elaine this led to her initial referral from the GP being rejected (without assessment or contact

with Elaine) in favour of her accessing counselling via Addaction. Despite this, Elaine continued to ask for counselling from her GP, suggesting that her needs were not being met with Addaction's counselling, possibly because she needed someone to see past, or through, the alcohol misuse to her deeper issues. Unfortunately when the second referral for IAPT was processed and she was assessed, the high demand for the service led to a significant delay, and once started she seemed unable to engage.

- (e) St Mungo's highlight how "traditional pathways to support which focus on one condition at a time often mean that help is provided in silos", and this can be seen with Elaine, where there was minimal contact between the three services she was most engaged with – the GP, Addaction, and the IDVA service (this list could also include Children's Social Care, see below).
- (f) 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.

4.2.3 *Professional curiosity and creativity*

- (a) The MARAC process can facilitate a creative approach to supporting victims, in particular those who are difficult to engage. For Elaine this was seen in the first meeting, where, in addition to the IDVA service re-attempting contact, an action was given for Addaction to attempt to re-engage Elaine, and to refer her to CRI as an appropriate service.
- (b) Unfortunately, when it transpired that Addaction had already closed Elaine's case, there were no further actions made to re-engage Elaine in services, and it was not until a third referral to the IDVA service in May 2014 that Elaine was once again engaged with support. Given that Addaction had referred Elaine to this MARAC meeting, we need to question what they felt their responsibility was, and what they expected the MARAC to do given they had already closed her case. A recommendation is added here to address this.
- (c) Elaine's GP was not engaged with the MARAC process. This situation is found across the country, as it is difficult for MARAC Coordinators or Chairs to engage with every GP, or for GPs to commit time to MARAC meetings. However, some areas have addressed this through link workers, or actions for MARAC Coordinators or Chairs to contact GPs. A recommendation is therefore added here to address this gap in Brent.
- (d) Given all of her needs, the Panel discussed whether Elaine could have been seen as a vulnerable adult, and received support through this route. There was agreement that the GP, and possibly others, could have considered seeking advice and information from the safeguarding adult's service. This could have led to Elaine accessing support through a different route, that looked at the risk she faced as a result of her circumstances, and how to

minimise that through supporting her – rather than focusing on only one of her issues.

- (e) Any of the agencies working with Elaine could have – and at times did – recognised that whatever was being offered was not ‘working’ for Elaine, in that her behaviour did not change (or if it did it was temporary). Elaine disclosed to Addaction, and was presumably known by her GP, to have had issues with alcohol and depression for around twenty years. It must be asked then, at what point is an alternative 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.

4.2.4 *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, with her chaotic lifestyle, lack of a stable home, experiences of abuse, distress and stress, poor sleeping, alcohol misuse and mental health issues – 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) Elaine’s difficulties in engaging consistently, as required by services, can be seen as far back as 1996 when she was in contact with CNWL counselling services. Despite highlighting her unresolved issues, the service took Elaine’s lack of attendance at two appointments as a wish to no longer be in counselling, and discharged her back to the GP.
- (c) The question that needs to be asked, therefore, is 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.
- (d) 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.
- (e) 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.

- (f) An alternative view is presented in the Blue Light Project Manual, which suggests that it is wrong to assume that because a client is stating they do not wish to change, or acting in a way that does not support change, that they therefore cannot be worked with:

“Miller and Rollnick’s work on motivational interventions is built on the recognition that denial is simply a façade. Behind that veneer of denial is a person who is in a state of ambivalence. They may be uncertain about whether they can change, they may believe that family history destines them to be a drinker, they may be scared of what change entails. Other evidence has shown that 40% of apparently non-changing higher risk and dependent drinkers try and change each year.”

- (g) This is relevant for Elaine, who referred to her mother as an ‘alcoholic’, who seems to stop and start drinking repeatedly, and who has been drinking for such an extended length of time (over twenty years) that to stop completely could have been frightening. In addition, drinking was just one of many, many issues she was contending with, and to focus on her changing that pattern, without addressing those other issues – housing, domestic abuse and mental ill health being the prime ones – was unrealistic.

4.2.5 *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.

4.2.6 *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.
- (b) What was available, that could have been offered to Elaine to support her in making the changes required to have contact with her daughter? This contact was clearly a motivating factor for Elaine, and shaped many of her decisions. For example following a domestic incident on 8 July 2011, Elaine tells Victim Support that she doesn't want to press charges against Andrew because she was due to see Children's Social Care and wants contact.
- (c) Elaine also disclosed to Addaction that she was frustrated with Children's Social Care as she "doesn't see what more I can do", and it was at this point that she disengaged, perhaps giving up her wish to see her daughter, due to the incessant focus on her alcohol use regardless of her many other problems.
- (d) 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.

4.3 Review Panel Recommendations

4.3.1 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.

4.3.2 Recommendation 2

The Metropolitan Police Service to review all DHR recommendations, as made in MPS IMRs (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.

4.3.3 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.

4.3.4 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.

4.3.5 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).

4.3.6 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

4.3.7 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.

4.3.8 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.

4.3.9 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.

4.3.10 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.

4.3.11 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.

4.3.12 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.

4.3.13 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.

4.3.14 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.

4.3.15 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.

4.3.16 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.

4.3.17 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.

4.3.18 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.

4.3.19 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.

Appendix 1: Domestic Homicide Review

Terms of Reference

This Domestic Homicide Review is being completed to consider agency involvement with **Elaine, Elijah** and **Michael** following her death. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHRs) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.
2. To review the involvement of each individual agency, statutory and non-statutory, with Elaine, Elijah and Michael during the relevant period of time: May 2011 and.
3. To summarise relevant agency involvement prior to May 2011.
4. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
5. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
6. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
7. To commission a suitably experienced and independent person to:
 - a) chair the Domestic Homicide Review Panel;
 - b) co-ordinate the review process;
 - c) quality assure the approach and challenge agencies where necessary; and
 - d) produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
8. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
9. On completion present the full report to Brent Community Safety Team.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.
11. The following agencies are to be involved:
 - a) Clinical Commissioning Group (formerly known as Primary Care Trusts)
 - b) General Practitioner for the victim and perpetrator
 - c) Local domestic violence specialist service provider (IDVA)
 - d) Children's services (through the Safeguarding representative)
 - e) Adult services
 - f) Health Providers – to be agreed but to include Acute, Mental Health and others as necessary
 - g) Substance misuse services
 - h) Housing services
 - i) Local Authority
 - j) NHS England
 - k) Police (Borough Commander representative, Critical Incident Advisory Team officer, Family Liaison Officer and the Senior Investigating Officer)
 - l) Probation Service
 - m) Victim Support (including Homicide case worker)
12. If there are other investigations or inquests into the death, the panel will agree to either:
 - a) run the review in parallel to the other investigations, or
 - b) conduct a coordinated or jointly commissioned review - where a separate investigation will result in duplication of activities.

Collating evidence

13. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
14. Each agency must provide a chronology of their involvement with Elaine, Elijah and Michael during the relevant time period.
15. Each agency is to prepare an Individual Management Review (IMR), which:
 - a) sets out the facts of their involvement with Elaine, Elijah and Michael;
 - b) critically analyses the service they provided in line with the specific terms of reference;
 - c) identifies any recommendations for practice or policy in relation to their agency, and

- d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.
16. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Elaine, Elijah or Michael in contact with their agency.

Analysis of findings

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

Liaison with the victim's and alleged perpetrator's family

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

Development of an action plan

21. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.
22. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.
23. There was a gap between completion of the report and submission to the Home Office due to action plan to be completed.

Media handling

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

Confidentiality

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

Disclosure

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

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Appendix 2: Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<p><i>What is the over-arching recommendation?</i></p>	<p><i>Should this recommendation be enacted at a local or regional level (N.B national learning will be identified by the Home Office Quality Assurance Group, however the review panel can suggest recommendations for the national level)</i></p>	<p><i>How exactly is the relevant agency going to make this recommendation happen?</i></p> <p><i>What actions need to occur?</i></p>	<p><i>Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?</i></p>	<p><i>Have there been key steps that have allowed the recommendation to be enacted?</i></p>	<p><i>When should this recommendation be completed by?</i></p>	<p><i>When is the recommendation and actually completed?</i></p> <p><i>What does the outcome look like?</i></p>

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<p>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.</p>	Local	Agencies to update CSP on action plan recommendation 6 months after the overview report action plan has been approved.	All			

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
The Metropolitan Police Service to review all DHR recommendations, as made in MPS IMRs (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.	Regional	The recommendation s working group will next convene on 20 th November 2015 and review police IMRs for the previous two years, from the date of the first meeting, in order to identify any service wide lessons.	Metropolitan Police Service	This group will be responsible for considering all learning and recommendations arising from Domestic Homicides within London.	On-going	On-going The group will be responsible for advising the senior MPS Domestic Abuse lead and implementing any changes to policies and procedure to improve our service delivery to victims of domestic abuse.
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.	Local	CSU to devise a task and finish group incorporating Brent CSU and victim support.	CSP VAWG Delivery Group	Delegated to CSP until completed Outcomes would be: 1) Identify scale of issue 2) Identify remedial steps necessary 3) Complete remedial tasks	Ensure all staff are fully trained and aware of all the questions to ask and fill out the forms accurately. On-going	On-going
The MARAC Steering Group, with support from the Violence Against Women and Girls Delivery Group, to agree a way	Local	To meet with CCG to highlight and advocate for good practice to	Hestia	Action update the MARAC coordinator to identify the appropriate person from the CCG and arrange a meeting to feedback progress	MARAC Steering Group meeting	October 2017 training was provided to GP's to advocate for good

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
forward for involving GPs in the MARAC, with reference to good practice elsewhere; to report to the Delivery Group on progress.		include GP information sharing at the MARAC.				practice and information sharing at the MARAC. On-going
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).	Local	Domestic Abuse and MARAC training made available and compulsory for all safeguarding practitioners in Brent. Social workers to consult with IDVAs for specialist advice; where domestic abuse is present in ta family home.	Safeguarding children	Domestic abuse training including MARAC is included in Level 3 CP training. 90% Of safeguarding practitioners in Brent have completed training.	On-going	On-going, making sure all new practitioners have completed the training.
CNWL to report to the Violence Against Women and Girls Delivery Group on their	Local	Update on practitioner training history/ future plans	CNWL	Representation at the MARAC who can support all CNWL Services in Brent and participate in appropriate training for this role.	Completed	Practitioner with capacity and skill to undertake this role.

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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.		regarding domestic abuse and MARAC. Update on how MARAC cases are flagged.				Has good relationships with wider MARAC members
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.	Local	Staff to provide written rationale for actions taken	CNWL	Documentation with rationale to be included in the clinical system work for System 1 roll out	Implementation on roll out in Brent 2016/17	Documentation supported by training enables staff to clearly record rationale for decisions taken.
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.	Local	Ensure all staff have access to good clinical supervision	CNWL	Email reminder to Divisional Director of Nursing in Diggory Audit of case notes in Diggory to check reference to clinical supervision	Completed From March 2016	Completed

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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.	Local	Prompt question on assessment forms	CNWL	Documentation with domestic abuse prompt question to be included in the clinical system work for System 1 roll out		Review compliance for Addictions – All staff to have awareness of domestic abuse and know how to support patients and their families.
To ensure that Domestic Abuse awareness training is available for all staff, at a level suitable to their needs	Local	This is part of the staff mandatory training programme	CNWL	Review will be via the quarterly mandatory training dashboard	On-going	On-going
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.	Local	Update on staff/practitioner training history/ future plans regarding domestic abuse and MARAC. Update on how MARAC cases are flagged.	Addaction & all partner agencies involved in MARAC	Addaction/Evolve to continue attending the VAW&GDG and MARAC. All staff are expected to complete mandatory Safeguarding and other training. Evolve staff to receive Gang training during induction or refresher training. Evolve to attend Matrix Gang meeting.	Monthly/ Quarterly Annually As necessary Quarterly	Action on going, already being actioned. By end of each calendar year for e-learning modules to be completed. Action on going, already being actioned. Action on going,

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
				Alerts added when risk identified on file and electronic data management system	As necessary	already being actioned. Action on going, already being actioned.
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.	Local	Domestic Abuse policy and procedure to be developed for the GP of Elaine. Brent GPs to show proactivity enquiry into potential domestic abuse victims.	Brent CCG	The IRIS model of responding to domestic abuse in General Practice has been trialled in Bristol and Hackney. This is a comprehensive model of identification and referral to improve safety of victims of domestic abuse specifically aimed at GP staff. This model has been highlighted by Dr Sarah Basham as 'gold standard' in terms of best practice and the CCG Team Agrees. Action: A business case to be developed by SB covering safeguarding adults and children which would need to be sustainable the networks to take forward.	Work in progress	
The General Practice for Elaine (with support from NHS England) to ensure that pathways are in place for	Local	GP of Elaine to ensure they are sighted on homelessness	Brent CCG	Current level three\Safeguarding Children training programme for Brent GPs includes a domestic abuse scenario where	Safeguarding Level 3 training sessions	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
patients who attend reporting homelessness and advise the Violence Against Women and Girls Delivery Group on progress.		options/referral routes for presenting patients		national and local information is given including the Brent MARAC. GPs are also signposted to the Royal College of General Practice (RCGP) website where further resources can be found.		
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.	Local	The learning and practice referenced in Recommendations 7 and 8 to be provided to all General Practices and advised regarding this best practise.	Brent CCG	A draft DV training pack has been reviewed and updated by the Violence Against Women, Girls (and Boys) group. A lesson plan will also be developed outlining all the timings. Once completed a final draft including the lesson plan will be sent out to agreed training pool for comments. Work in progress: CCG to: •Deliver the domestic abuse training specifically to General practice •To deliver domestic abuse training across the health economy •To include DV training in LSCB training programme	Work in progress	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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.	National	Correspond with 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.	Review Chair	Immediately after review report accepted by Brent CSP and forwarded to Home Office	May 2017	May 2017
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.	Local	Review reports and guidance for the following projects: St Mungo's Rebuilding Shattered Lives and the Alcohol Concern Blue Light Project and feed back to the VAWG Delivery group on how practice can work with women with multiple and	Public Health commissioners of drug and alcohol services	Both documents to be circulated to Treatment and Recovery Sector leads with a study session / workshop to take place at a TARS weekly meeting before onward discussion at VAWG and Brent Community Safety Partnership	01/09/16 Circulation of documents to TARS leads completed Workshop seminar 3/09/16	Presentation to VAWG Delivery Group October/November

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
		complex needs, and how best is to engage clients who find it difficult to engage.				
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.	Local	Update report bi-quarterly to the Community Safety Team to include caseload numbers and plans for further reduction. Report to also include joint working with Substance misuse IDVA service and the overall supervision of this role.	Hestia	Hestia to provide quarterly report to CSU (current reporting format) on Caseloads and case management data amending its	On-going for each quarters	On-going for each quarters – until November 2017 (end of service)
The Violence Against Women and Girls Delivery Group to conduct a review, with Hestia and their referring agencies, to understand the process when	Local	Flow-chart analysis to be completed and presented to the VAWG delivery	Hestia	Hestia to liaise with VAWG Delivery group members to establish current practice / process followed when refer the referring agency when they are informed by the IDVA service that contact has not		All actions completed November 2017

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
<p>contact cannot be made with victims referred into the IDVA service. This should include:</p> <ul style="list-style-type: none"> ▪ 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 <p>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.</p>		<p>group highlighting the processes involved when a victim is contact. Analysis to include information on what the process is when a victim cannot be contacted and at what point the referring agency is updated of any activity.</p>		<p>been achieved. Practice to be shared (flow chart analysis) to VAWG Delivery Group with its members.</p> <p>Individual Solution Focussed Action Meetings to be held with VAWG Delivery Group Members</p> <p>Review and proposal including the development of a Local IDVA Community Engagement Policy to be presented to the CSU</p> <p>Final Report/ recommendation to VAWG Delivery Group</p>		
<p>The MARAC Chair, coordination service 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</p>	<p>Local</p>	<p>Actions for perpetrators to be included for each MARAC case where possible.</p> <p>Monitoring MARAC actions</p>	<p>Hestia</p>	<p>Action update – Actions for perpetrators are added to the MARAC minutes as appropriate. Hestia to provide minutes from meetings that evidence this at the MARAC steering group.</p>	<p>All MARAC Steering Group meetings</p>	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
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.		to ensure actions being completed. Update on completed actions to MARAC steering group.				
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.	Local	Review 10 MARAC cases where domestic abuse victim arrested or accused of abuse – to review processes and procedures taken.	Hestia	This is in progress and the information will be brought to the MARAC steering group. Action update Hestia (MARAC coordinator) to identify 10 cases for review, circulate a list prior to the next steering group for each member to review the process and procedures taken by their individual agency and report back outcomes to the group. The group can then formulate and agree any actions required going forward.	MARAC Steering Group meetings	
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.	Local	Review 10 MARAC cases to ensure whether housing options have always been referred to and exhausted for such high risk	Hestia	Action update – the same 10 cases as noted above to be circulated and reported back the housing situations of the sample group.	MARAC Steering Group meetings	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones in enacting the recommendation	Target Date	Date of Completion and Outcome
Outcome of review and actions required as a result to be presented to the Delivery Group and CSP.		victims.				
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.	Regional	Correspond with the London Chief Crown Prosecutor outlining concerns about the lack of prosecutions that may have been possible in this case. Request that further efforts are made to ensure that the CPS's violence against women and girls policies are more consistently implemented at operational level.	Review Chair	Immediately after review report accepted by Brent CSP and forwarded to Home Office	May 2017	May 2017

<p>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.</p>	<p>Local</p>	<p>VAWG Delivery group structure to be reviewed for optimum effectiveness.</p> <p>Ensure appropriate level of authority is represented by partner agencies at the VAWG delivery group. Any DHR recommendations to be actioned by the VAWG Delivery chair and ensured completion.</p>	<p>VAWG Delivery Group Chair</p>	<p>To be reviewed every six months</p>	<p>On-going</p>	<p>On-going</p>
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Appendix 2: Home Office Letter



Home Office

Public Protection Unit
2 Marsham Street
London
SW1P 4DF

T: 020 7035 4848

www.gov.uk/homeoffice

Community Protection Project Officer
Community Protection Services
London Borough of Brent

6 December 2017

Dear Sir/Madam,

Thank you for submitting the Domestic Homicide Review (DHR) report for Brent to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 25 October 2017. I very much regret the delay in providing the Panel's feedback.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel concluded this was a well written report which clearly articulates a complex case. The review demonstrates a good understanding of the dynamics of domestic abuse and the impact it can have and appropriate lessons have been identified.

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

- The Panel felt further narrative may be helpful to reassure readers that there was sufficient independence and robust oversight of the review given the information set out in paragraphs 3.5.1 and 3.4.1;
- Linked to the above, it would be useful if the report could explain why an IMR was not requested covering the MARAC;

- It would be helpful if the report could set out whether the recommendations were agreed with the agencies concerned;
- You may wish to update the action plan so that it includes specific target dates;
- The Panel reiterated the importance of offering advocacy services to families when inviting them to engage in reviews;
- In line with the statutory guidance, the executive summary should be a separate, standalone document that can be read in isolation;
- It would be helpful if the narrative could include details of the gap between completion of the report and submission to the Home Office;
- Please proof read the report to correct typing errors before publication.

The Panel does not need to review another version of the report, but I would be grateful if you could include our letter as an appendix to the report. I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the Mayor's Office for Policing and Crime for information.

Yours sincerely

Hannah Buckley

Acting Chair of the Home Office DHR Quality Assurance Panel



