SAFER LAMBETH PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Sophia

May 2017

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date: August 2018

1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Lambeth Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Sophia, a resident of the London Borough of Lambeth.

1.1.2 Sophia was murdered by her former partner, Daniel, shortly after she had collected Child B from their Primary School and while walking home. Both the Primary School and Sophia's home were in the same part of Lambeth. In addition to Child B, Sophia was in the company of Child A and a friend (June).

1.1.3 This review has been anonymised in accordance with the statutory guidance. The specific date of the homicide and the sex of the children have been removed (with anonymity further enhanced by the children being referred to as Child A and Child B). Only the chair and Review Panel members are named.

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

- Victim – Sophia (33 at the time of the homicide)
- Perpetrator – Daniel (41 at the time the homicide)
- Victim's sister – Cora
- Colleague / Friend – Anna
- Colleague / Manager – Ava
- Colleague / Manager – Dawn
- Friend of Sophia – Grace
- Friend of Sophia – June
- Colleague / Friend – Harper
- New boyfriend of Sophia – Noah
- Colleague / Friend – Tejbir
- Mother of perpetrator – Victoria.

1.1.5 As Sophia both worked in, and had been a patient with, Kings College Hospital NHS Foundation Trust (KCH) the Review Panel discussed whether it would be appropriate to anonymise the Trust. It was agreed that this was a decision for the family. The chair discussed this issue with Cora (Sophia's sister) after she had reviewed the draft report in July 2018. She said she was comfortable with KCH being identified.

1.1.6 Additionally, the Primary School and Secondary School are not named as this could make the children identifiable. The General Practitioners (GPs) contributing to the review are also not named

as their location could be used to identify the subjects of the review. They are referred to as 'Medical Centres'.

1.1.7 The criminal trial concluded in November 2017, with Daniel pleading guilty to Sophia's murder. In December 2017 Daniel was sentenced to life imprisonment with a minimum term of 21 years.

1.1.8 The DHR began when the Safer Lambeth Partnership, in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'*, commissioned this review. Having received notification from the Metropolitan Police Service (MPS) in late June 2017, a decision was made to conduct a DHR in consultation with the Local Authority Chief Executive and the Chairs of the Lambeth Safeguarding Adults Board (LSAB) and Lambeth Safeguarding Children's Board (LSCB). Subsequently, the Home Office was notified of the decision in writing at the start of July 2017.

1.1.1 Standing Together Against Domestic Violence (STADV) was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in July 2017. The completed report was handed to the Safer Lambeth Partnership in August 2018. In September 2018, it was tabled at an extraordinary meeting of the Safer Lambeth Partnership Executive Board and signed off, before being submitted to the Home Office Quality Assurance Panel in the same month. In January 2019, the completed report was considered by the Home Office Quality Assurance Panel. In February 2019, the Safer Lambeth Partnership received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.2 Contributors to the Review

1.2.1 This review has followed the statutory guidance. On notification of the homicide agencies were asked to check for their involvement with any of the subjects of the review, complete a summary of engagement form and secure any records. The approach adopted was to then seek Individual Management Reviews (IMRs) from those agencies that had been in contact. A total of 22 agencies were contacted. Eight agencies returned a nil-contact, 12 agencies submitted IMRs and chronologies, and two agencies provided summary of engagements only due to the brevity of their involvement. The chronologies were combined, and a narrative chronology produced.

1.2.2 The following agencies were contacted, but recorded no involvement:

- Lambeth Council Adult Social Care
- South London and Maudsley NHS Foundation Trust (SLAM)
- National Probation Service
- London Community Rehabilitation Company
- London Ambulance Service
- NHS 111
- Turning Point (Substance misuse service)

- Croydon Council Children Social Care.

1.2.3 The following agencies and their contributions to this DHR are:

Agency		Contribution
Croydon Medical Centre (Daniel's GP) – completed by Croydon Clinical Commissioning Group (CCG)		IMR and Chronology
Guy's and St Thomas' NHS Foundation Trust (GSTT)		IMR and Chronology
KCH	As a health provider	IMR and Chronology
	As Sophia's employer	
Lambeth Children's Social Care (CSC)		IMR and Chronology
Lambeth Housing		IMR and Chronology
Lambeth Medical Centre (Sophia, Child A and Child B's GP) – completed by Lambeth CCG		IMR and Chronology
MPS		IMR and Chronology
Primary School		IMR and Chronology
The Gaia Centre (provided by Refuge)		IMR and Chronology
Secondary School		IMR and Chronology
Victim Support		IMR and Chronology

1.2.4 In addition to the above agencies, it was also identified at the first Review Panel meeting that Sophia had been in contact with the Child Maintenance Service (CMS)[1], having made two applications for child maintenance during the time period being considered. Securing an IMR from the CMS was challenging, and this took up a significant amount of time, particularly for the chair, with a commensurate cost being incurred by the Safer Lambeth Partnership. These challenges were ultimately resolved and are more fully described in the Overview Report. The root cause was identified as uncertainty about the process, as this was the first time the CMS had been asked to participate in a DHR. Recommendations have been made to address this issue.

1.2.5 It was also identified at the first panel meeting that Daniel had contact with the National Society for the Prevention of Cruelty to Children (NSPCC) Helpline[2] during the period under review. Contact was made with the NSPCC, who promptly provided a summary of engagement of good quality. As

[1] The role of the CMS is to support separated families to establish effective financial arrangements for their children. For more information, go to: https://childmaintenanceservice.direct.gov.uk.

[2] The NSPCC helpline provides help and support to thousands of parents, professionals and families. https://www.nspcc.org.uk/services-and-resources/nspcc-helpline/.

their contact was limited it was agreed that the NSPCC would not attend the Review Panel but would be updated via the chair and invited to contribute as needed.

1.2.6 Lastly, during the course of the review, it was established that Sophia had contact with the Lambeth Council's Revenues and Benefits Service in relation to Council Tax. This team was approached for, and provided, a summary of engagement.

1.2.7 *Independence and Quality of IMRs*: IMRs were written by authors independent of case management or delivery of the service concerned. Most of the IMRs received were of a good quality, although some IMR authors adapted the templates provided. However, it was noticeable that where contact was limited, the quality of the IMRs submitted was of a lower standard. Nonetheless, all the IMRs submitted enabled the Review Panel to analyse the contact with Sophia, Daniel and / or Child A and B, and to produce learning for the DHR. Where necessary further questions were sent to agencies and responses were received. Additionally, Refuge and the Primary School were asked to revise their IMRs to specifically reflect good practice.

1.2.8 One area that was noticeably weak in agency IMRs was the analysis of equality and diversity. Some IMRs did not consider equality and diversity issues at all. Even where equality and diversity issues were considered, this tended to be focused on: whether agency records recorded any equality or diversity issues; how professionals worked with Sophia (few engaged with Daniel specifically); or framed in relation to compliance with organisational policies. While no recommendation is made in relation to this issue, it serves as a reminder that the commissioning Community Safety Partnership (CSP) and the chair must encourage IMR authors to engage fully with equality and diversity issues in their analysis. This issue is more fully described in the Overview Report.

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Name	Agency
Cheryl Wright, Safer Croydon Partnership Manager	Place Department, Safety Division. Crime & ASB, Croydon Council
Debbie Saunders, Head of Nursing Safeguarding Children	GSTT
Hillary Williams, Interim Deputy Director for Lambeth Operational Directorate	Mental Health, SLAM
Head of School[3]	Primary School
Head Teacher[4]	Secondary School
Janice Cawley, Acting Detective Inspector	Specialist Crime Review Group (SCRG), MPS

[3] Not named to ensure anonymity of school, see 1.1.6.

[4] Not named to ensure anonymity of school, see 1.1.6.

Jessica Ralph, Senior Operations Manager	Victim Support
Moira McGrath, Director of Integrated Commissioning and CCG Lead for Adult Safeguarding	Lambeth CCG
Naeema Sarkar, Assistant Director (Quality Assurance)	Lambeth CSC
Rachel Blaney, Designated Nurse for Safeguarding Adults	Croydon CCG
Richard Outram, Head of Safeguarding and Quality	Adults & Health, Lambeth Council
Heather Smith, Head of Adult Safeguarding Service	KCH
Seamus Costello, Alcohol/Stimulants Team Leader	Lambeth Addictions, SLAM
Shade Alu, Deputy Medical Director (Safeguarding)	Croydon Health Services NHS Trust
Sophie Taylor, Violence Against Women and Girls Programme and Commissioning Manager	Lambeth Council, Neighbourhoods and Growth
Stacey Bradburne, Violence Against Women and Girls Prevention and Engagement Officer	Neighbourhoods and Growth, Lambeth Council
Tunde Akinyooye, Acting Area Housing Manager	Lambeth Housing Services
Valerie Wise, Senior Operations Manager and Sharon Erdman, Head of Operations	Refuge (runs the Gaia Centre)

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

1.3.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 22 September 2017. There were further meetings on the 26 January 2018, 4 April 2018 and 27 June 2018. The Overview Report and Executive Summary were agreed electronically thereafter, with Review Panel members providing comment and sign off by email in August 2018.

1.3.4 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The chair and author of the review is James Rowlands, an Associate DHR Chair with STADV. James Rowlands has received DHR Chair's training from STADV. James Rowlands has chaired and authored two previous DHRs and has previously led reviews on behalf of two Local Authority

areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.4.2 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.4.3 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.4.4 *Independence*: James Rowlands has no current connection with the local area or any of the agencies involved. James has had some contact with Lambeth prior to 2013 in a former role, when he was a Multi Agency Risk Assessment Conference (MARAC) Development Officer with SafeLives (then CAADA)[5]. This contact was in relation to the development of the local MARAC as part of the national MARAC Development Programme and is not relevant to this case.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared brief information about agency contact with subjects of the review, and as a result, established that the time period to be reviewed would be from 2008 (when the relationship is believed to have begun) to the date of the homicide. Where there was agency involvement with either subject prior to 2008, agencies were asked to summarise this, and review any issues pertinent to the review.

1.5.2 The Review Panel comprised agencies from Lambeth, as the victim was living in that area at the time of the homicide. Additionally, the perpetrator lived in and had some limited contact with agencies in the neighbouring London Borough of Croydon. Agencies in that borough were contacted for information and involved in the review, with this coordinated through a Review Panel member from the Safer Croydon Partnership.

1.5.3 *Key Lines of Inquiry*: The Review Panel considered both the 'generic issues' as set out in the statutory guidance and identified and considered equality and diversity, as well as the following case specific issues:

- The communication, procedures and discussions, which took place within and between agencies
- The co-operation between different agencies involved with Sophia, Daniel and the wider family, specifically Child A and Child B

[5] For more information, go to: http://www.safelives.org.uk.

- The opportunity for agencies to identify and assess domestic abuse risk, including during any contact with Sophia, Daniel and / or Child A and Child B in relation directly to domestic abuse and / or other needs and issues
- Agency responses to domestic abuse issues
- Organisations' access to specialist domestic abuse agencies
- The policies, procedures and training available to the agencies involved in domestic abuse issues
- What might have helped or hindered engagement in services.

1.5.4 Additionally, the following issues were identified as potentially pertinent to the case and agencies were asked to consider these in their analysis where relevant: parental mental health and well-being; substance use; civil orders such as Non-Molestation Orders[6] and Prohibited Steps Orders[7]; and the impact of domestic violence and abuse on children.

1.6 Summary of Chronology

1.6.1 A range of agencies had contact with Sophia. Broadly this contact related to the following themes:

- Health
- Children
- Employment
- Domestic violence and abuse
- Child maintenance
- Other issues.

Health

1.6.2 Sophia had contact with a range of health services, including KCH (during pregnancy) and GSTT (health visiting services). No specific issues have been identified in relation to Sophia's contact

[6] A Non-Molestation Order may be made under Part IV of the Family Law Act 1996. Non-Molestation Orders aim to protect victims of domestic violence from being abused. A non-molestation order prohibits the abuser from being violent or threatening violence and carries the power of arrest.

[7] A Prohibited Steps Order may be made under section 8 of the Children Act 1989. It is an order that stops a parent who has parental responsibility from exercising that in relation to the issue set out in the order without the permission of the court. I.e. it tells a parent what they cannot do in respect of their child(ren). Examples including: stopping a child being removed from a particular parent's care, preventing a child being removed from a jurisdiction (England and Wales) or stopping a child being removed from their school.

with KCH. In relation to GSTT, while the medical care provided was appropriate, there were opportunities when routine enquiry could have been undertaken about domestic violence and abuse, but it is not clear if this happened.

1.6.3 Sophia's most significant contact was with the Lambeth Medical Centre. This contact related to her own or her children's health and can broadly be described as consisting of routine consultations or responses to specific health needs. Sophia made some disclosures relating to the end of her relationship, and to her *"domestic circumstances*". While the medical care Sophia received was appropriate, there were missed opportunities to directly enquire around domestic violence and abuse.

Children

1.6.4 Sophia had contact with both the Secondary and Primary School around Child A and Child B's education. This included disclosing domestic violence and abuse to the latter but not the former. Additionally, there seems to have been issues with information sharing by Lambeth CSC to the Primary School and no information sharing with the Secondary School. The review has also identified issues with how Non-Molestation Orders and Prohibited Steps Orders are shared with education providers.

1.6.5 Both Child A and Child B were seen by staff from GSTT in relation to their developmental needs. Opportunities for staff to make direct enquiry in the context of health visiting services are described above, but it is also clear that despite extensive contact over time, Sophia did not make any disclosures to GSTT staff about domestic violence during her contact with them around the developmental needs of her children. The reasons for this should be considered further. Although no specific issues were identified in relation to the response by health professionals, the Review Panel noted that Sophia's experience may highlight some of the challenges for a parent in navigating the local pathway for the assessment / diagnosis of a learning difficulty.

1.6.6 Lambeth CSC had contact with Sophia on two occasions in 2016. The first (in April 2016) led to no action being taken. The second (from June 2016 onwards) related to Daniel's allegation that Child A had hit Child B. The review has identified a range of issues with Lambeth CSC's response including: the extent to which it accessed information from the wider professional network; the completeness of its assessment; the consideration of domestic violence and abuse; and the robustness of supervisory oversight. This review has also identified how Lambeth CSC over relied on the presence of Protective Orders in its assessment of risk and did not engage with Daniel directly in relation to his abusive behaviour. Significantly, this meant that Daniel's allegation in June 2016 was not considered more broadly in the context of domestic violence and abuse in the relationship, including whether it might be an example of 'abuse of process'.

Employment

1.6.7 Sophia was employed by KCH and made disclosures to her manager(s). It appears that these were dealt with sympathetically at the time. However, KCH has identified opportunities to further develop support for staff and managers in relation to domestic violence and abuse. Additionally, as a whole, members of the Review Panel discussed their own agency provision for staff and managers and identified that a number do not have a policy or procedure in place.

Domestic violence and abuse

1.6.8 Sophia had contact with the MPS, the Gaia Centre and Victim Support around domestic violence and abuse.

1.6.9 There were significant issues with the MPS response, with this being compromised by disputes over procedural issues which likely affected Sophia's confidence that the MPS could provide help, as well as limited inter-agency engagement with the Gaia Centre. Additionally, opportunities to undertake enforcement of the Non-Molestation Orders were not exploited.

1.6.10 The Gaia Centre provided extensive support to Sophia over a period of some months in 2016. This appears to have been useful to Sophia, although the review has identified a number of issues with the Gaia Centre's response. In particular this includes: the review of the Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC); consideration of a referral to the local MARAC on professional judgement; and issues around Protective Orders (in particular safety netting advice about what to do when an order is due to end). While Victim Support had very limited contact with Sophia, the fact that both services had contact with her is an important reminder of the need for specialist services to establish if someone is accessing support from another provider.

1.6.11 Learning that is relevant to all agencies (but particularly Lambeth CSC, MPS, Gaia Centre in this case) relates to the different levels of knowledge about Protective Orders generally and specifically in relation to what orders were in place in relation to Sophia and the children.

Child maintenance

1.6.12 Sophia had contact with the CMS on two occasions to apply for child maintenance. The CMS also had (or attempted) contact with Daniel in relation to Sophia's applications. The CMS's response to Sophia was inadequate. The review has also identified systemic issues in relation to how domestic violence and abuse are addressed by the CMS in its contact with the public generally; the management of domestic violence and abuse; and staff training.

Other issues

1.6.13 Sophia had contact with Lambeth Housing, as well as Lambeth Council's Revenue and Benefits Service. This contact was limited to the management of maintenance or Council Tax and benefit issues. While this contact was appropriate, it could have been an opportunity to explore the cause of the issues Sophia was having. This may have created space to encourage disclosure of, or enquiry about, domestic violence and abuse.

1.6.14 In contrast, the contact with Daniel was more limited. There were no issues identified in relation to his limited health contact with the Croydon Medical Centre and Croydon Health Services. Despite his reported alcohol use, he does not appear to have accessed help around this from either his GP or other services (which is perhaps unsurprising as he denies this was an issue).

1.6.15 The MPS had contact with Daniel, in relation to both an allegation by Sophia and his own allegation that Child A had hit Child B. The MPS's management of both these issues was poor and opportunities to undertake enforcement of the Non-Molestation Orders were not exploited.

Analysis

1.6.16 Tragically, Sophia's death means that it will never be possible to know the full extent of her experiences. Considering the government definition of domestic violence and abuse, information

gathered by the MPS as part of the murder investigation, provided by other agencies, and accounts from family and friends, Sophia was clearly the victim of domestic violence and abuse from Daniel. Sophia made disclosures to a number of agencies and obtained a Non-Molestation Order and a Prohibited Steps Order, and these actions speak to her fears about what Daniel might do. They are also a testament to the steps Sophia took to protect herself and her children.

1.6.17 Although he claimed that he had never been violent or abusive in the relationship, the Review Panel concluded that Sophia was subject to a range of violence and abuse by Daniel. This included:

- Physical abuse: at least one assault, with disclosures by Sophia that Daniel had hit her in the past
- Coercion, threats and intimidation: threats including statements like: "*you are dead".* Other behaviours including harassment (e.g. multiple texts and phone calls) and potentially stalking (e.g. when Daniel approached Sophia on a bus after an application to the CMS, and successfully pressured her into withdrawing the application)
- Emotional abuse and isolation: examples of verbal abuse in person and by text and phone, including name calling. Friends also re-counted Sophia's experience of these calls, as well as other examples of Daniel's behaviour, including hanging up
- Sexual violence: no evidence was shared with the Review Panel in relation to sexual violence.

1.6.18 There is evidence that Daniel used Child A and Child B, in particular in relation to contact and care arrangements, but was also controlling over whether or not Child B's developmental needs were explored.

1.6.19 Sophia also experienced financial abuse (with Daniel withholding money, being threatened when she made a child maintenance application and ultimately murdered), and there is an indication that Daniel also sought to use economic abuse (Sophia told her employers and friends that Daniel wanted her to lose her job).

1.6.20 Taken together, Daniel's behaviour would have enabled him to exert coercive control over Sophia.

1.6.21 There is another feature of Daniel's abusive behaviour that should be explicitly named: Daniel's (unsubstantiated) allegation that Child A had hit Child B. This could be seen as an example of 'abuse of process', which involves the use of different platforms to continue unwanted contact, undermine someone's credibility, exercise control or to demonstrate an abuser's own power.

1.7 Conclusions

1.7.1 Daniel waited for Sophia at a place where he knew she would be (Child B's school, at the end of the school day, when she was in the company of Child B, Child A and a friend), before confronting her and shortly thereafter stabbing her to death. This tragedy, and the fact that Child A and Child B will have to grow up without their mother as a result of Daniel's actions, is made even worse given their proximity to the attack. Sophia's family and friends have also been deeply affected.

1.7.2 But Daniel's actions must not be allowed to overshadow Sophia's life. The Pen Portrait of Sophia provided by her sister, as well as interviews with her friends and colleague, speak to her character and spirit. Sophia was dedicated to her children. She was also a well-liked, dynamic and funny friend and colleague, as well as a valued employee.

1.7.3 There has been significant learning identified during the course of this review, which the Review Panel hopes will prompt individual agencies, as well as the appropriate partnerships, to further develop their response to domestic violence and abuse. This learning is summarised below.

1.7.4 The Review Panel extends its sympathy to all those affected by Sophia's death and thanks all those who have participated in the review.

1.8 Lessons To Be Learnt

1.8.1 The most substantive learning in this case has related to four areas: Protective Orders, child maintenance, the assessment of domestic abuse in a family context and the police response.

1.8.2 In the case of Protective Orders, these were useful tools for Sophia: she had obtained a Non-Molestation Order (in place until shortly before the homicide), as well as a Prohibited Steps Order. However, in practice, agencies had different levels of knowledge, both about orders generally, as well as specifically in relation to what orders were in place. Sophia's murder demonstrates why it is critical to look beyond the existence of an order and ensure that the potential risk posed by an (alleged) perpetrator is considered in and of its own right, including when an order comes to an end. While the specific learning relates to a number of agencies, it has a broader relevance to all professional and agencies. This has included identifying an opportunity to consider whether more can be done to enable the activation of Protective Orders and better support a victim in their use of such tools. Recommendations have been made to address these points.

1.8.3 Child maintenance is central to this case within a wider context of financial and economic abuse. Daniel was able to use threats to force Sophia to drop her original application for child maintenance. That in and of itself is important learning about the necessity to understand and identify financial and economic abuse, including how it operates in the context of an abusive relationship underpinned by coercive control. This case has also identified critical learning for the CMS, the agency responsible for managing child maintenance applications. Its management of Sophia's case was inadequate. Additionally, the evidence available to the Review Panel has illuminated concerns beyond Sophia's experience, highlighting what appear to be systemic issues in the CMS's response to domestic violence and abuse. Despite estimates that a third of its users will have been affected by domestic violence and abuse, there are significant problems in: the profile given to this issue; the CMS's procedures (including the management of risk from an

(alleged) perpetrator); and staff training. The CMS's current response to domestic violence and abuse is therefore insufficient. Urgent action is required to address the learning from this review and a number of recommendations have been made.

1.8.4 Being able to assess domestic abuse in a family context is essential in order to safeguard children and the non-abusive parent, as well as to hold the perpetrator to account. In Sophia's case, Lambeth CSC did not undertake a holistic assessment. This meant they did not consider the reason for the allegations made by Daniel, including whether this was an example of abuse of process, and failed to draw on all the resources at their disposal (both in terms of information from other agencies, but also conceptually in terms of understanding the impact of domestic violence). Nor was Daniel's abuse directly addressed. Those familiar with findings from DHRs will be aware that such learning is not uncommon. More pressingly, not dissimilar findings have been a feature of a previous SCR in Lambeth. There are recommendations for both Lambeth CSC and the LSCB to address this learning.

1.8.5 Conversely, there has also been learning for two agencies, the Gaia Centre (provided by Refuge) and the Primary School, in relation to their information sharing with Lambeth CSC. In both cases these agencies could have shared information more proactively.

1.8.6 Sophia reached out for help to the MPS. Yet procedural issues likely comprised Sophia's confidence in the MPS. This is unacceptable. These issues also meant there was limited inter-agency engagement with the Gaia Centre and missed opportunities around enforcement. The MPS has acknowledged these issues, and a recommendation has been made to ensure that the learning from this case is disseminated force wide.

1.8.7 In addition to the learning in these four substantive areas, a range of other learning has also been identified by agencies (reflected individually as part of their IMRs), as well as by the Review Panel (which has made a number of recommendations in response).

1.8.8 This review has highlighted some procedural issues, relating to the role of government departments (and the agencies and public bodies that they are responsible for) in the DHR process. The review has also highlighted and explored a weakness in the approach of participating agencies in fully considering equality and diversity issues in their analysis of their contact with the subjects of a review.

1.8.9 There have however been examples of good practice. For example, despite learning for the Gaia Centre, they provided timely support to Sophia, while health and education providers offered interventions to Sophia and her family around a range of issues. The NSPCC's response is also commendable.

1.8.10 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. Fortunately, Lambeth has a well-developed VAWG strategy. Many of the recommendations made in this review will build on, or add to, the initiatives that are already underway to develop local processes, systems and partnership working. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

1.9 Recommendations

1.10 IMR Recommendations (Single Agency):

1.10.1 The following single agency recommendations were made by the agencies in their IMRs:

CMS

1.10.2 Updating our call scripts for our Applications caseworkers at the front end of the CMS business.

1.10.3 Implementation of coaching on domestic abuse for all our caseworkers by end October 2018 – which covers the points set out at section 8 above.

GSTT

1.10.4 Undertake an audit in regards to routine enquiry regarding domestic abuse across services. This is to look at whether routine enquiry is being undertaken; what the responses to domestic abuse were and actions undertaken as a result of any disclosure.

1.10.5 Develop a Trust domestic abuse strategy.

KCH

1.10.6 Drive/ promotion within Kings to raise awareness on Domestic Violence with a focus on the impact on staff / colleagues and the existing help available including the Employee Assistance Programme.

1.10.7 “Standalone policy/ guidelines for supporting staff experiencing Domestic Abuse. Completion by September 2018.

Lambeth CSC

1.10.8 Domestic Violence workshop at a Social Work for all Social Workers to stress the importance of using the Barnardo’s Risk Assessment Matrix, talking to perpetrators and sharing risk assessments with Gaia.

1.10.9 Lambeth Commissioners to improve the resources for perpetrators of domestic violence, in particular when the threshold for ongoing involvement of Children’s Social Care is not met.

The (Lambeth) Medical Centre

1.10.10 Practice Adult Safeguarding policy needs to be updated outlining the local resources available to support victims of Domestic Abuse.

MPS

1.10.11 It is recommended that Lambeth Borough Operational Command Unit (BOCU) Senior Leadership Team debrief the officers involved in this incident to remind them of the importance of ensuring risk has been adequately identified and managed in cases where responsibility for investigation is at dispute. Officers should be reminded of their responsibilities under the Code of Practice for Victims of Crime.

1.10.12 It is recommended that Croydon BOCU Senior Leadership Team debrief the officers involved in this incident to remind them of the importance of ensuring risk has been adequately identified and managed in cases where responsibility for investigation is at dispute. Officers should be reminded of their responsibilities under the Code of Practice for Victims of Crime.

Primary School

1.10.13 The school ensures that a member of the SLT or the Family Services Officer is on site whilst there are pupils on site. This is to respond to/ address any safeguarding or CP concerns that might arise.

Refuge

1.10.14 Refuge should review within the next 6 months whether a threat to kill on the SafeLives risk indicator checklist should be considered on a case by case basis to be escalated to high and therefore referred to the MARAC.

1.10.15 Refuge should ensure staff are aware of Refuge's policy to review the SafeLives risk indicator checklist every 4 weeks or earlier if a significant change occurs e.g. the granting of a Non-Molestation Order. This is to be conveyed to staff within the next 3 months.

1.10.16 Refuge should endeavour to ensure the last contact with a client is prior to case closure. In this case, a further telephone conversation should have been attempted following the call on 13th June 2016. This is to be conveyed to staff within the next 3 months.

Victim Support

1.10.17 Ensure that all Victim Support staff are aware of the timeframes stipulated in the DA Operating Procedure, provide training in areas where this practice has not been adopted. Managers to address this with their teams, through team meetings and one to one supervision.

1.10.18 Ensure that present day Victim Support procedure and practice is adhered to through the continued use of dip-sampling and case review and feedback to staff. This is already being actioned through the introduction of an improved case review and auditing process throughout the organisation on a national level. The Victim Assessment and Referral Centre staff should be included in this explicitly.

1.10.19 Victim Support has a robust induction process, including training on operating procedures but it would be good practice for procedures to be regularly circulated and discussed in team meetings as a standard agenda item.

1.10.20 When changes are made to policy and procedure to bring them up to date, this needs to be accompanied by a "briefing note" circulated throughout the organisation and feature on team meeting agendas within a month of launching revised policy/procedure to identify any further training need.

1.11 Overview Report Recommendations:

1.11.1 The Review Panel has made the following recommendations.

1.11.2 These recommendations should be acted on through the development of an action plan, with progress reported on to the Safer Lambeth Partnership within six months of the review being approved. In relation to the recommendations with national implications, the Chair of the Safer Lambeth Partnership should write the relevant government department, to share these recommendations and updates on the actions taken should be provided within six months of the review being approved.

1.11.3 **Recommendation 1:** The DWP to ensure that its agencies and public bodies have processes in place to enable them to participate in DHRs in a timely and appropriate manner.

1.11.4 **Recommendation 2:** The Home Office to amend the multi-agency statutory guidance for the conduct of DHRs by extending the duty 'to have regard' to government departments and the agencies and public bodies associated with them.

1.11.5 **Recommendation 3:** The UK Government to include abuse of process in the statutory definition of domestic violence and abuse and the associated statutory guidance.

1.11.6 **Recommendation 4:** MOPAC to work with local boroughs to develop a sustainable media-based public health awareness campaign to establish people's rights and promote community-building and primary prevention activities that tackle underlying assumptions in society.

1.11.7 **Recommendation 5:** The MPS quarterly recommendations meeting to review the learning from this report and take action to be assured that there is consistent practice across BOCU's regarding the resolution of disputes over responsibility for an investigation so that these are resolved promptly, and the safety of victims is prioritised.

1.11.8 **Recommendation 6:** The Gaia Centre (run by Refuge) to revise its operating procedures to ensure staff routinely enquire of a client whether they are working with other services.

1.11.9 **Recommendation 7:** Victim Support to ensure the practice in its specialist domestic abuse teams (to routinely enquire of a client whether they are working with other services) is reflected in its procedures.

1.11.10 **Recommendation 8:** The DWP to direct the CMS to urgently review its public facing literature to ensure it addresses domestic violence and abuse in line with best practice around awareness raising, including specific reference to economic abuse (what it is and how it operates in post separation abuse).

1.11.11 **Recommendation 9:** The DWP to urgently commission an independent review into the CMS's policy and procedure around domestic violence, informed by substantive consultation with victim/survivors and specialist domestic abuse services. This review to include in scope: the response to disclosures of domestic violence when making a child maintenance application; provision of independent specialist advice in that context; and the identification and management of risks by (alleged) perpetrators.

1.11.12 **Recommendation 10:** The DWP to direct the CMS to urgently commission a specialist domestic abuse service to review, develop and support the delivery of a robust domestic violence training programme.

1.11.13 **Recommendation 11:** The Safer Lambeth Partnership to identify how it can support the raising of awareness of domestic violence and abuse across the public, voluntary and private sector by encouraging employers to develop robust workplace policies to support employees who may be victims of domestic abuse, violence or stalking.

1.11.14 **Recommendation 12:** Representatives from organisations participating in this review that do not have a workplace policy to support employees who may be victims of violence, abuse or stalking to escalate this issue within their organisation so that a robust policy can be put in place.

1.11.15 **Recommendation 13:** The Lambeth CCG to work with general practices in the borough to incorporate the RCGP domestic abuse guidance for general practitioners into policies and practice.

1.11.16 **Recommendation 14:** The Lambeth CCG to develop a programme for general practices in the borough providing access to: training (including reflective practice) and a referral pathway (including specialist advocacy) to enable a consistent response to domestic violence and abuse.

1.11.17 **Recommendation 15:** The LSCB Performance and Quality Assurance Sub Group to undertake a wider case audit to explore the issues identified in this case (the limited exploration of domestic violence, the use of the Barnardo's Risk Assessment, decision making and supervisory oversight) and identify any actions required to improve performance**.**

1.11.18 **Recommendation 16:** Lambeth CSC to undertake a skills audit and a training needs analysis in relation to work with perpetrators, in order to develop and embed a consistent response to perpetrators across its workforce. This should include upskilling Team Managers, so they are able to provide the proper supervision and support.

1.11.19 **Recommendation 17:** The Safer Lambeth Partnership to implement and evaluate the planned multi-agency training on work with perpetrators being developed as part of the 'Prevention and Change' project.

1.11.20 **Recommendation 18:** The Safer Lambeth Partnership to review the referral route to the local MARAC in order to be assured that professionals are making appropriate referrals, in particular that they are confident in doing so on professional judgement.

1.11.21 **Recommendation 19:** The Gaia Centre (run by Refuge) to review the practice issues identified in this case and develop an improvement plan for agreement with the local commissioner**.**

1.11.22 **Recommendation 20:** Lambeth Housing to review national best practice in relation to housing management, including the Domestic Abuse Housing Alliance, and develop a local programme to further develop the housing management response to domestic violence and abuse.

1.11.23 **Recommendation 21:** The Safer Lambeth Partnership to undertake awareness raising and training activity to increase professional understanding of financial and economic abuse locally.

1.11.24 **Recommendation 22:** The Safer Lambeth Partnership to work with local partners to identify issues and barriers in relation to protective orders locally (particularly around professional understanding, application, use and expiration) and ensure that appropriate guidance and procedures are in place.

1.11.25 **Recommendation 23:** The Safer Lambeth Partnership to ensure that multi-agency training addresses protective orders so staff are aware of and understand their use of in domestic violence cases.

1.11.26 **Recommendation 24:** The Home Office work with the Ministry of Justice to implement a system whereby protective orders can be input directly to the Police National Computer.

1.11.27 **Recommendation 25:** The LSCB Performance and Quality Assurance Sub Group to consider the learning from this case about the children's journey and whether this may be indicative of any wider issues in relation to the assessment / diagnosis of a learning difficulty. If so, to seek assurance that the local pathway is easy to navigate and facilitates early identification and intervention**.**

1.11.28 **Recommendation 26:** The Safer Lambeth Partnership to explore approaches to protective orders so that a wider range of professionals and services can take an active role in enforcement and activation.

1.11.29 **Recommendation 27:** The LSCB and the Safer Lambeth Partnership to review policy, procedures and training to ensure that the evidence relating to risks associated with stepchildren is adequately addressed.