SAFER LAMBETH PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview 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

"*Sophia was my little sister and she was tragically taken away from us.*

As a child Sophia suffered from birth. She was born with Talipes (commonly known as club foot), from the age of 6 months old she was having regular surgery to try and correct them. These surgeries continued until Sophia was 14 years old. She had terrible scars on her feet and always kept them covered up unless she was at home where she felt comfortable with her family. Sophia also contracted Meningitis at the age of four and almost lost her life. Sophia was always a fighter and fought this awful illness although it left her with poor eyesight. She wore glasses until the age of 18 and then moved onto contact lenses. Having these setbacks and also our Dad leaving the family home, also when Sophia was four, made her into a strong person and gave her confidence to face anything and everything, good or bad!

Sophia didn't really enjoy school apart from the social side. She was popular and made lots of friends, she was always saying "hello" to people and I often wondered how she knew so many people. Sophia completed her GCSE's and went onto sixth form to complete a business studies course. Sophia then started a job at Kings College Hospital as a receptionist, the same job and in the same place as our Mum. Sophia only worked here for a short time before she discovered she was pregnant with her first child. Sophia was so happy and couldn't wait to be a mum.

Things weren't great with the father of her child, but Sophia always tried to be positive and soon was too busy getting everything ready for the baby to arrive and she just wanted everything to be perfect. [In 2003] *Sophia became a mum to a little boy. Although Sophia loved being a mum, she found it difficult at times. She became a young single mother as things didn't work out with her son's father. She suffered from post-natal depression. Sophia thought it would help her to be out of the house more, she decided to get a part time job and her son attended a nursery.*

Being able to work was very important to Sophia, not only for herself but she wanted to show her children that in order to have nice things in life, you needed to work hard for them. Nothing is just handed to you and she didn't want them to live off the benefit system. Sophia went on to have another child and again was eager to be back at work once her maternity leave was over.

Sophia was always there for me, she let me live with her for 3 weeks when I needed somewhere to stay. I would call her, and she would call me, on a regular basis. We were both pregnant at the same time with our second children, it was lovely to share this experience and bought us even closer together. When our Mum died suddenly in February 2016, we supported each other through our grief. We cleared Mum's flat and organised her funeral. Sophia helped me, and I hope I helped her too!

In the week leading up to her death Sophia was scared, anxious and worried. She rang me every evening to keep me updated with what was happening and how she was feeling. She always tried to reassure me that she was ok and didn't want to bother the police, she thought she would be wasting their time and there wasn't much they could do. Sophia final words to me were 45 minutes before she died, "I'll call you when I get home".

Pen Portrait of Sophia by her sister, Cora

1. Preface

1.1 Introduction

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

1.1.2 This report of a DHR (hereafter 'the review') examines agency responses and support given to Sophia, a resident of the London Borough of Lambeth (hereafter 'Lambeth') prior to her death towards the end of May 2017. Sophia was murdered by her former partner, Daniel, who attacked her shortly after she had collected her youngest child from school and while walking home. She was in the company of her oldest child and a friend.

1.1.3 The review will consider agencies contact/involvement with Sophia and Daniel from 2008 (when their relationship is believed to have begun) to her murder in May 2017.

1.1.4 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

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

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

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

1.2 Timescales

1.2.1 The Safer Lambeth Partnership, in accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (thereafter 'the statutory guidance'), 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.

1.2.2 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.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision to establish one. This timeframe was not met due to: the timing of the first panel (held in Autumn 2017 to ensure agencies could attend); to allow the completion of the criminal trial (this concluded in December 2017); to secure input from the Child Maintenance Service (CMS)[1] (which began in December 2017 and ran through to June 2018, see 1.7.3 to 1.7.10); to meet with family and friends, as well as allowing time for the family

[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.

to feedback on the draft report (from February to July 2018, see 1.9); and to interview the perpetrator in prison (in June 2018, see 1.10).

1.3 Confidentiality

1.3.1 The findings of this report are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Prior to this, information is available only to participating officers/professionals and their line managers.

1.3.2 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.

1.3.3 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
- Perpetrator – Daniel
- 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.

1.3.4 These pseudonyms were agreed by Sophia's family in discussion with chair. Where an interview was completed with a friend, they were also invited to suggest or agree a pseudonym.

1.3.5 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.

1.3.6 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'.

1.4 Equality and Diversity

1.4.1 The chair and the Review Panel did bear in mind all the Protected Characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation during the review process.

1.4.2 At the first meeting of the Review Panel, it was identified that the Protected Characteristic of sex required specific consideration. This is because Sophia was female, and Daniel is male. A recent analysis of DHRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators[2].

[2] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

1.4.3 At the second meeting of the Review Panel, the chair encouraged a more nuanced consideration of equality and diversity issues. This reflected the limited consideration given to these issues in the Individual Management Reviews (IMRs) submitted by agencies. This is described more fully in 1.6.9 – 1.6.10 below. Subsequently, the Review Panel explicitly considered the following issues in relation to Race:

- Sophia was White British, and it is therefore important to consider if her lived experience and particular cultural context may have affected her experience of abuse, help seeking patterns/perceptions or the response of services
- Daniel was Black British, and it was also important to consider how his lived experience and particular cultural context may have affected his abusive behaviour, help seeking patterns/perceptions or the response of services.

1.4.4 These issues are considered throughout the review and analysed in 5.3 below.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at **Appendix 1**. This review aims to identify the learning from this case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel comprised agencies from Lambeth, as the victim was living in that area at the time of the homicide. Agencies were contacted as soon as possible after the DHR was established to inform them of the review, their participation and the need to secure their records.

"Analysis of the whole STADV DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

1.5.3 Additionally, the perpetrator lived in and had some limited contact with agencies in the neighbouring London Borough of Croydon (hereafter '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.

1.5.4 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.

1.5.5 *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 described in 1.4 above, 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
- 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.

1.5.6 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[3] and Prohibited Steps Orders[4]; and the impact of domestic violence and abuse on children.

1.5.7 While the Review Panel included agencies that could bring expertise in relation to these additional issues, the local Drug and Alcohol Service (provided by the South London and Maudsley (SLAM) NHS Foundation Trust[5]) was also invited, even though they had not been previously aware of the individuals involved. SLAM offers assessment, treatment and advice for people, aged over 18, who have substance misuse (drug and/or alcohol) related problems) and the Review Panel felt it would be useful to have their involvement.

1.6 Methodology

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

1.6.2 "*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.*

[3] 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.

[4] 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.

[5] For more information, go to: http://www.slam.nhs.uk/our-services/service-finder-details?CODE=SU0354.

1.6.3 *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.*

1.6.4 *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."*

1.6.5 This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.6.6 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.

1.6.7 *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.

1.6.8 There were significant challenges in obtaining an IMR from the CMS. These challenges were ultimately resolved and are more fully described below in 1.7.3 – 1.7.10. Of note in relation to quality is that the MPS IMR provided additional information that was not included in the CMS IMR. In particular, the MPS IMR included information about contacts with Sophia, as well as direct quotes from call transcripts between Sophia and the CMS. While IMRs from the local police service are likely to provide an extensive overview of agency contact, reflecting the information gathered as part of a murder enquiry, this should supplement other IMRs, not underpin them. This highlights an issue around agencies familiarity with, and ability to participate in, the DHR process. Recommendations have been made to address this issue and are further discussed in 1.7.3 – 1.7.10 below.

1.6.9 One area that was noticeably weak in agency IMRs was the analysis of equality and diversity. A summary of the consideration given is as follows:

Agency		**Summary of consideration**
Croydon Medical Centre (MM's GP) – completed by Croydon Clinical Commissioning Group (CCG)		Rules out equality and diversity issues on basis of no evidence of barriers to accessing service
CMS		No consideration – refers to work to revise guidance to 'vulnerable customers'
Guy's and St Thomas' NHS Foundation Trust (GSTT)		No consideration
KCH	As a health provider	No consideration
	As Sophia's employer	
Lambeth Children's Social Care (CSC)		No consideration
Lambeth Housing		No consideration
Lambeth Medical Centre (Sophia, Child A and Child B's GP) – completed by Lambeth CCG		Rules out equality and diversity issues on basis of no evidence of barriers to accessing service

MPS	Notes ethnicity of Sophia and Daniel Notes sex as a risk factor in the context of gender-based violence
Primary School	Framed in relation to compliance with organisational policies
The Gaia Centre (run by Refuge)[6]	Notes gender-based violence
Secondary School	No consideration
Victim Support	Notes gender-based violence Framed in relation to compliance with organisational policies

1.6.10 As illustrated in the table above, 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.

1.6.11 IMRs identified changes in practice and policies over time. Nine IMRs made recommendations of their own. These are noted within this report.

1.6.12 *Documents Reviewed:* In addition to the 12 IMRs, documents reviewed have included:

- Local strategies and operational documents from a number of agencies (these are identified and discussed in the analysis)

[6] The Gaia Centre provides confidential, non-judgmental and independent support services for those living in the London borough of Lambeth who are experiencing gender-based violence. For more information, go to: https://www.refuge.org.uk/our-work/our-services/one-stop-shop-services/the-gaia-centre/.

- Previous DHR reports in the area, as well as a Serious Case Review (SCR) (see 1.14)
- Sophia's statement to the MPS in April 2016, as well as other witness statements obtained by the MPS during the murder enquiry (see 1.9).

1.6.13 The chair has also been mindful of the respective STADV and Home Office DHR Case Analysis.

1.6.14 *Interviews Undertaken:* The chair has undertaken four interviews in the course of this DHR. This has included one face to face interview (as well as subsequent contact by phone and email) with the victim's family; two face to face interviews with friends of the victim, and a face to face interview with the perpetrator. The chair also conducted two telephone discussions with Department for Work and Pension (DWP) representatives in relation to the CMS submission, with this more fully described below in 1.7.3 – 1.7.10.

1.6.15 The chair is very grateful for the time and assistance given by the family and friends who have contributed directly or indirectly to this review.

1.7 Contributors to the Review

1.7.1 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.

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

Agency		Contribution
Croydon Medical Centre (Daniel's GP) – completed by Croydon CCG		IMR and Chronology
GSTT		IMR and Chronology
KCH	As a health provider	IMR and Chronology
	As Sophia's employer	
Lambeth 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

1.7.3 In addition to the above agencies, it was also identified at the first Review Panel meeting that Sophia had been in contact with the CMS, having made two applications for child maintenance during the time period being considered. In making these applications, Sophia initially had contact with the Child Maintenance Options (CMO) service[7]. The CMO is the gateway to, and the public face of, the CMS. If a parent decides to approach the CMS about child maintenance, they first speak to the CMO who provide information about the different types of arrangement available. If someone makes an application, they are transferred to the CMS. For convenience, the CMO and the CMS are described collectively in this report as 'the CMS'. The CMS is a delivery arm of the DWP.

[7] For more information on the CMO service, go to: https://www.cmoptions.org/en/about/index.asp.

1.7.4 A request for a summary of engagement was made to the CMS in December 2017. The CMS responded in early January 2018, declining to provide any information to the DHR in the absence of court order or a legal precedent.

1.7.5 At the second Review Panel in late January 2018, it was agreed that, regardless of the CMS response, an IMR and Chronology were required. This was based on what had since become known about Sophia and Daniel's contact with the CMS from the other IMRs reviewed at that meeting.

1.7.6 To resolve this matter, advice was sought from the Home Office, which interceded with DWP. The chair is grateful to Birol Mehmet who facilitated this process. Ultimately a chronology was provided by the CMS in March 2018, along with some training and procedural information, followed by an IMR at the start of May 2018.

1.7.7 As the CMS was not represented on the Review Panel[8], the chair offered to share the relevant extract(s) from the draft report and invited the CMS to feedback on matters of accuracy and comment on the analysis and draft recommendations. This was duly done in mid-May 2018, with a submission being provided by the CMS at the end of May 2018. Having reviewed this, the chair agreed to make some minor changes in relation to matters of fact and accuracy. However, no further changes were made. This was because the first submission did not substantively address the analysis or the draft recommendations. Consequently, the chair invited a further response. A second submission was then returned by the CMS in early June 2018. The chair considered this but felt that the further information provided neither gave assurances about, or resolved, the issues identified in the analysis and the draft recommendations. During this time the chair had two telephone discussions with a representative of the DWP and agreed to receive a third and final submission. This final submission by the CMS focused on some of the language used to describe the quality of the CMS response. This was submitted towards the end of June 2018.

[8] An agency with CMS's level of involvement would normally have been invited to be on the Review Panel. This was not feasible given the length of time it took to secure a response to the request for a Summary of Involvement, then the Chronology and IMR.

1.7.8 All these submissions, along with the Chronology and IMR, were considered at the fourth Review Panel meeting. The Review Panel discussed this matter at some length, including the contact by the CMS with Sophia and Daniel, as well as the language used by the chair in the analysis and the draft recommendations. While the Review Panel endorsed the analysis and draft recommendations, having reflected on the final CMS submission, it was agreed that some minor changes would be made to the language used. However, these changes did not alter the substance of the report's findings. The report as presented reflects the outcome of the final panel meeting.

1.7.9 Securing the CMS input 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. In correspondence with the chair in May 2018, the CMS acknowledged that the initial response to the request for a summary of engagement was "*unfortunate*". 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.

1.7.10 In relation to the conduct of DHRs, the statutory guidance places a duty on a range of agencies "*to have regard*" to the statutory guidance (*Section 2, point 4*), and also includes a general statement that any agency approached to provide an IMR should do so (*Section 4, point 32*). However, the statutory guidance does not explicitly address government departments, nor the agencies and public bodies associated with them. As demonstrated by the contact with the CMS, this can present a challenge in securing timely participation in the DHR process.

The statutory guidance identifies that there are agencies which may have a key role to play in the review process even though they are not named in the statutory guidance. Ensuring all agencies provide a comprehensive chronology of any involvement with the victim, children and/or perpetrator is critical in order that the Review Panel and chair can fully analyse events leading up to a homicide. The Review Panel therefore made the following recommendations:

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.

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.

1.7.11 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[9] during the period under review. Contact was made with the NSPCC, who promptly provided a summary of engagement of good quality. As 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.

1.7.12 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.

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Name	Agency
Cheryl Wright, Safer Croydon Partnership Manager	Place Department, Safety Division. Crime & ASB, Croydon Council

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

Debbie Saunders, Head of Nursing Safeguarding Children	GSTT
Hillary Williams, Interim Deputy Director for Lambeth Operational Directorate	Mental Health, SLAM
Head of School[10]	Primary School
Head Teacher[11]	Secondary School
Janice Cawley, Acting Detective Inspector	Specialist Crime Review Group (SCRG), MPS
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

[10] Not named to ensure anonymity of school, see 1.3.6.

[11] Not named to ensure anonymity of school, see 1.3.6.

Valerie Wise, Senior Operations Manager and Sharon Erdman, Head of Operations	Refuge (runs the Gaia Centre)

1.8.2 *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.

1.8.3 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.

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

1.9 Involvement of Family, Friends and Colleagues

Family

1.9.1 Initially, the Safer Lambeth Partnership notified the family of Sophia of their decision to undertake a review via the MPS Family Liaison Officer (FLO) in July 2017.

1.9.2 Thereafter, the chair and the Review Panel acknowledged the important role Sophia's family could play in the review.

Known in the review as	Relationship to Sophia	Means of involvement
Cora	Sister	Witness statements Interview

1.9.3 A letter was sent from chair via the FLO, describing the DHR process, that participation in the review was voluntary, and that the family could contribute in a number of different ways. The letter was accompanied by the Home Office leaflet for families, as well as a leaflet describing the support available

from Advocacy After Fatal Domestic Abuse (AAFDA). This letter was sent to the FLO in September 2017.

1.9.4 As the first panel meeting was shortly before the criminal trial, the family initially indicated through the FLO that they did not want to participate until that process had concluded, and that they would be represented by Sophia's sister, Cora. However, the FLO was able to attend the first meeting of the Review Panel and share a request from the family that specific consideration should be given to the use of Civil Orders like Non-Molestation / Prohibited Steps Orders. This was duly reflected in the Terms of Reference.

1.9.5 There was a delay in establishing direct contact with the family as the FLO was on long term leave. However, Cora contacted the chair in February 2018 and a face to face meeting was arranged for the start of March 2018. Cora attended with her partner. This meeting confirmed that Sophia's family felt that the Non-Molestation Order and Prohibited Steps Order should be a focus of the review, as well as how the CMS managed Sophia's application for child maintenance. This reflected Cora's view that: "*things weren't done properly.* [I am] *not saying that Daniel wouldn't still have murdered Sophia, but maybe it could have been avoided"*. A record of this meeting was made and shared with the family for their approval. At this meeting the chair confirmed that Cora was accessing support (this was being provided by a caseworker from the Victim Support Homicide Service). The caseworker provided support to Cora throughout the course of the review.

1.9.6 After this face to face meeting, Cora also consented to the chair having access to the witness statement she had provided to the MPS during the murder enquiry.

1.9.7 During the review process, the chair provided regular updates to Cora, communicating by email and phone. Cora was then invited to read and comment on the final draft of the Overview Report. She received this at the start of July 2018 and reviewed it with support from her caseworker. At the end of July 2018, the chair and Cora spoke. Cora said she felt that the report gave a good insight into what Sophia was going through, and that the key issues she had wanted explored (relating to the CMS and Non-Molestation /

Prohibited Steps Orders) had been covered. Cora expressed surprise at what she had learnt about MPS involvement in the case, particularly their response to Sophia in April 2016. Cora asked that her comments on the recommendations related to the CMS and the MPS were included in the report. This has been done.

1.9.8 Given the age, and specific needs, of both Sophia's children, the Review Panel did not feel it was appropriate to interview them.

1.9.9 From the outset, the Review Panel decided that it was important to take steps to involve Sophia's family, work colleagues, neighbours and wider community.

Friends and colleagues

1.9.10 Consideration was initially given to engaging with friends and colleagues, as well as the boyfriend (Noah) who Sophia had begun seeing sometime after her separation from Daniel.

1.9.11 The MPS SCRG facilitated a reading session, which allowed the chair to review potentially relevant witness statements that had been collected during the murder enquiry. Following this reading session, a letter from the chair was sent via the MPS explaining the purpose of the review, attaching the relevant Home Office leaflet, and inviting the recipients to participate in the review directly (by agreeing to be interviewed) or indirectly (by giving consent to share their witness statements). The outcome was as follows:

Known in the review as	Relationship to Sophia	Means of involvement
Grace	Friend	No response received
June	Friend	No response received
Noah	New boyfriend	No response received

1.9.12 During the reading session, the chair also reviewed the witness statements taken from colleagues / friends of Sophia. However, as the employing trust (KCH) was on the Review Panel, the chair made an approach via that route. A letter was sent via KCH, explaining the purpose of the review, attaching the

relevant Home Office leaflet, and inviting the recipients to participate in the review directly (by agreeing to be interviewed) or indirectly (by giving consent to share their witness statements). The outcome was as follows:

Known in the review as	Relationship to Sophia	Means of involvement
Anna	Colleague / friend	Declined to be interviewed or give permission for witness statement to be used
Harper	Colleague / friend	Interviewed and gave consent to use of witness statement
Tejbir	Colleague / friend	Interviewed and gave consent to use of witness statement

1.9.13 Two further colleagues, both managers of Sophia, were identified (Ava and Dawn). As their contact with Sophia was summarised in both the MPS and KCH IMRs, it was decided that additional interviews were not necessary.

1.9.14 Where a witness was interviewed or gave consent for their witness statement to be shared, the information they provided is quoted directly. For witnesses who did not do so, their information is not used directly but may be referenced in summary reflecting the use of this information in agency IMRs.

1.10 Involvement of Perpetrator and/or his Family:

1.10.1 On the 17 April 2018 Daniel was sent a letter from the chair via the prison with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. The letter was delayed, while Daniel's Offender Manager sought to resolve some internal issues relating to the approach by STADV. Daniel subsequently sent back a signed consent form at the end of May and the chair met him in prison for interview at the end of June 2018. Daniel was sent a copy of the transcript of the interview and agreed this as accurate in July 2018. A summary of the interview is included below (see 4.2).

1.10.2 Daniel's mother was also approached, following the process in 1.9.11 above. The outcome was as follows:

Known in the review as	Relationship to Daniel	Means of involvement
Victoria	Mother	No response received

1.11 Parallel Reviews

1.11.1 *Criminal trial:* 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.

1.11.2 The MPS Senior Investigating Officer (SIO) was invited to the first meeting of the Review Panel. It was agreed approaches would not be made to witnesses until after the criminal trial had been concluded, with the exception of an introductory letter to Sophia's family as described in 1.9 above. However, as the trial was concluded shortly after this first meeting, this had relatively limited impact on the timeframe of the review.

1.11.3 *No parallel reviews:* An Inquest was opened and adjourned on the 1 June 2017 at Southwark Coroners Court. Following Daniel's conviction Her Majesty's Coroner decided no investigation was required and therefore closed the matter. Consequently, following the completion of the criminal investigation and trial, there were no parallel reviews that impacted upon this review.

1.11.4 While not a parallel review, since Sophia's death, both Child A and Child B are in the care of Sophia's sister, their aunt Cora. She is receiving support from the Lambeth CSC as a full-time carer and the children have 'Looked After' status to ensure their needs are met. Once finalised, this report should be attached to Child A and Child B's CSC records so that, if they wish to read the review when they are older, it is available to them.

1.12 Chair of the Review and Author of Overview Report

1.12.1 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.

1.12.2 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.

1.12.3 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.

1.12.4 *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)[12]. 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.

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

1.13 Dissemination

1.13.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Lambeth Partnership for approval and thereafter will be sent to the Home Office for quality assurance.

1.13.2 Once agreed by Home Office, the Executive Summary and Overview Report will be: shared with the LSCB and SAB; be published; and there will be a range of dissemination events to share learning.

1.13.3 The Executive Summary and Overview Report will also be shared with the Safer Croydon Partnership for dissemination, as well as the Commissioner of the MPS and the Mayor's Office for Policing and Crime (MOPAC).

1.13.4 The recommendations will be owned by Safer Lambeth Partnership. The Violence Against Women and Girls Programme and Commissioning Manager will be responsible for disseminating / monitoring recommendations.

1.14 Previous learning from DHRs

1.14.1 This is the third DHR commissioned by the Safer Lambeth Partnership, with the two previous DHRs having been published[13]. The chair reviewed these DHRs to identify if there were any issues relevant to this DHR, determining:

- Review 001 – no findings / recommendations directly relevant to this DHR
- Review 002 – some findings / recommendations directly relevant to this DHR. This included recommendations for Lambeth CSC (4.9: the '*use of DV risk matrix to be reiterated to managers and social workers'*) and for GSTT (4.8, in particular: a '*Domestic violence risk assessment training / update for Health Visitors'*).

1.14.2 Additionally, a Serious Care Review (SCR) involving domestic violence and abuse has also been published by the Lambeth LSCB. The SCR looked at the

[13] Available at: https://www.lambeth.gov.uk/social-care-and-support/abuse-and-violence.

death of Child H[14] and was reviewed by the chair. A number of findings / recommendations were relevant and are summarised on the following page.

1.14.3 The Review Panel considered the learning and recommendations from other reviews in the analysis and the development of recommendations for this DHR.

[14] Available at: https://www.lambethscb.org.uk/training/case-reviews.

SCR into the death of Child H		
Relevant finding	**Relevant learning**	**Links to this DHR**
Finding 1. A tendency among professionals in all agencies to focus on the emotional impact on children of living with domestic violence, and not on the increased probability that they will be physically harmed, impedes a full understanding of the risks to which they are exposed.	○ Professionals involved did not consider there to be a risk of physical harm to the children as a result of living with a father with a recent history of violence toward his wife ○ Staff across agencies were unaware of the body of available research evidence on the risks to children of domestically violent parent ○ Research evidence about the increased risk of physical harm to children who are living with a violent adult is not informing practice. This means that physical risks to children may not be reflected in assessments and plans, increasing the chances of children being left at risk of harm.	○ Assessment of risk by Lambeth CSC (see 5.2.71 onward); existence of a Non-Molestation and Prohibited Steps Order (see 5.2.131 onward) ○ Specific recognition of the potential risk to Child A, Daniel's step child (see 5.2.153 onward)
Finding 2. Are the mechanisms, which are intended to pick up errors of human reasoning, functioning well and consistently in agencies? Where they are not, inaccurate judgements are more likely to go unchallenged.	○ Two key 'checks and balances' to help review judgements are professional supervision and a culture of mutual challenge in multi-agency working ○ The quality of the SW's individual supervision meant that the need for	○ Supervisory oversight within Lambeth CSC (see 5.2.78) ○ Challenge and debate among the professional network, to voice and explore differences in professional opinion. This is relevant to Lambeth CSC, which did not fully use the wider

	ongoing assessment of risk was not identified and acted upon ○ [The need for] challenge and debate among the professional network, to voice and explore differences in professional opinion.	professional health network (see 5.2.72 onward), but also Refuge (see 5.2.103 onward).
Finding 4. Where there is no known recurrence of domestic violence incidents, professionals tend to be reassured about the welfare of children in the household and/or believe their grounds for purposeful engagement with the parents are diminished. The consequence is that they get no further in understanding the causes and triggers of incidents of domestic violence, and the actual level of risk to children these imply.	○ A tendency among multi-agency professionals to give greater weight to whether domestic violence is known to be currently occurring, than to what historical incidents of domestic violence reveal about risk now and in the future.	○ Assessment of risk by Lambeth CSC (see 5.2.71 onward); the existence of a Non-Molestation and Prohibited Steps Order (see 5.2.131 onward).

2. Background Information (The Facts)

The Principle People Referred to in this report						
Referred to in report as	**Relationship to V**	**Age**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Sophia	Victim	33	White	No religious affiliation	British Citizen	N
Daniel	Ex-partner	41	Black Caribbean	No religious affiliation	British Citizen	N
Child A	Child	13	Dual heritage	No religious affiliation	British Citizen	Identified special educational needs but no formal diagnosis
Child B	Child	6	Dual heritage	No religious affiliation	British Citizen	
Cora	Sister					
Anna	Colleague / Friend					
Ava	Colleague / Manager					
Dawn	Colleague / Manager					
Grace	Friend					
Harper	Colleague / Friend					
June	Friend					
Noah	New boyfriend					
Tejbir	Colleague / Friend					
Victoria	Mother of ex-partner					

2.1 The Homicide

2.1.1 *Homicide:* 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).

2.1.2 Sophia had phoned June and asked her to accompany her, because Daniel had been seen in the vicinity of the school. Sophia described Daniel in that call as "*being a pain*". On the walk home, Daniel emerged from an alleyway. An argument started about Sophia's recent application for child maintenance.

2.1.3 June later told the MPS that Daniel had smelt of alcohol and she was fearful he would hit Sophia. She and Sophia were concerned about Daniel's behaviour and asked the children to walk on ahead. The argument continued for some time, after which Sophia decided to walk away. Daniel then produced a knife from his bag and stabbed Sophia a number of times. June bravely tried to protect Sophia, pushing Daniel away. He then fled.

2.1.4 The London Ambulance Service (LAS) and the MPS attended the scene, but tragically Sophia died shortly after Daniel's attack.

2.1.5 *Post Mortem*: A Home Office Pathologist conducted a Special Post Mortem examination of Sophia at Greenwich Mortuary the day after her death. The cause of death was given as multiple incised wounds, with the most serious wounds to the chest. The probable mode of death was hypovolaemic shock (due to blood loss) and acute respiratory failure.

2.1.6 *Criminal trial outcome*: 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.

2.1.7 *Judge's sentencing summary:* On sentencing Daniel at the start of December 2017, the Judge said: "*He must* [have] *know[n] the children…* [were] *nearby. And having seen the children, he must know that he…* [was] *leaving them without a mother*".

2.2 Background Information on Victim and Perpetrator

2.2.1 *Background Information relating to Victim:* At the time of her death, Sophia was 33 years old. She was White, British and had no known disability or religious affiliation. Sophia grew up in London and had been a tenant with Lambeth Housing since 2004. At the time of her death, Sophia was employed by KCH as a Ward Clark, a role she had held since July 2015. Prior to this Sophia had been employed by a large high-street retailer.

2.2.2 Sophia had two children. Daniel was the biological father of the youngest child (Child B). The father of the oldest child (Child A) was not contacted as part of the review as there was no reported contact or agency involvement with him.

2.2.3 Sophia had one sister, Cora. Their mother had died in February 2016.

2.2.4 *Background Information relating to Perpetrator:* Daniel was 41 when he murdered Sophia. He is Black Caribbean, British and has no known disability or religious affiliation. He had previously been employed by a major supermarket chain, had worked in a pub and was then unemployed for a period of time. He started working again for the supermarket in October / November 2017. Daniel privately rented a room in Croydon at the time of the homicide.

2.2.5 *Synopsis of relationship with the Perpetrator:* Sophia met Daniel in 2008 and shortly after meeting, he moved into her flat. In 2010, Sophia became pregnant and Child B was born in March 2011. Sophia said later that the relationship became violent in 2014, when Sophia and Daniel separated, and Daniel moved out. They reconciled in the summer of that year but lived apart. The relationship ended in March 2016, with Daniel moving to Croydon.

2.2.6 *Members of the family and the household:* At the time of her death, Sophia lived with her two children, Child A and Child B.

3. Chronology

3.1 Overview

3.1.1 The following chronology describes the contact that Sophia and Daniel had with agencies. In developing the chronology, the Review Panel considered how best to share information relating to Child A and Child B. This reflected two issues. Firstly, there was significant amount of contact with agencies during the period under review in relation to Child A and Child B. It is important to understand the lived experience of Sophia, Child A and Child B and this necessitates describing that contact. Secondly, the Review Panel was mindful of proportionality and risk of sharing too much information about Child A and Child B. To manage this, although contact with Child A and Child B was described in the draft overview report that was circulated to participating agencies, Cora's family and the Safer Lambeth Partnership, an abridged version of the report has been produced for publication. This is in order to protect the privacy of the Child A and Child B. Consequently, contact related to Child A and B in each year is presented as a short summary.

3.2 Contact before 2008

3.2.1 Sophia became a tenant of Lambeth Housing in March 2004. Between this date and the end of 2007, she had intermittent contact with Housing Management, mostly relating to visits by a gas engineer for boiler maintenance. These occurred annually throughout the period covered by the review, with no other maintenance issues being reported.

3.2.2 Sophia also had some additional contact with Lambeth Housing, firstly requesting assistance with Housing Benefit (in April 2004) and then rent arrears (from February 2015).

3.2.3 In 2007, Sophia was a witness to a serious injury to the child of her then partner. This occurred at her address, although Sophia did not witness the incident directly and there was no suggestion she was involved in the case.

Contact relating to Child A and Child B

Sophia received maternity care at KCH in 2003 in relation to Child A. There is no record of social or safeguarding concerns.

3.3 Contact by year from 2008 onwards

2008

3.3.1 Sophia met Daniel in 2008 and within a few months, Daniel had moved in.

3.3.2 In this year, agencies had some contact directly with, or related to, Sophia including:

- Sophia sought advice from the Lambeth Medical Centre, seeing a General Practitioner (GP) relating to minor medical issues and smoking cessation. The most significant of these was a self-report of depression for which Sophia was prescribed anti-depressants
- A GP received a request for information from Lambeth CSC for information about Child A
- Housing Management arranged an engineer's visit for the annual gas service and issued a Notice of Eviction due to non-payment of rent.

2009

3.3.3 Sophia received a further Notice of Eviction in May 2009 due to non-payment of rent and applied in the same month for a stay of execution of the warrant.

3.3.4 Sophia also saw her GP twice in this year for minor medical issues.

Contact relating to Child A and Child B

In this year, Sophia had a number of contacts with Child A's Primary School. These concerned Child A's behaviour and a discussion of their developmental needs. Sophia also accompanied Child A to appointments with GSTT services.

2010

3.3.5 In this year Sophia attended the Lambeth Medical Centre for some routine medical issues. There are several contacts related to Sophia that are of note:

- May – told a GP that she had been trying to become pregnant
- June – saw a GP for a bruise on her shin, telling them that she was not sure how she had got it and that it had been there a long time. Days later Sophia attended the surgery for advice around smoking cessation and told a Practice Nurse that it had been a "*very stressful two weeks*"
- August – Sophia was pregnant, and a GP made a referral for maternity care, with a first antenatal appointment with KCH Community Midwives in October. At this contact, there was a routine enquiry about domestic violence. Sophia did not disclose any concerns
- Through to December there were a series of other medical appointments related to Sophia's pregnancy, including with the GP and at KCH for an ultrasound scan.

Contact relating to Child A and Child B

In this year, Sophia had contact with Child A's Primary School relating to behaviour issues. Sophia also accompanied Child A to appointments with GSTT services and took them to the Lambeth Medical Centre for a number of routine medical appointments.

2011

3.3.6 Sophia had numerous contacts with health professionals at the start of the year, principally relating to medical issues around pregnancy. In March, she gave birth to Child B.

3.3.7 Sophia was contacted by the GSTT Health Visiting service to book a New Birth Visit on the 30 March, with this happening a day later. Child B was reported to be well, with Sophia reporting some minor medical issues. Sophia told the Health Visitor that she had good support from her partner and her mother. Sophia also disclosed the incident in 2007 in relation to her ex-partner's child (see 3.2.3 above). She said she had been depressed after that

incident, as she had broken up with her ex-partner, but she did not report any current depression or low mood.

3.3.8 Daniel was present at the New Birth Visit, so the Health Visitor did not undertake routine enquiry about domestic violence.

3.3.9 There was a follow up visit in April and no concerns were identified. It is not clear if Daniel or Child A were present in the home and there is no record as to whether there was consideration to undertake routine enquiry about domestic violence.

3.3.10 At a further Home Visit in May Daniel and Child A were recorded as not being present. There is no record as to whether routine enquiry about domestic violence was considered and / or undertaken.

3.3.11 Throughout the rest of the year Sophia saw a number of different health professionals at the Lambeth Medical Centre. This contact was all routine.

Contact relating to Child A and Child B

In this year, Sophia had contact with Child A's Primary School relating to behaviour issues.

Sophia also saw a number of different health professionals with Child B after their birth, including the Health Visitor and clinical staff at the Lambeth Medical Centre. This contact was all routine.

2012

3.3.12 Throughout 2012, Sophia had a range of contact with health professionals, including medical consultations. These were all routine. During this time Sophia also returned to work at a large high-street retailer.

Contact relating to Child A and Child B

In this year, Sophia had contact with Child A's Primary School relating to behaviour issues, with the Primary School providing support to both Child A and Sophia. This included completing a Common Assessment Framework (CAF). (The CAF is an early help inter-agency assessment. It offers a basis for early identification of children's additional needs, the sharing of this information between organisations and the coordination of service provision). At one meeting Sophia said "[I] *can't cope and …* [I am] *at breaking point*" and was considering going to her GP to get anti-depressants.

The Primary School made referrals related to Child A's developmental needs. On a referral in December it was recorded that Sophia and Daniel had separated, although Daniel still saw both Child A and Child B.

At a meeting with the Primary School, Sophia was told that Child A had said that Sophia and Daniel "*argued lots*". In response Sophia said that while they often bickered, she and Daniel never argued. At another meeting, staff noted that Child A *"appeared worried/scared when collected by their step dad*". Sophia said she did not understand why this would be the case, as Child A had a good relationship with Daniel and, additionally, Daniel was not involved in discipline at home. In a follow up discussion, Sophia said she thought Child A's demeanour was because "*they just knew their step-dad didn't like waiting and didn't want to upset him*".

Until September, staff had only been in contact with Sophia. However, on 28 September, Child A left school at the end of the day without being dismissed by an adult. As the Class Teacher was unable to contact either Sophia or Daniel, she attended the home address and spoke with Daniel. He confirmed that Child A was in his care. He is reported to have said he "a*sked Child A to come because he* [Daniel] *couldn't wait around*".

Sophia had a number of health contacts related to Child B. These were all routine and included a One Year Mandated Development Health Review. No issues were identified.

2013

3.3.13 During the year were a small number of health contacts for Sophia. These were all for routine health matters

Contact relating to Child A and Child B

In this year, Sophia had contact with Child A's Primary School relating to behaviour issues (which had improved), as well as progressing a Secondary School application.

There were a small number of routine health contacts for Child B. A 2-year Development Review was also completed, which led to a referral for some developmental support.

2014

3.3.14 On the 2 February there is the first police contact with Sophia and Daniel, which was in response to a reported verbal argument. This was reported by a neighbour who could hear a female screaming. Police Officers attended the scene and spoke with Sophia and Daniel, who stated that they had argued. Sophia wanted Daniel to leave the address and he agreed to do so. The children were at the property at the time. The Initial Investigating Officer (IIO) completed a Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC) with Sophia. She gave negative answers to all the questions and a five-year domestic abuse intelligence check did not reveal any previous incidents. The risk was assessed as standard. Daniel's date of birth was recorded incorrectly.

3.3.15 The incident was reviewed by the local Community Safety Unit (CSU), with the report subsequently being closed. An information pack containing contact details for support services was posted to Sophia's address (Daniel had moved out after the incident).

3.3.16 The IIO completed a MERLIN[15] report and this was shared with Lambeth CSC on the 3 February. In this report, Child A was included as the primary subject (although their sex was incorrectly recorded), with no details included for Child B although they were referred to as a subject of the report.

3.3.17 Subsequently, Lambeth CSC reviewed this report. No further action was taken as the threshold for intervention was not met. This was on the basis that while the children were present, there was no evidence of injury and this was a verbal argument.

3.3.18 During the year were a number of other health contacts for Sophia. These were all for routine health matters.

3.3.19 During 2013, Daniel attended the Emergency Department at Croydon University Hospital nine times, reporting a variety of medical issues relating to chest pains, breathing problems or anxiety. At one attendance it was noted

[15] Merlin is an intelligence database used by the MPS.

that he had been smoking cannabis, and at another that he smelt of alcohol. No concerns were raised by staff at the time and Daniel made no disclosures.

Contact relating to Child A and Child B

In this year, Sophia had contact with Child A's Primary School relating to behaviour issues (which had deteriorated). Child A began Secondary School in September.

There were a number of contacts with services relating to Child B developmental needs, including GSTT services.

In September Child B attended an appointment with GSTT with Daniel. The GSTT records note that "*Child B observed to be lacking in confidence when speaking and Father spoke negatively about them*".

There was one assessment with GSTT which Sophia and Daniel attended together. No concerns about the relationship or presentation were identified during the assessment.

In September, Child B started at the Primary School.

During the year were a number of other health contacts for Child A and Child B. These were all for routine health matters.

2015

3.3.20 In January and February 2015, Sophia attended or spoke on the phone with a GP at the Lambeth Medical Centre on four occasions. This was related to back pain which Sophia attributed to lifting at her job. She was given appropriate medical advice.

3.3.21 On 27 July, Sophia started work at KCH as a Ward Clerk.

3.3.22 During the year were a number of other health contacts for Sophia with the Lambeth Medical Centre. These were all for routine health matters.

Contact relating to Child A and Child B

There were a number of reports about Child A in this year at Secondary School. These related to behaviour and their experience of bullying. In November, Daniel contacted the Secondary School, complaining about Child A's treatment. He spoke with a receptionist who recorded that "*he was very angry when I spoke to him on the phone, his language was vulgar and his tone aggressive, borderline threatening*". Sophia was not present at this meeting but was informed by phone of most of these incidents. Daniel was subsequently contacted by the Assistant Head Teacher, and this led to a meeting at the end of the month where an action plan was agreed to address the bullying.

During this year, the Primary School made some referrals to GSTT in relation to Child B's developmental needs.

2016

3.3.23 In January, Sophia had contact with a GP at the Lambeth Medical Centre, again for advice around smoking cessation.

3.3.24 At the start of February, Sophia's mother died suddenly. Sophia told her sister Cora that Daniel did not show any sympathy for her loss.

3.3.25 On the 19 February, Sophia saw a GP at the Lambeth Medical Centre, for advice around pain in her knee, neck and pins and needles in her arms. Sophia accounted for these issues as a result of work and having been in a minor car accident.

3.3.26 Sophia and Daniel separated on the 11 March. Sophia's witness statement to the MPS on the 11 April gave the reason for this separation as being "*due to ongoing verbal arguments"*.

3.3.27 On the 10 April Sophia and Cora were planning to go to the crematorium to collect and scatter their mother's ashes. Later, in her witness statement, Sophia described how she had arranged for Daniel to look after Child B for the day, but he did not turn up. She said Daniel was being verbally abusive, and he sounded like he had been drinking. Sophia ended the call, but Daniel continued to call her, and she became concerned that he would come to the crematorium. After the ceremony, Sophia went to stay with a friend.

3.3.28 Later that day, Sophia contacted the MPS to report abusive text messages from Daniel. She said that she and Daniel had been arguing over childcare, that he had attempted to call her a number of times and when she answered the phone had said "*you're dead*".

3.3.29 Sophia did not want Daniel arrested, so was advised to seek a Non-Molestation Order. Sophia agreed to a referral for this. Additionally, Police Officers contacted Child B's school to ensure Daniel would not be able to take them out of school. The DASH RIC was completed, and the risk was graded as standard risk, on the basis that Sophia and her children were safe and staying at an address not known to Daniel.

3.3.30 On the 11 April, the Lambeth CSU reviewed the report and a Detective Sergeant stated that additional information was needed regarding the nature of the text messages.

3.3.31 Later that morning, a Station Reception Officer at Croydon Police Station also updated the report detailing that Sophia had been to the Family Justice Centre and had been advised to obtain a Non-Molestation Order and tell the MPS about other text messages she had received[16].

3.3.32 At some point during the day, Sophia spoke to the Family Services Officer at the Primary School, disclosing an incident of domestic violence. She said that she had moved out of the family home, which caused Child B to be absent from school on this day. Sophia requested that Child B only be released to Sophia or to Sophia's friend (June). She was advised that school staff had to treat parents equally, as Daniel had parental responsibility along with Sophia.

3.3.33 That afternoon Daniel came to the Primary School and said he needed to collect Child B. This is the only time that he was recorded by the Primary School as attending to collect Child B. The staff at the school office were concerned about his presentation, because:

[16] The Family Justice Centre is a domestic abuse service in the London Borough of Croydon. The FJC was contacted as part of the DHR and confirmed that they had no record of Sophia. It is likely that this was a phone call for advice and that Sophia would have been signposted to the Gaia Centre. For more information, go to: https://www.croydon.gov.uk/community/dabuse/fjcentre.

- He appeared clammy
- His speech was slurred
- He appeared unstable and agitated
- His eyes were glazed
- There was a slight smell of alcohol.

3.3.34 Daniel was informed that Child B was absent from school. He was asked to leave. The Family Support Offer was alerted.

3.3.35 Sophia spoke to the Police Officer who had been tasked to gather more information about the text messages. This happened after Daniel went to the Primary School, as Sophia told Police Officers about his attendance.

3.3.36 A witness statement was completed with Sophia, which described the "*large amount of texts*" she had received, as well as 26 phone calls, from Daniel on the 11 April. This also described the attempt by Daniel to collect Child B from Primary School.

3.3.37 The Detective Sergeant at Croydon CSU agreed an investigation plan, with the IIO obtaining screen shots of messages and a statement from Sophia. This information was then emailed to the Lambeth CSU and an arrest enquiry set up for Daniel.

3.3.38 An arrest attempt at Daniel's home address was unsuccessful.

3.3.39 When reviewing the case, the Detective Sergeant at Croydon CSU also directed that a MERLIN report should be completed, and the Primary School notified and advised not to release Child B to anyone but Sophia. A MERLIN report was completed in relation to Child B, although Child A was not included on the report. This was sent to Lambeth CSC.

3.3.40 On the 11 April Sophia also referred herself to the Gaia Centre. She said that she had called the MPS the previous day, that they had taken a statement and that her ex-partner (Daniel) was abusive. She said he:

- Was name calling
- Made threats that she would be dead

- Had hit her in the past
- Had grabbed her and pinned her against the wall.

3.3.41 Sophia described herself as at risk and did not feel safe in the area as he knew her whereabouts. She wanted to know what safety measures could be put in place and explained that, while she did not want any contact with Daniel, she did not want to deny him contact with his child (Child B, although the Gaia Centre recorded a different first name).

3.3.42 The next day, on the 12 April, Sophia was contacted by an Outreach Worker from the Gaia Centre. Sophia disclosed:

- She had known Daniel for 8 years, that he had alcohol problems
- That Daniel was known to the MPS as a result of an incident two years ago when a neighbour had reported a domestic violence incident. Sophia described this as Daniel having restrained her, saying she had suffered minor cuts and bruises at the time but that this had only happened once[17]
- That she tried to separate from Daniel on more than one occasion, and was contacting the Gaia Centre because she no longer lived with him
- Verbal abuse, which was happening more often and getting worse
- Psychological abuse over the last two years, which made her feel nervous, and which was happening more often
- Intimidation and control, including threats to kill (Sophia gave an example from the previous Sunday when Daniel had called her and said "*you are dead*" before hanging up)
- Stalking and harassment, giving examples of constantly receiving texts, calls and being followed

[17] While Sophia said that this had been reported to the MPS, this was presumably the incident reported to the MPS on the 2 February 2014, described above in 3.3.14. At the time Sophia had not made any disclosures to Police Officers.

- Economic abuse, because she could not leave Child B with Daniel anymore when she went to work, and that she had rent arrears
- That she was frightened
- That she felt isolated.

3.3.43 Sophia also made explicit disclosures in relation to her concerns for Child B, describing:

- An example of Child B witnessing psychological abuse
- Conflict over child contact and her fear that Daniel would harm Child B unintentionally when he was drunk
- She also said that the worst incident of abuse was when Daniel had pinned her against the wall, after which he went to pick up Child B from school.

3.3.44 A DASH RIC was completed, giving a score of 13. This is described in the Refuge IMR as being 'standard' risk.

3.3.45 Based on the information provided by Sophia, a needs assessment was completed, identifying the following actions as immediate actions:

- Obtain a civil order – Sophia was provided with information about the National Centre for Domestic Violence (NCDV)[18]
- Change the locks to the current property, and to find safe accommodation – Sophia agreed to call back with her housing offers name so that the locks could be changed.

3.3.46 Personal safety advice was also discussed, including calling 999, staying in a public place if Sophia saw Daniel, and changing her routines. Sophia did not want to consider refuge, as she felt it would be disruptive to her children.

[18] The National Centre for Domestic Violence (NCDV) provides an emergency injunction service to survivors of domestic violence. http://www.ncdv.org.uk.

3.3.47 On the 12 April, there was a dispute between the Lambeth and Croydon CSU about which borough should hold the investigation. This was unresolved until the 14 April when the Croydon CSU accepted responsibility. A new Investigating Officer (IO) was assigned.

3.3.48 On the 13 April, Sophia was contacted by her Key Worker at the Gaia Centre. Sophia repeated her main concerns, which were that Daniel had tried to pick up Child B when drunk and that he had made threats by phone. Sophia also explained that she wanted to continue working but felt that Daniel was making this difficult by trying to destabilise her work routine by withdrawing the child care he was providing for Child B. The needs assessment was updated:

- Support around safety of Child B during contact because Daniel was turning up at the school drunk – Sophia was advised to inform the Primary School of the situation, her rights to stop contact if she believed contact was unsafe, and offered an appointment with the family law solicitors at the Gaia Centre for advice
- Sophia had been in contact with NCDV and reported that a Non-Molestation Order and a Prohibited Steps Order were being progressed
- Sophia had rent arrears – no actions identified.

3.3.49 In the records, there is no reference to the action previously agreed around security at Sophia's property, although this was subsequently discussed in a call on the 20 April.

3.3.50 On the 14 April the MPS IO suggested the investigation should sit with Lambeth CSU because they had a number of different crimes to investigate and were shortly due to leave the department. This was not agreed by Lambeth CSU and no further action was taken until the 25 April.

3.3.51 On 19 April, Lambeth CSC contacted Sophia in response to the MERLIN report generated by the MPS. The Duty Social Worker was not able to speak to Sophia directly, but left a message asking her to get in touch if she needed support. Sophia does not appear to have called back. As she was deemed to

have taken appropriate action and contacted the MPS, and because the case did not meet the threshold for intervention, no further action was taken.

3.3.52 On the 19 April a Non-Molestation Order was granted, lasting until 19 April 2017. This included forbidding:

- The use or threatening of violence, as well as intimidation, harassment or pestering
- The use of telephone, text email or text other than for the purposes of child contact or unless through a solicitor
- Going to, entering or attempting to enter any property where Sophia was living, including Sophia's then address, (including going within 100 meters of it or entering the road on which it was located).

3.3.53 The MPS IMR summarises the statement Sophia made in support of the Non-Molestation Order application. She stated that Daniel was controlling, did not like her to leave Child B with anyone else apart from him and his family; did not like her spending time with friends and would make her feel guilty if she wanted to go out with them; would check her social media accounts and tried to make her delete her Facebook account; and would become jealous if she spoke to an ex-partner. Sophia also stated that Daniel was verbally abusive towards her; would lose his temper easily if he had been drinking; and told her she was a bad mother. She reported that Daniel was first violent towards her in 2014 (this is the incident that a neighbour reported to the MPS, see 3.3.14 above).

3.3.54 On the 20 April Sophia was contacted by her Key Worker at the Gaia Centre. They discussed:

- The Non-Molestation Order, although this had not been served yet on Daniel
- A Prohibited Steps Order, for which there was a hearing on the 27 April
- Housing options, with Sophia again declining refuge. She was given further advice on her options to make a homelessness application. In this conversation Sophia declined further support around securing her

property, stating she felt more vulnerable in the surrounding area than in her home

- Sophia said she had not heard from the MPS since making her statement – the Key Worker offered to get an update
- Sophia talked further about her rent arrears, and her hope that she would resolve a Housing Benefit claim which would help pay this off – no actions are recorded as having been agreed
- Security at work, considering safety to and from, as well as at, work.

3.3.55 The Key Worker at the Gaia Centre had further contact with Sophia on the 25 April when they discussed the terms of the Non-Molestation Order. Sophia also disclosed that Daniel had rung and apologised for his actions, telling her that he loved her. The Key Worker discussed this as a form of emotional manipulation. Sophia also said that Daniel had tried to arrange contact with Child B on the day before the Family Court hearing for a Prohibited Steps Order. She had not agreed to this, feeling he might use it against her in court.

3.3.56 On this same day, the Croydon CSU again suggested that the investigation should sit with the Lambeth CSU, citing Home Office counting rules. The investigation was passed back to Lambeth CSU.

3.3.57 On the 26 April, a Police Officer at Lambeth CSU noted that Sophia's Refuge Key Worker had been in contact requesting an update on the case. This led to the investigation being reviewed by a Detective Sergeant, who redirected it back to Croydon CSU, again citing Home Office counting rules.

3.3.58 On the 27 April Sophia was referred to Victim Support for harassment, as a result of her report to the MPS on the 10 April. This is the same day as the hearing for a Prohibited Steps Order.

3.3.59 On the 28 April, the investigation was accepted by Croydon CSU and re-allocated to the IO who had previously recommended it was allocated to Lambeth CSU because they were leaving. The IO attempted to contact Sophia and left a message on her voicemail.

3.3.60 On the 29 April, Sophia was contacted by her Key Worker at the Gaia Centre. They discussed the Prohibited Steps Order, which had been granted, and the role of Children and Family Court Advisory and Support Service (CAFCASS[19]). There was a further court date in June.

3.3.61 On the 1 May, the MPS shared a further MERLIN report with Lambeth CSC regarding the Non-Molestation Order.

3.3.62 On the 7 May, the IO spoke with Sophia who declined to provide a further statement. She stated she had been granted a Non-Molestation Order and a Prohibited Steps Order and that no further incidents had occurred. This contact was 27 calendar days after Sophia had made her report.

3.3.63 On the 10 May, Sophia was contacted by her Key Worker at the Gaia Centre to provide an update. She was encouraged to contact her solicitor to check the terms of the Non-Molestation Order and the Prohibited Steps Order. The Key Worker also told Sophia that her case had been re-assigned to a new Police Officer.

3.3.64 On the 11 May:

- A Victim Contact Officer from Victim Support attempted to call Sophia but there was no answer (this was 14 calendar days after her referral to Victim Support)
- A Detective Sergeant at the Croydon CSU reviewed the investigation and, noting that Sophia did not want to provide a statement or go to court, advised the IO to complete a closing risk assessment and submit the report for closure. At this point one unsuccessful arrest attempt had been made
- The IO closed the report as standard risk, although there is no evidence that a further DASH RIC was completed with Sophia.

[19] Cafcass represents children in family court cases in England and is responsible for safeguarding and promoting the welfare of children going through the family justice system. A Family Court Advisers may be asked by the court to work with families and then advise the court on what we consider to be the best interests of the children involved. For more information, go to: https://www.cafcass.gov.uk/about-cafcass/.

3.3.65 Sophia had further contact with her Key Worker at the Gaia Centre on the 18 May and, because it was identified that a discussion about domestic violence might be helpful, information was provided about a support group. Sophia also talked about contact arrangements, saying that this was being facilitated through family or friends and that there had not been any issues.

3.3.66 On the 18 May, Sophia also went to the Lambeth Medical Centre, seeing a GP and reported abdominal pain. The cause of this pain is unknown. Sophia mentioned she had recently separated from her partner. This was the first time Sophia had mentioned relationship issues to the GP. The records do not show any enquiry around domestic violence.

3.3.67 On the 20 May, a Victim Contact Offer from Victim Support attempted to call Sophia but there was no answer.

3.3.68 Sophia had further contact with her Key Worker at the Gaia Centre on the 24 May and was informed that the MPS were not taking further action as Sophia had obtained a Non-Molestation Order and Prohibited Steps Order. On the 26 May, Sophia and her Key Worker agreed her case should be closed. Sophia is recorded as saying she felt much safer and she felt confident in knowing how to access help. The DASH RIC was completed again and scored 2.

3.3.69 On the 27 May, a Victim Contact Officer from Victim Support attempted to call Sophia but there was no answer.

3.3.70 On the 6 June Daniel contacted the NSPCC Helpline. He shared concerns that Child B was being abused by Child A, citing a "*bust lip*". He also confirmed that there was a history of domestic violence with Sophia and that a Non-Molestation Order was in place. He admitted to breaking this by contacting Sophia by text message. A referral was made to the Lambeth CSC because of concerns about physical abuse towards Child B, and to the MPS as Daniel had said he had breached the Non-Molestation Order.

3.3.71 On the 7 June, the MPS received a referral from the NSPCC, relating to Daniel's contact with their Helpline. There was some delay while the MPS tried to open a password protected folder sent by the NSPCC, although

appropriate advice was sought from the Child Abuse Investigation Team (CAIT).

3.3.72 On the 8 June a call was made by the MPS to Sophia, but there was no answer. A further call was scheduled for the 9 June, but this did not happen because there were no units available. It was agreed that a Welfare Check would be made on the 10 June.

3.3.73 Several attempts were made to complete the Welfare Check on the 10 June, with Sophia being spoken to that evening. She denied any knowledge of the injuries. Child B was also spoken to but did not make any disclosures about Child A hitting them. The report was closed (i.e. no further action was taken), with the MPS sharing a MERLIN report to Lambeth CSC on the 10 June and the 22 June. There was an error in the MPS record, which had the wrong date of birth for Daniel.

3.3.74 Sophia spoke by phone with a GP at the Lambeth Medical Centre on the 7 June, saying she had "*difficult*[y] *coping with everything*". She talked about splitting from her partner, managing children and work, as well as various court proceedings. Sophia explicitly referenced having to "*take out a court order against him*". Sophia described having panic attacks, and that she was not coping at work. The GP provided a sick note for 1 week (recorded as "*stress at home*") and a face to face review was booked in for the 10 June. The records do not show any enquiry around domestic violence.

3.3.75 On the 10 June, Lambeth CSC decided (with the MPS CAIT) to carry out a Section 47 Investigation[20], based on the MERLIN report which described a "*bust lip"*. When the Social Worker spoke with Daniel, he gave a different account saying he had seen a scratch on Child B's nose and a bruise on their knee. In this contact, there do not appear to have been any checks with professionals such as the Lambeth Medical Centre or the Gaia Centre.

3.3.76 The same day, Sophia attended a pre-booked face to face appointment with a GP at the Lambeth Medical Centre. Sophia talked about feeling anxious,

[20] A Section 47 Enquiry is undertaken, following receipt of a referral, when there is reasonable cause to suspect that the child is suffering, or likely to suffer, significant harm.

having negative thoughts, and having limited support (a friend had moved away, and her mother had died). Sophia referred to "*domestic hassle*". Sophia wanted medication and prescribed anti-depressants. She was also advised to contact the local Improving Access to Psychological Therapies service (IAPT)[21] service. The records do not show any enquiry around domestic violence. Based on the information available, Sophia did not contact the IAPT service.

3.3.77 On the 13 June, Sophia was contacted by the MPS CAIT IO. She expressed her concern that the allegations were malicious.

3.3.78 On the same day, Sophia contacted her former Key Worker at the Gaia Centre. She wanted advice about the report Daniel had made about Child B being assaulted by Child A. Sophia was offered an appointment with the solicitor at the Gaia Centre (she declined this, as she wanted to see what happened with the MPS), and she was told that she could provide the Key Worker's details to the Social Worker.

3.3.79 Following an initial call to the Primary School on the 14 June, on the 15 June a Social Worker and MPS CAIT IO visited Child B in school. Sophia was present. There were no injuries noted and the Primary School had no concerns. It was decided that it would not be in the public interest to speak with Child A. No information was sought from their Secondary School.

3.3.80 The MPS CAIT IO made attempts to contact Daniel but he did not respond.

3.3.81 During 2016, Daniel attended the Emergency Department at Croydon University on one occasion (in June) for an injury to a finger. No concerns were raised by staff and Daniel did not make any disclosures.

3.3.82 This is also the only year that Daniel had contact with a GP, attending the Croydon Medical Centre on three occasions. One of these presentations related to the injury to his finger noted above. The other two presentations,

[21] In Lambeth, IAPT is provided by the Lambeth Talking Therapies Service, which is part of SLaM. The service is available to anyone 18 years and older registered with a Lambeth GP. The service offers therapies for people experiencing mild to moderate depression, general anxiety and worry, panic attacks, social anxiety, traumatic memories and obsessive compulsive disorder.

(one also in June and the other in July) related to minor injuries. No concerns were raised by staff and Daniel did not make any disclosures.

3.3.83 At some point in July, Sophia met Noah and started a relationship with him, although this relationship was described by one of her colleagues as 'on-off'. Sophia did not tell Daniel about the relationship because she was fearful of his reaction.

3.3.84 On the 1 July, a Victim Contact Officer from Victim Support called Sophia. They spoke briefly but Sophia declined support and her case was closed.

3.3.85 That same day Sophia asked KCH if she could change her hours from evening to daytime to better manage childcare. This change was agreed, with Sophia's contract changing on the 4 July. During this discussion Sophia told her manager that Daniel was unreliable about child care and had let her down on a number of occasions. She also said Daniel was playing "*mind games*", including referring her to Lambeth CSC, which her manager gave her time off to manage. Her manager also asked her if she felt unsafe and Sophia responded: "*not really*", although she did say she was worried about Daniel's drinking. Her manager asked Sophia to let her know if anything changed and reminded her that there was an on-site Police Officer if she was worried.

3.3.86 On the 8 July, the Lambeth CSC investigation concluded, with no further role being identified. Although the Social Worker thought that Sophia was taking appropriate steps to safeguarding Child B, it was decided that a Child and Family Assessment should be completed to see if the children had any other support needs.

3.3.87 On the 19 July, Sophia's case was closed by the Gaia Centre.

3.3.88 On the 8 August, the Child and Family Assessment was completed, although the Social Worker did not use the Barnardo's Risk Assessment Matrix. This concluded that Child B had not been hit by Child A and that Sophia had acted to protect herself and the children. The Lambeth CSC IMR record that Sophia had told the Social Worker:

- That the relationship had ended
- There a Non-Molestation Order and the Prohibited Steps Order

- There had been "*just one*" incident of physical abuse.

3.3.89 Additionally, the assessment records:

- There were occasional incidents of verbal abuse
- These were interspersed by periods of amicable discussion particularly around contact arrangements for Child B
- No evidence that Child B or Child A were drawn into physically abusive exchanges
- "*No evidence of Daniel exerting dominance and control over Sophia in her day to day life and she had managed to separate, get legal advice and take protective steps*"
- The risks of ongoing exposure to children was "*mitigated by* Sophia*'s insight on the impact of domestic violence on children and she provided a nurturing environment at home*".

3.3.90 It was recorded that the Gaia Centre had completed a DASH RIC with Sophia. However, as the Social Worker did not contact the Gaia Centre to explore this further, they did not have any knowledge of its contents.

3.3.91 At part of the assessment, Daniel had also been spoken to. He had said he was not concerned about Child B's welfare at home. However, there was no direct conversation with Daniel about domestic violence.

3.3.92 The assessment concluded that there was no evidence of risk to Child B from ongoing contact with Daniel and the case was closed. A letter was sent to Child B's Primary school. Child A's Secondary School was not notified.

3.3.93 The following section describes contact with the CMS in this year. It is based on information from the CMS IMR, and supplemented with information from the MPS IMR, including direct quotes from the transcripts of call logs that were reviewed as part of the murder enquiry.

3.3.94 On the 1 November, Sophia made the first of a series of calls relating to a child maintenance claim against Daniel in relation to Child B. She called the CMS at 6.30pm, providing information to support her claim. As Sophia

disclosed a history of domestic violence, which had been reported to the Police, the £20 application fee for starting a claim was waived.

3.3.95 Based on the MPS IMR, Sophia told the CMS call handler that Daniel had "*turned nasty*" following the breakdown of their relationship, that she had a court order and that he was refusing to provide any money. Sophia was told that CMS were: "*not experts on wider separation concerns*" but they could send information on help and support by email. After her options were explained, Sophia confirmed that she wanted to make an application. As this would take 40 minutes or so, she said she would call back later that evening.

3.3.96 Based on the information provided in the CMS IMR, it is not possible to determine whether the information on help and support was sent, or whether Sophia did call back later that evening.

3.3.97 That same evening, a call was placed to Daniel in relation to the application after some initial checks had been completed. This was unsuccessful.

3.3.98 The next day, the 2 November, Daniel called the CMS to discuss the claim. He advised the call handler that he had a lot of debt from loans and credit cards and could not pay child maintenance. He was given advice about suitable organisations to assist with debt problems and it was suggested that he contact the various financial institutions to renegotiate repayment terms. He was also advised that the maintenance liability had not yet been calculated. Daniel ended the call before the application process could be fully completed.

3.3.99 On the 3 November:

- A 'Welcome Pack' was sent to Sophia. The pack included information about Daniel being contacted to complete the application
- A 'Notification of Application' was also sent to Daniel, detailing that he would become eligible for child maintenance from November 2016, with an estimated liability of just under £2,000 for the next 12 months.

3.3.100 Based on the MPS IMR, Daniel responded by waiting for Sophia outside work and trying to talk her out of continuing the application. Sophia is reported to have tried to walk away but Daniel followed her onto the bus where he

continued to shout at her, telling her to drop the claim. The information about this incident was obtained from interviews undertaken by the MPS during the murder enquiry and was not reported at the time.

3.3.101 Later that day, the CMS received a call from Sophia saying she wished to withdraw the application because Daniel had visited her at work and threatened her with violence unless she did so.

3.3.102 In relation to this call, based on the MPS IMR, the following conversation is reported to have happened between Sophia and the call handler. Sophia told the call handler, that "… [Daniel] *had visited her at work and had threatened her with violence unless she withdrew the child maintenance application*". In response, the call handler said: "*oh my goodness, I'm sorry to hear that*". She confirmed with Sophia that she definitely wanted to close her case and that a confirmation letter would go to both her and Daniel. Sophia was not asked about her personal safety or offered advice around domestic violence. The application was closed.

3.3.103 The CMS made an unsuccessful call to Daniel to tell him the claim was closed, with a voicemail message being left.

3.3.104 On the 4 November, a CMS staff member called Daniel again and confirmed that the application had been closed. On the 11 November, the claim was cancelled, with a cancellation notice being sent to Daniel on the 14 November.

3.3.105 Daniel is reported to have had no contact with Child B over the festive period, despite Sophia wanting him to do so.

Contact relating to Child A and Child B

Child A was receiving support in the Secondary School in this year. Sophia had some contact with the Secondary School about Child A's behaviour, as well as her concerns about their experience of bullying. Sophia and the Secondary School discussed how to deal with these issues.

Child B was attending Primary School, and this included a place that Sophia organised at both the Breakfast Club and After School Provision. There were referrals GSTT services.

Once during the year Child B was seen twice by their GP for minor medical issues.

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3.3.106 Sophia had agreed to meet Daniel in January 2017 to "*clear the air*" but told her sister (Cora) that nothing had changed following the meeting.

3.3.107 On the 3 January, Sophia called the CMS to restart the application process. As this would take 40 minutes to complete, and there was insufficient time to do this, she was advised to call the following day. Sophia did not subsequently call back until May.

3.3.108 At some point in January 2017 (the date is unknown) Sophia met with her new manager. During this meeting Sophia mentioned personal issues, that she had a 'restraining order' but that this was valid so "*not to worry*". She mentioned Child A and Child B.

3.3.109 On the 1 April, KCH records show that Sophia was late for work. The following day, Sophia disclosed that this was because the fees had not been paid for Child B's Breakfast Club, which meant she had to wait with Child B until the school day started. Sophia explained that the fees were meant to be paid for by Child B's father, as part of an agreement she had with him rather than applying for child maintenance. Sophia also said she was reluctant to make an application as Daniel had threatened her previously when she had done so, but that she felt to would have to. Sophia concluded by saying she thought Daniel wanted her to lose her job. Her manager told Sophia that she could be flexible around her needs and working times.

3.3.110 The MPS had contact with Daniel on the 10 April, unrelated to Sophia, as a result of a dispute in a chicken shop. No further action was taken.

3.3.111 The Non-Molestation Order expired on 19 April.

3.3.112 On the 10 May Sophia informed the Secondary School that any communication regarding Child A should only go to her.

3.3.113 On the 16 May, Sophia called the CMS about child maintenance. As before, Sophia disclosed that a history of domestic violence had been reported to the Police. She also referred to a Non-Molestation Order being in place. The £20 application fee for starting a claim was waived.

3.3.114 Of note in the CMS IMR is that at some point during the call the caseworker put Sophia on hold while they updated the IT system. In the playback, Sophia can be overheard having a conversation with a third party discussing a worry about Daniel's likely reaction, and the need for the third party to be available to support her - but that she did not want this third party to get too involved. This playback was reviewed as part of the IMR and it is unlikely the caseworker would have heard this conversation.

3.3.115 Based on the MPS IMR, Sophia was asked about the call in January which had not been completed. She said that this was because Daniel had threatened her at her place of work. There is no record of a discussion with Sophia about domestic violence support.

3.3.116 On the 17 May:

- A 'Welcome Pack' was sent to Sophia. The pack included information about Daniel being contacted to complete the application
- A 'Notification of Application' was also sent to Daniel, detailing that he would become eligible for child maintenance from May 2017, with an estimated liability of just over £1,000 for the next 12 months (this was lower than the previously estimated liability and this likely reflects the financial information available at the time).

3.3.117 The CMS were unable to speak to Daniel despite several attempts. Voicemail messages were left.

3.3.118 This was followed by another letter to Daniel on the 24 May (this was the last contact attempt by the CMS before the murder, with the CMS being informed on the 9 June 2016 by the MPS that Sophia was dead, and that Daniel was in custody).

3.3.119 On the 25 May, shortly after 4.30pm, a member of school staff reported seeing Daniel sitting on a road sign in a road neighbouring the Primary School. Daniel was drinking[22]. It is likely that this was around the same time

[22] This information was identified during the MPS murder enquiry and was not shared internally or externally at the time.

that Child A also saw Daniel near the school, with Sophia ringing Cora to say she was concerned and was going to collect Child B.

3.3.120 Early that evening, Sophia collected Child B from the Primary School After School Club. She explained to After School staff that no one should be allowed to collect Child B without her authorisation. Sophia told the Primary School that Child A had seen Daniel (or someone who looked like him) near the school. She also said that she was "*always scared*" since her separation from Daniel. School staff asked if she needed to speak to someone about the situation. Sophia said she did not as the MPS were aware of the situation and "*would not be able to do anything*".

3.3.121 There was no member of Primary School management team available to meet with Sophia and they could also not be contacted by phone. Sophia called a friend (June) and asked her to meet her and walk her home, telling her that Daniel was being "*a pain*". Sophia also spoke to her sister Cora, who felt she was worried and asked her to call her as soon as she got home. When June arrived, a member of After School staff escorted Sophia out. Sophia also told the staff member that she had received a text message from Daniel but did not say what it said. Child A repeated their disclosure to Sophia that they had seen Daniel earlier that day.

3.3.122 After walking for a short while, Daniel emerged from an alleyway. An argument started about Sophia's recent application for child maintenance. June later told the MPS that Daniel had smelt of alcohol and she was fearful he would hit Sophia. She and Sophia were concerned about Daniel's behaviour and asked the children to walk on ahead. The argument continued for some time, but Sophia then decided to walk away. Daniel then produced a knife from his bag and stabbed Sophia a number of times. Sophia died at the scene.

Contact relating to Child A and Child B

There were a number of contacts with the Secondary School, relating to Child A's behaviour issues and their developmental needs. A CAF was started, although this had not been completed by the time of Sophia's homicide.

In March, an administrator from GSTT tried to contact Sophia and Daniel to arrange an appointment but could not make contact.

In May, Sophia went with Child A to saw a GP at the Lambeth Medical Centre. She discussed a CAMHS referral.

On one occasion, Child B was seen by a GP at the Lambeth Medical Centre in the company of Sophia for a minor medical issue.

4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

Family

4.1.1 During an interview with the chair, Cora talked about Sophia's relationships with Daniel. She said that he was controlling, and gave a number of examples of this, describing how:

"…after Child B was born and [he] *didn't want* [Sophia] *to go back to work but she did anyways"*

"He also did not help with work around the house. [Sophia] *had to re-arrange her work schedule to care for her children"*

"[Sophia] *wanted to learn how to drive but he told her she couldn't"*

"He never helped her with money; specifically, he never gave [Sophia] *any to help pay bills"*

"He was controlling of Sophia*'s relationship with our mum…Daniel would text our mum rude messages, probably using* Sophia*'s phone, pretending to be Sophia*".

4.1.2 Cora was also aware of the two occasions when Sophia contacted the MPS. In relation to the February 2014 incident, Cora's account of what happened is very different to what Sophia told the MPS at the time:

"Sophia phoned, and her voice was shaking. She said Daniel had hit her and left. She said they had been arguing all day. Sophia was in the kitchen, bending over the dishwasher. As he walked by her, he pushed her into the dishwasher then picked her up and held her against a wall and shouted at her. I don't know how long this went on for".

4.1.3 As recorded in her Pen Portrait of Sophia at the start of this report, while Cora had nightly contact with Sophia in the week leading up to her death in May 2017, Sophia told her that "*she didn't want to bother the police, she thought she would be wasting their time and there wasn't much they could do".*

4.1.4 Cora said that Daniel moved out after this incident, although the relationship – after a break of a few months – continued. Sophia and Daniel later separated after the incident in April 2016. Cora described this incident, which was also reported to the MPS. She said that Daniel did not turn up to look after Child B, which he had agreed to do so that she and Sophia could scatter their mother's ashes.

"He then called Sophia and was abusive to her over the phone. At one point during the phone call, he threatened to kill her. He lived near the crematorium, so she was very frightened. This ruined the distribution of ashes as Sophia was very scared".

4.1.5 Cora was not aware that Sophia had accessed help from the Gaia Centre but did know that she had sought a Non-Molestation Order and a Prohibited Steps Order. She said that Sophia felt confident about these, and used them to protect herself, even though Daniel would ask her to cancel them:

"There were times where Daniel was abusive over the phone, and Sophia reminded Daniel of the non-mol. He would then back off. There were also occasions where he would drink and text her, but then leave her alone when she reminded him via text that the non-molestation order was in place".

4.1.6 However, Sophia wanted Child B to have a relationship with their father and so remained in contact with Daniel over contact arrangements.

4.1.7 When talking about the Non-Molestation Order, Cora said that she felt Sophia would not have gone back for a further Non-Molestation Order after it expired in 2016 because to do so "*cost money and took her time off work*"[23]. However, as recorded in her Pen Portrait of Sophia at the start of this report, Sophia was scared, anxious and worried in May 2017.

4.1.8 Cora also described how Daniel interacted with Child A and Child B:

[23] It has not been possible to determine who Sophia had contact with in relation to the application for Civil Orders. The Police referred her to the NCDV, while the Gaia Centre referred her to a local solicitor.

- She said that Daniel was controlling in relation to Child B, saying that he "*refused to hear of* it" when it was suggested that Child B may have had developmental needs. Cora's experience of Sophia was that she "*shut down*" if someone tried to have a conversation about this. Cora also gave an example of Daniel telling his mother (Child B's grandmother, Victoria) that she could no longer see Child B
- Cora and her partner also gave accounts of Daniel's behaviour towards Child A, saying Daniel was abusive and would say that Child A needed a "*firm hand"*. Her partner summarised this as *"apparently, Daniel used to hit Child A with a spatula if they spelt something incorrectly. He would grab them by their ear or nose when they lost games against friends as well".* Cora also said that whenever Daniel was in the flat he and Child A would be kept apart, with Child A staying in their room, to avoid Daniel bullying them.

4.1.9 Cora was also aware that Sophia struggled for money and was in financial difficulty (principally rent arrears, although she was not aware of the full extent of this and, after Sophia's death, found letters relating to council tax arrears and bailiffs, as well as credit card debt).

4.1.10 While Sophia asked Daniel for money, Cora felt that: "*His money was always spent on his terms*". Cora said that he never gave Sophia money for rent when he lived with her, or for Child B after they separated, although he would occasionally buy groceries. Sophia also said that Daniel would use the money, saying that: *"Daniel would dangle money in front of her. He said at one point that he would only give her money if she was a 'good girl'"*.

4.1.11 In her witness statement to the MPS as part of the murder enquiry, Cora said Daniel had told Sophia that he would rather be in prison or dead than give her any money. She also said he sent Sophia a number of threatening text messages. Cora said that although she had encouraged Sophia to report this to the MPS, Sophia said that nothing could be done unless she suffered physical abuse. She described Sophia as "*not knowing what to do*".

4.1.12 Talking about Sophia's understanding of domestic abuse, Cora said that Sophia would not have wanted to be thought of as a victim because she was "*very proud*". She also said she would tell different people different bits of

information, and probably would not have felt comfortable talking about her experience of abuse.

4.1.13 Cora was aware that Sophia experienced depression and had sought help from her GP.

4.1.14 During an interview with the chair, Cora and her partner said that Daniel was a binge drinker.

Friends

4.1.15 Harper worked with Sophia for less than a year at KCH. When she was interviewed by the chair, Harper described how she and Sophia had "*just clicked and became really close*". Harper said that Sophia "… *loved her job and everyone on that ward was her friend*". She also recalled how she would often talk about her children.

4.1.16 Harper was aware from Sophia of some of the issues with Daniel. She told the chair that when Sophia spoke with Daniel, it was often difficult: "*you could see on her face that she didn't want to be on the phone*" and he would often hang up. Sophia also told her that Daniel threatened her, telling her that Daniel said things like: "I *am going to make you lose your job*" and "*I'll make your life ten times more difficult*". Harper explained that one of the ways that he did this was by not helping Sophia with childcare (and that he also did not want his mother (Victoria) to help her either). This echoed her witness statement in which she said that Daniel did not seem interested in Child B, having not seen them at Christmas, and cancelled having them during half term.

4.1.17 Sophia had also told Harper about the incident in 2014 when the MPS were called to the house. Sophia said that Daniel had grabbed her arm and neck and that later "*he always held it against* [her] *that the Police were called, and he said that* [Sophia] *was a snitch*". When talking about the MPS, Harper said that Sophia did not want to contact them because she "…*didn't want to bother* [the MPS] *with petty phone calls*".

4.1.18 Sophia had also spoken with Harper about an application for child maintenance, explaining that Sophia just wanted Daniel to help contribute

financially. Harper said that ""*He knew that by not giving her money that he would make her life difficult*".

4.1.19 Harper told the chair that for a two-week period she had walked Sophia from work to the bus stop in early May 2017. This was after an incident when Daniel had waited outside work and followed Sophia to the bus. Sophia told Harper that Daniel had been saying "*who do you think you are*?", was being "*really aggressive*" and that he had only agreed to leave if she gave up the child maintenance claim. Sophia said to Harper that she wanted her to walk with her because "…*if anything does happen I have a witness*"[24].

4.1.20 Harper was with Sophia when she made the second application for child maintenance on the 16 May 2017[25]. Harper said that "*Sophia called them* [the CMS] *and warned them to be careful handling her claim with Daniel because he can be aggressive and will not be happy about this*". At this time, she described Sophia as feeling overwhelmed.

4.1.21 Another colleague (unnamed by Harper) would later tell Harper that on the day of the homicide Daniel had been texting Sophia all day, threatening her, and that Sophia mood had changed.

4.1.22 Tejbir had worked with Sophia for over a year at KCH. When he was interviewed by the chair, Harper described Sophia as an "*absolutely amazing person*" who was "…*beautiful in every way*", saying that as a friend and a colleague "*she'd always go that extra mile*". Tejbir said that Sophia *"… made me laugh all the time*" and would often talk about her children or the activities she was doing with them.

4.1.23 When Tejbir first met Sophia, he said that she and Daniel were co-parenting, and this seemed to ok, but over time things changed. Sophia told him that Daniel would not come around to see Child B, or he would agree to come

[24] Although the account is the same, there is a discrepancy in the date of this incident. The Police IMR records this as being associated with the first child maintenance application in November 2016. When interviewed Daniel also said he had approached Sophia in November 2016.

[25] It is likely she was the third person who Sophia was overheard talking to on a recording of her call to the CMS.

around but then not turn up. "Sophia *would really struggle – she had to tell a child that their Dad wasn't coming*"

4.1.24 Tejbir said Sophia told him: "*I am so sick of picking up the pieces for him*". He said that despite this she would always made it up for the kids when Daniel let them down.

4.1.25 Tejbir was aware that money was tight. He said that, from their conversations, he thought Sophia only approached Daniel because "*she just wanted him to help her*" because she wanted "*the best for her children*".

4.1.26 Tejbir described both applications for child maintenance, saying that after the first in November 2016, Sophia dropped the application after Daniel got angry and threatened her. In May 2017, Sophia told Tejbir that Daniel had threatened her again. Like Harper, Tejbir was aware of the incident when Daniel had confronted Sophia on the bus[26].

4.1.27 Two days before Sophia was murdered, Tejbir said that she had shown him a text message from Daniel in which he was calling her names and saying she was making the child maintenance application out of spite. Tejbir also observed that "*He (Daniel) was sending those kinds of messages before, but once he knew* [about the child maintenance application] *it got more intense*"

4.1.28 Both Harper and Tejbir described being close to Sophia and having a number of conversations about her experiences, as well as providing what support and encouragement they could. Both also talked about how Sophia could be a very private person.

4.2 Summary of Information from Perpetrator:

4.2.1 Daniel was cooperative throughout the interview, which was conducted in June 2018. This included providing background information to the chair which helped clarify some facts about his biography and the timeline of his

[26] As with Harper, Tejbir also recalled this as being in May 2017.

relationship with Sophia. This information has been integrated into the report where appropriate.

4.2.2 Talking about his own family, Daniel said that his father had been abusive towards his mother and had been strict towards him and his siblings as children, including using physical chastisement. Daniel said that some of his father's behaviour reflected his upbringing, explaining that he had come to the United Kingdom from the Caribbean so had very traditional values.

4.2.3 Daniel said that in his own relationship with his children he had wanted to behave differently. He said he had played an active role in terms of childcare when he and Sophia had lived together. In this part of the interview, Daniel said that he cooked and cleaned and that he did "*most*" of the childcare until he moved out. He also said that, after he and Sophia had separated, he wanted to have regular child contact. As an example, he said that he had wanted to see Child B over Christmas 2016 but had not been allowed to. Talking about Child A, Daniel acknowledged that he was had been responsible for discipline but said that this was because Sophia wanted him to take this role.

4.2.4 When asked about alcohol use, Daniel said that he used to drink more when he worked in a pub (estimating at around 10 to 15 units a week) but that in 2017 he had been barely drinking anything. He said he did not have an issue with alcohol.

4.2.5 Daniel also said that he had never been violent or abusive in his relationship with Sophia or in any previous relationship.

4.2.6 Daniel described the incident in February 2014. He said he had come home from work and said something about the area being dirty and that Sophia had started to shout at him. Trying to get out of the situation, Daniel said he walked past Sophia towards the balcony, so he could go outside for a cigarette. In doing so he said that he accidentally stepped on Sophia's ankle, which had been hidden beneath some laundry that she had been sorting while sitting on the floor. Daniel said that Sophia become angry and tried to punch him, and that he had pushed her back and she had then accidentally hit her head (describing this as "*her head's gone back and hit the washing*

machine"). Daniel went onto say Sophia had actually been abusive towards him in the relationship and that, when the MPS attended following a call from a neighbour, he told Police Officers that she had pushed him. Daniel expressed his surprise that he was the one who had been asked to leave. He told the chair "*As far as I'm concerned, she said something to them and that's why they told me to leave*"[27].

4.2.7 In relation to the incident in April 2016, Daniel said this related to childcare. In his account, he said he had agreed to care for Child B. The night before he and Sophia argued by text. He admitted that during this exchange he had called Sophia an offensive name. Daniel said that the next day, when he was on the way to collect Child B, he became late due to unavoidable travel delays and had texted Sophia to let her know. He said she had replied and referenced the argument the night before when he had called her an offensive name. By the time he had arrived, Daniel said Sophia had left. Describing this, he said: "*she* [Sophia] *had no intention of letting me see* [Child B] *that day*". When the chair reminded Daniel that the childcare had been arranged because Sophia was scattering her mother's ashes with her sister, he acknowledged this. However, Daniel dismissed it (describing Sophia as "…*making a big deal about the ashes"*), focusing on what he felt was her unreasonable behaviour around Child B. When talking about the allegation of harassment made against him following this incident, Daniel told the chair that he only learnt about this sometime later and had never had any contact with the MPS in relation to this matter[28].

4.2.8 Daniel suggested that Sophia had made the first child maintenance as soon as she knew he was working again. He described contact with the CMS, saying that he told them he would not be able to pay because this would make him homeless. He said he was not offered any information on help or support in relation to this, noting: "*they didn't give me any advice*"[29].

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[27] The Review Panel saw no evidence to indicate any record of a counter-allegation being made to Police Officers at the time of this incident.

[28] This is consistent with the MPS IMR which describes an unsuccessful arrest attempt.

[29] This contradicts the CMS IMR.

4.2.9 Daniel admitted confronting Sophia after she left work in November 2016. In his words: "*I got on the bus and I waited for her. I spoke to her and said I can't believe you are doing this to me* [making the children maintenance application]". Daniel said he was angry at the time and had "*explained*" things to Sophia. When this was queried by the chair, Daniel acknowledged this included swearing. He went onto say: "*I said to her …*[if] *someone makes me homeless I'll kill them, that's exactly what I said. I had enough, you're telling people I have tried to kidnap my daughter, that I've hit her. In the non-molestation order"*. In relation to this threat to kill, Daniel told the chair that he meant this generally towards anyone who tried to make him homeless [something he said would happen as a result of the cost of meeting child maintenance]. Discussing Sophia's decision to withdraw the application, Daniel said that she had done so because he had said he would give her the money when he could.

4.2.10 Talking about the second child maintenance application in May 2017, Daniel said that "[Sophia] *put in the application to get at me*". Daniel also contrasted his financial situation (he said he had little money) with Sophia's, saying: "*she can spend her money on what she wants and it's okay. You don't look at that side, you only look at the money in my account*".

4.2.11 The night before the homicide, Daniel said he felt suicidal because of the child maintenance claim and his fear of being made homeless. When asked whether he had sought any help, he said he had not. Daniel talked about seeking help with depression in his twenties but that this had not been useful at the time. He said help was not available to people in his situation.

4.2.12 When talking about the homicide itself, Daniel said he felt the child maintenance application had been encouraged by other people. During the confrontation with Sophia before he murdered her, he said that Sophia had told him he had to pay the child maintenance claim because he had "*responsibilities*". He went onto to tell the chair that "[Sophia] *was repeating exactly what they said to her at CMS, she's not exactly good with big words".*

4.2.13 In the interview Daniel expressed remorse for Sophia's death, and accepted responsibility for it. He said that it was a result of his "*pride*".

4.2.14 The chair's personal reflection after the interview was that while Daniel said he had accepted responsibility for Sophia's death this was superficial. Furthermore, Daniel's account of his own role in the relationship, particularly childcare, does not fit with the information available to the Review Panel. Lastly, in the interview he largely minimised or denied his behaviour and its impact on others, while his account was underpinned by a narrative that both blamed Sophia and also sought to undermine her credibility.

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 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

4.3.2 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 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.

4.3.3 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

4.3.4 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.

4.3.5 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.

4.3.6 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

4.3.7 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

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

4.3.9 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.

4.3.10 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 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.

4.3.11 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

4.3.12 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

4.3.13 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.

4.3.14 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).

4.3.15 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.

4.4 Any other Relevant Facts or Information:

4.4.1 No other additional facts or information has been identified.

5. Analysis

5.1 Domestic Abuse/Violence:

5.1.1 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.

5.1.2 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.

5.1.3 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. The impact on Child B and Child A is considered below (see 5.2.137 onward).

5.1.4 Sophia also experienced financial abuse, which is a form of abuse that involves the use of tactics like: making all the financial decisions, reducing someone's ability to acquire, use, and maintain money, and/or forcing them to rely on someone for all of their financial needs. Financial abuse can include financial control (e.g. demanding to know how money is spent) and financial exploitation (e.g. spends money needed for household bills, build up debt under partner's name)[30].

5.1.5 Sophia's experiences of financial abuse included:

- Withhold money: One friend (Harper) described this, saying: "*He knew that by not giving her money that he would make her life difficult*". An example is when Daniel did not pay for Child B's Breakfast Club, despite an agreement that he would do so
- Being threatened by Daniel when she applied for child maintenance: This threat worked, as Sophia subsequently withdrew her first application and was worried about making a second application. The specific issues around her contact with the CMS are explored below (see 5.2.20 onward)
- Ultimately Daniel confronted Sophia in late May about child maintenance. He was carrying a knife and went on to murder her.

5.1.6 There is also an indication that Daniel sought to use economic abuse. Economic abuse involves tactics used by abusers to affect someone's economic self-sufficiency (e.g. the use of accommodation or property, access to education or training, or sabotage to work efforts)[31]. In this case, Sophia told her employers and friends that Daniel wanted her to lose her job. For example, he would break or change or childcare arrangements, meaning that

[30] Adams, A., Sullivan., C., Bybee. D and Greeson, M. (2008) 'Development of the Scale of Economic Abuse', *Violence Against Women,* 14(5), pp. 563-588.

[31] Judy L. Postmus, Sara-Beth Plummer, Sarah McMahon, N. Shaanta Murshid, Mi Sung Kim (2012) 'Understanding Economic Abuse in the Lives of Survivors', *Journal of Interpersonal Violence,* 27(3), pp. 411 - 430.

Sophia would be late for work. Sophia told her manager that she thought Daniel wanted her to lose her job.

5.1.7 The Review Panel noted that the absence of a nationally agreed definition of economic and financial abuse is problematic, as it means that professionals (and other institutions such as banks and building societies) may not be able to name, identify and respond to such abuse. The Review Panel considered making a recommendation in relation to this issue. However, the UK Government has proposed, as set out in its consultation on a draft Domestic Abuse Bill, to: include economic abuse in a new statutory definition of domestic abuse; improve perception and understanding of this aspect of abuse; and develop statutory guidance for professionals. Consequently, no recommendation was made.

5.1.8 Different forms of violence and abuse usually operate together, or in parallel, and can be used by a perpetrator to create a web of violence and abuse. Such behaviours are underpinned by coercive control, which restricts a victim's autonomy and space for action, because coercive control: "*play[s] off the restrictions on autonomy, marriage choices, education, career options and comportment at home or in public that continue to characterize communities*[32]*".* Taken together, Daniel's behaviour would have enabled him to exert coercive control over Sophia.

5.1.9 There is another feature of Daniel's abusive behaviour that should be explicitly named. This was when Daniel made an (unsubstantiated) allegation to the NSPCC that Child A had hit Child B. This triggered a joint strategy meeting between the MPS and Lambeth CSC and lead to a Section 47 assessment. While this may have been the appropriate response in terms of ensuring that Child B was safe, the Review Panel noted that this episode was the most substantive contact these services had with Sophia.

5.1.10 What is striking is that Daniel made a disclosure that triggered a statutory response and likely caused considerable stress and anxiety for Sophia. Yet when agencies tried to explore Daniel's concerns as part of this process he

[32] Evan, S (2008) *Coercive Control: How Men Entrap Women in Personal Life*, Oxford: OUP. p238.

either played them down (to Lambeth CSC) or did not respond (to the MPS). The issues this raises are discussed further in relation to Lambeth CSC from 5.2.71 onward.

5.1.11 Arguably, Daniel's allegation that Child A had hit Child B could be seen as an example of 'abuse of process'. The Review Panel considered the emerging understanding of this type of abuse, 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. The most common examples include the use of the Civil and Family Court, but also allegations to the police[33]. However, knowledge of this form of domestic violence is relatively limited. For example, the cross-government definition of domestic violence does not refer to abuse of process and there is no nationally agreed definition.

5.1.12 The Review Panel agreed to make a recommendation in relation to this issue. This is because the UK Government's consultation on a draft Domestic Abuse Bill does not explicitly address the abuse of process within either the proposed statutory definition of domestic abuse or the statutory guidance for professionals.

The absence of a nationally agreed definition of abuse of process is problematic, as it means that victim/survivors, informal networks and professionals may be less able to name, identify and respond to a perpetrator's use of different platforms to abuse. The Review Panel therefore made the following recommendation:

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

5.1.13 This case once again demonstrates that perpetrators can continue to pose a significant risk post separation. The immediate months following a separation are often a period when the perpetrator poses a significant risk, but there is also evidence that risk continues beyond this timescale[34]. Here, Sophia ended

[33] Waxman, C. and Fletcher, F. (2016) *Abuse of Process.* Available at: http://www.voice4victims.co.uk/abuse-of-process-campaign-launches-to-help-victims/ [Accessed: 31st January 2018].

[34] Brennan, D. (2017) *The Femicide Census: 2016 findings - Annual Report of Cases of Femicide in 2016*. Available at: https://www.womensaid.org.uk/femicide-census-published/ [Accessed: 31st January 2018].

her relationship with Daniel in April 2016 and was murdered 13 months later in May 2017. Although Daniel did not tell anyone, it is also of note that he talked about feeling suicidal the night before the homicide.

5.1.14 Sophia's murder occurred shortly after a Non-Molestation Order expired. Specific issues relating to Non-Molestation Orders are discussed in 5.2.131 onwards. However, the short gap between the end of the Non-Molestation Order and Sophia's murder serves as demonstration that, while Protective Orders may be a useful tool which can have a positive impact on a victim's safety (in this case Cora felt that while the order was in place Sophia had been able to use it to manage Daniel), the existence of an order in and of itself cannot be used as a proxy for assessing the potential risk posed by a perpetrator. Obtaining a Protective Order may demonstrate the steps a victim is taking to protect themselves, but it is no more than an *external* constraint on a perpetrator which, if effective, may in some circumstances restrict their space for action. However, an order cannot bring about *internal* behaviour change in a perpetrator and so does not reduce risk per se. It is therefore critical that professionals do not take any false comfort from the presence of a Protective Order. This is because threat should always be located with the perpetrator. Additionally, safety netting advice should always be given to victims about what to do if circumstances change including when an order is coming to an end. These two issues are discussed below in relation to Lambeth CSC (see 5.2.71 onwards) and Refuge (5.2.103 onwards).

5.1.15 This review has also identified why it remains important to continue working to raise awareness of domestic violence and abuse. As summarised below (5.3.2) Sophia does not appear to have been comfortable or confident in naming her experiences to some professionals. Additionally, it appears that people in her informal network (in particular friends at work) were aware of some of the challenges she was facing in relation to Daniel, including his behaviour and issues around child maintenance. While her friends did their best, providing support in a number of ways, this illustrates the challenge for a victim's friends and family around helping someone identify, cope and recover from domestic violence and abuse. A final feature of this case is that Daniel was resident in a neighbouring borough, which meant that event if Lambeth

had a proactive communications campaign targeting perpetrators, he may not have been exposed to this.

5.1.16 Both Lambeth and Croydon undertake a range of activity around awareness raising:

Lambeth Council	Croydon Council
The council has developed and leads on a partnership communications campaign strategy, clearly outlining a zero-tolerance approach to VAWG. The council publicises Lambeth, London and national specialist services using targeted engagement aimed at victims, practitioners, family, friends and community groups. The council adjust its communication methods to ensure all communities and individuals receive information in the most accessible format i.e. non-English speakers. In summer 2018 the council created a campaign on pharmacy prescription bags targeting older victims of domestic violence and Portuguese speakers.	The council works in partnership with a wide range of partners to promote awareness all year round. Internally the council regularly undertake messaging on where to get help, and also how to help others by becoming an ambassador. Externally the council have worked to raise awareness. As an example, during the World Cup period the council has run stall for staff to seek help, posted messaging on Decaux boards, put up posters in 900 stairwells in its housing stock, press releases, newsletter entries and social media on where to speak help. The council works closely with Crystal Palace, the MPS, Croydon Voluntary Action (CVA), third sector and Pubwatch on these issues.

5.1.17 While the activity in both boroughs is welcome, the Review Panel noted that there are limits to this, particularly because campaigns are often over a short period of time and not sustained. There is also limited capacity in terms of reaching victims and perpetrators who live, work or travel between boroughs.

5.1.18 The Mayor of London has published the London Tackling Violence against Women and Girls Strategy 2018-2021 '*A Safer City for Women and Girls*'[35]. This addresses a range of issues, including challenging the cultural norms which give some men the belief that it is acceptable to attack, abuse, harass and degrade women, as well as encouraging a culture of respect towards women and girls and a better understanding of their rights. The strategy includes a specific commitment that: "*MOPAC will work with partner agencies and communities to develop and deliver a campaign that not only raises awareness of VAWG but also robustly tackles unacceptable attitudes to women and girls. We will bring partners together as a subgroup of the London VAWG Board to take this forward*".

While it is positive that the London Tackling Violence against Women and Girls Strategy 2018-2021 includes commitments to develop and deliver awareness raising campaigns, this should explicitly address how MOPAC and London boroughs will work together. Any work should take the form of a public health awareness campaign that targets victims, communities, and perpetrators, and is sustained over time.

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.

5.2 Analysis of Agency Involvement:

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference.

Analyse the communication, procedures and discussions, which took place within and between agencies.

Within the MPS

5.2.2 The delays in the MPS response in April 2016 meant that a significant period of time elapsed after Sophia's report (27 calendar days) before she received

[35] Greater London Authority. (2018) *The London Tackling Violence against Women and Girls Strategy*. Available at: https://www.london.gov.uk/sites/default/files/vawg_strategy_2018-21.pdf [Accessed: 27 June 2018].

substantive follow up contact, by which time Sophia declined to provide a further statement and did not wish to go to court.

5.2.3 As a Non-Molestation Order and Prohibited Steps Order were in place by the time Sophia was contacted again (something that Sophia told the IO who called her) it may be that she felt safe. It is also not possible to know whether her previous experiences affected her subsequent decision not to make further reports. However, Sophia's disclosure to her sister, friends and the Primary School – that nothing could be done unless she was physically hurt or that (as she told Harper) she "*didn't want to bother [the police] with petty phone calls*" – suggests she may have lost confidence in the criminal justice response as a result of this delay.

5.2.4 It is disappointing that procedural issues (in this case, over Home Office reporting standards) were prioritised over Sophia's experience, which runs counter to the Code of Practice for Victims of Crime[36] which commits the criminal justice system to put victim's first. The Police IMR engages with this robustly, describing in detail the back and forth between the Lambeth and Croydon CSUs, and acknowledging that the service provided to Sophia in April 2016 was below the expected standard.

5.2.5 The MPS IMR included two recommendations, which the Review Panel welcomed:

- *"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"*
- *"It is recommended that Croydon BOCU Senior Leadership Team debrief the officers involved in this incident to remind them of the*

[36] Ministry of Justice. (2015) *Code of Practice for Victims of Crime*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/476900/code-of-practice-for-victims-of-crime.PDF [Accessed: 31st January 2018].

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".

5.2.6 It is positive that action is being taken to address these recommendations, and at the time of writing, one of these two BOCUs (Lambeth) had already circulated guidance to its staff. The guidance states that if the location of an offence is not clear, but the victim lives in Lambeth, the BOCU will take responsibility for the investigation. Additionally, if there is a dispute between the Lambeth BOCU and another area, then the BOCU currently holding the crime must update the victim and their Personal Safety Plan, with disputes being escalated to a management level (Detective Inspector) to be resolved within 24 – 48 hours.

5.2.7 These actions are welcome, as they place the victim first. However, one of the purposes of a DHR is to identify lessons and apply these to service responses more broadly. The Review Panel was informed that the MPS holds a quarterly recommendations meeting chaired by a Detective Chief Superintendent. This reviews DHRs and is attended by the Review Officer for the case from the SCRG and a representative from the MPS Continuous Policing Improvement Team. Recommendations (including single agency recommendations from the MPS IMR and any multi-agency recommendations from the DHR itself) are revisited and a representative from BOCU (which the recommendation(s) relate to) is invited to update on the progress of implementation. The outcomes are recorded on a master recommendations grid which can be accessed by all members of the SCRG and can be used to provide updates for the Senior Leadership Team.

5.2.8 The Review Panel felt this was an example of good practice and made the following recommendation for consideration by this meeting:

Any organisation participating in a DHR needs to be able to ensure that the implications of any case specific learning are considered beyond the professionals and / or area involved in a case. This is in order that the organisation can be confident that the issues identified were either localised or, if they have a wider reach, this is identified with the appropriate remedial action being taken. The Review Panel therefore made the following recommendation:

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.

5.2.9 After reading the draft report, Cora was happy with the recommendation made in relation to the MPS. Commenting on the MPS response, she said:

> *"If this* [the report in April 2016] *had been resolved sooner, Sophia would have had a bit more confidence that the Police would do something. She didn't feel they took her seriously enough. That's what this is about. Who knows what would have happened, but it might have made a difference".*

Between the MPS and the Gaia Centre (run by Refuge)

5.2.10 The MPS IMR notes that Police Officers gave Sophia advice about local support services (both in February 2014 and April 2016). This is positive. However, it does not appear that there was significant contact with the Gaia Centre directly. The exception to this was a request made by the Gaia Centre Key Worker to the MPS on the 26 April 2016 for an update on Sophia's case.

5.2.11 The Review Panel agreed that this limited contact between the MPS and the Gaia Centre was unsatisfactory. However, it concluded the underlying cause of this lack of contact was the issue of ownership of the investigation, discussed above, which meant that an OIC was not identified promptly. If there had been an OIC with investigative responsibility, the Review Panel felt it is likely they would have contacted the Gaia Centre in line with MPS procedures. Therefore, no further recommendation is made in relation to this issue.

Lambeth CSC with the MPS, the Gaia Centre (run by Refuge) and primary / secondary school

5.2.12 Lambeth CSC undertook a joint strategy meeting with the MPS when Daniel made an allegation to the NSPCC that Child A had hit Child B. As part of a Section 47 enquiry, this included a joint visit to Child B's Primary School.

5.2.13 While this suggests there was some multi-agency working, it is unclear to what extent Lambeth CSC and MPS shared information more broadly to develop a whole picture of the relationship. This is discussed more fully in relation to the issue of the Non-Molestation Order below (see 5.2.131). Additionally, there appears to have been limited communication from Lambeth CSC to the Gaia Centre, (see 5.2.74), Child A's Secondary School (see 5.2.153) and health professionals, in particular the Lambeth Medical Centre (see 5.2.62 onward).

Analyse the co-operation between different agencies involved with Sophia, Daniel and the wider family, specifically Child B and Child A

5.2.14 Issues in relation to co-operation are addressed elsewhere in the analysis. The exception is the co-operation between the Gaia Centre and Victim Support.

5.2.15 One feature of this case is that Sophia was open to two providers offering domestic violence support following her report to the MPS in April 2016. The Gaia Centre had extensive contact with Sophia (as a result of her self-referral to the service) while Victim Support (as a result of an automatic referral from the MPS) did not.

5.2.16 The Review Panel discussed this issue and sought additional information from both the Gaia Centre and Victim Support. The Refuge IMR noted that Sophia had self-referred to the Gaia Centre, so would not necessarily have been asked about her contact with other specialist services. In contrast, Victim Support confirmed that victims are routinely asked about contact with other specialist services. This means that when Sophia had contact with staff in Victim Support's generic assessment centre, and if she had accepted help

and support, she would have been referred to the Gaia Centre. This reflects the care pathway for domestic violence victims in Lambeth. However, Victim Support noted that while this is custom and practice it is not reflected in procedures.

5.2.17 Neither the Gaia Centre or Victim Support IMR addressed these points.

There are a range of specialist domestic violence services in Lambeth, reflecting different commissioning arrangements. This could pose a challenge for victim/survivors as they may have to navigate different offers, depending on their circumstances and how they are referred (or self-refer) to a service. Specialist services should do all they can to identify these different pathways, in order that they can give appropriate advice to a client and, where necessary, identify opportunities to work collaboratively. The Review Panel therefore made the following recommendations:

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.

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.

5.2.18 This also serves as an illustration for both local, regional and national commissioners about why they need to ensure that they are aware of the services in an area when developing commissioning strategies, ensuring that any activity is integrated and that there are clear expectations about how providers should work together. The Safer Lambeth Partnership has a VAWG Strategy[37], which considers the provision of services locally. Nationally, the National Statement of Expectations[38] outlines the importance of identifying what services are needed locally, and mapping support groups, to inform commissioning decisions. The Review Panel felt this was sufficient. Therefore, no further recommendation is made in relation to this issue.

[37] Safer Lambeth Partnership. (2016) *Safer Lambeth Violence against Women and Girls Strategy*. Available at: https://www.lambeth.gov.uk/sites/default/files/ssh-safer-lambeth-vawg-strategy-2016-2020_0.pdf [Accessed: 6th May 2018].

[38] Home Office (2016). *Violence Against Women and Girls National Statement of Expectations*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/574665/VAWG_National_Statement_of_Expectations_-_FINAL.PDF [Accessed: 6th May 2018].

Analyse the opportunity for agencies to identify and assess domestic abuse risk, including during any contact with Sophia, Daniel and / or Child B and Child A in relation directly to domestic abuse and / or other needs and issues.

5.2.19 This is addressed elsewhere in the analysis.

Analyse agency responses to domestic abuse issues.

CMS[39]

5.2.20 On both occasions when Sophia contacted the CMS to make an application for child maintenance, she disclosed her experiences of domestic violence. Additionally, she told called handlers:

- In her first contact in November 2016: that she was making the application because Daniel had "*turned nasty"*. When she later withdrew her application, she told the call hander that Daniel had visited her at work and threatened her with violence
- In her second contact in May 2017: that a Non-Molestation Order was in place. In this call, when asked about her approach to the CMS in January 2017, and why she had not completed an application then, said that this was because Daniel had threatened her.

5.2.21 Ultimately Sophia's death came shortly after her second application for child maintenance, an application which had triggered several attempts by the CMS to contact Daniel (by letter and phone, with voicemails being left). While Daniel is responsible for his actions, and these actions took place in the context of a history of abuse, the issue of child maintenance appears to have been the most significant precursor to the homicide.

5.2.22 The Review Panel initially considered the CMS's response to Sophia and concluded that the response to Sophia was inadequate. Additionally, the Review Panel were concerned that Sophia's experiences are illustrative of a

[39] With thanks to Surviving Economic Abuse (SEA) for advice in relation to financial abuse in the context of contact and maintenance. For more information, go to: http://www.survivingeconomicabuse.org.

more systemic set of issues. It concluded that the current response of the CMS to domestic violence and abuse is insufficient and could potentially heighten the risk to victims when making a child maintenance application.

5.2.23 In reaching these conclusion, the Review Panel focused on three areas:

- How domestic violence and abuse is addressed by the CMS in its contact with the public generally (this is important as any information provided has the potential to educate and inform those considering or making an application, including encouraging disclosures)
- The management of domestic violence and abuse (with reference specifically to Sophia and Daniel)
- Staff training (this is important if call handlers are to have the right skills and knowledge to respond appropriately to any disclosures).

5.2.24 Firstly, with reference to the public face of the CMS: The CMO is the gateway to, and the public face of, the CMS. In relation to domestic violence and abuse, the CMO has a poor representation of this issue. A review of the CMO website in February 2018 established that it does not include any easily accessible information on domestic violence and abuse, with the search function returning the response "*No documents match the query*" [40]. While not locatable via the search function, a series of guides (accessed and reviewed at the same time by the chair) do refer to domestic violence. The content in relation to domestic violence in each is described in summary below:

Name of guide	Summary of consideration
Information for parents with the day-to-day care of their child	Two references to risk of domestic violence or abuse; List of national helplines
Information for parents living apart from their child	Two references to risk of domestic violence or abuse; List of national helplines
Helping someone you know	Three references to risk of domestic violence or abuse; List of national helplines

[40] Child Maintenance Options (2018) *Search Results,* Available at: *http://cmoptions.org.master.com/texis/master/search/mysite.html?q=domestic+violence* (Accessed: 27 February 2018).

Talking about money guide	1 reference to risk of domestic violence or abuse; List of national helplines
Child maintenance and staying safe	Short section on domestic violence, which does not use the national definition or give examples of what violence and abuse might feel like; 1 reference to risk of domestic violence or abuse; List of national helplines
Practical support for separating parents	Short section on domestic violence, which does not use the national definition or give examples of what violence and abuse might feel like; 1 reference to risk of domestic violence or abuse; List of national helplines
Dealing with emotions after separation	1 reference to risk of domestic violence or abuse; List of national helplines
Getting in contact with your child's other parent	List of national helplines
Managing conflict with your child's other parent	1 reference to risk of domestic violence or abuse; List of national helplines
Parenting together after separation	1 reference to risk of domestic violence or abuse; List of national helplines

5.2.25 Overall, the Review Panel felt that the quality of information in these guides was poor. This is particularly disappointing given the number of applicants who are likely to have experienced domestic violence. Indeed, a report published by the DWP in 2012 estimated that 32 per cent of all new applications for child maintenance might disclose domestic violence[41]. The CMS itself reported more recent figures in correspondence with the chair, noting that 38 per cent of applications received between October and December 2017 were exempted from the application charge for the reason of domestic violence or abuse (10,200 out of 27,500 cases).

5.2.26 In its response to the draft report, the CMS pointed specifically to the guide '*Child Maintenance and Staying Safe'*. The CMS noted that the guide:

- States that those who are in imminent danger should seek help from the police and a solicitor

[41] Department for Work and Pensions. (2012) *Estimating the impacts of CSA case closure and charging*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/220461/estimating-impacts-csa-case-closure-and-charging.pdf [Accessed: 31 January 2018].

- Lists a number of organisations who can provide appropriate support or help
- Is clear that making a statutory arrangement could have implications and that the receiving parent should ensure they have sought appropriate support/help to ensure they remain safe before applying for a statutory arrangement. The CMS quoted the following excerpt from the guide: "*It's important for you to think about how the other parent might react to hearing from the statutory services. The Child Support Agency and the Child Maintenance Service will keep your personal details safe. But if you think that setting up a case could cause a problem, you may want to take steps to protect yourself and your family*".

5.2.27 The Review Panel did not agree with the CMS's view that this guide was an example of good practice. Indeed, and in stark contrast, the Review Panel felt the guide illustrates precisely the problem that is evident across all the CMS's guides and summarised in the table above. For example:

- While the guide reminds people to seek help if they are in "*imminent danger*", the meaning of this is not defined
- The guide also draws attention to the implications of contact by the CMS, but in doing so it does not address domestic violence and abuse explicitly and instead uses the rather euphemistic formulation of "*how someone might react*"
- Even if these respective terms were more fully defined, using them in the absence of a wider discussion of domestic violence and abuse (including what it is, how it operates and what it might feel like) is limiting. It also excludes a range of other behaviours that an abuser might use, in particular failing to locate this in the context of economic abuse or coercive control. Taken together, these behaviours can have a significant impact, as in the case of Sophia's experience of threats, but may not be understood by either an applicant or call handlers as representing an imminent danger.

5.2.28 The Review Panel felt that the information provided by the CMS in these guides, if some or all had been located and used by Sophia, was unlikely to

have enabled her to better understand her experiences or consider potential risks in the context of a child maintenance application. This judgement is based on the issues discussed in this report about how Sophia may have perceived domestic violence and abuse (in particular the information provided by her sister, as well as how Sophia managed disclosures of domestic violence and abuse to different agencies). Looking beyond Sophia's case, this is also potentially true of others making a child maintenance application to the CMS.

5.2.29 It is not possible to identify a CMS website, beyond an account log in page. The chair was therefore unable to review what (if any) information is provided to the CMS's users around domestic violence once an application had been made[42].

Raising awareness of domestic violence and abuse should be 'everyone's business' and embedded across a range of agencies in everyday settings in order to encourage help seeking. This must include child maintenance. The Review Panel therefore made the following recommendation:

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).

5.2.30 Secondly, with reference to the management of disclosures of domestic violence and abuse: In Sophia's contacts with the CMS she disclosed domestic violence. These disclosures led to the application fee being waived. The CMS IMR, and its response(s) to the draft report, focused on the decision to waive the application fees. The CMS noted that the offer of an application fee waiver on a light touch, self-declaration basis is an example of the steps it can take to protect those threatened by domestic violence and abuse. The Review Panel acknowledged that the availability of a fee waiver is positive and is likely to have been of benefit to Sophia. Given the number of

[42] Child Maintenance Service (2018) *Child Maintenance Service,* Available at: *https://childmaintenanceservice.direct.gov.uk/public/* (Accessed: 27 February 2018).

applications to the CMS as cited above, this waiver also offers some relief to a considerable number of applicants each year.

5.2.31 Additionally, the CMS identified some other steps it can take to protect victims of domestic violence and abuse. These include:

- Not putting clients directly in touch with each other, nor sharing their current location via any correspondence from the CMS
- Being able to arrange for payments to be made via bank payments that cannot be traced to a physical location, protecting a client's location.

5.2.32 The Review Panel also acknowledged that these steps are positive and are likely to be of benefit to a number of applicants (although they would not have been relevant to Sophia given she and Daniel were in contact and he knew where she lived).

5.2.33 However, while these steps are useful, they are but partial measures. They may make it easier for someone to make an application (by waiving the fee) and / or reduce a perpetrator's space for action (e.g. by avoiding direct communication relating to the application or ensuring a victim with a confidential address cannot be located via the CMS) but they do not pro-actively manage or eliminate risk. This is an issue because a child maintenance application is only one part of a wider constellation of factors, including historical or current violence and abuse, the status of the relationship and any contact arrangements. Therefore, a robust response to allegations of domestic violence and abuse during a child maintenance application is necessary to ensure that the application process itself is as safe as possible. Such a response would enable the CMS to play a part in the wider CCR.

5.2.34 Sadly, it appears CMS's current procedures are not informed by a consideration of the CCR, nor do they make a significant contribution to it. In Sophia's case, while she was offered information on support services at her first contact it is not clear whether this information was ever provided, and it does not appear that a further attempt was made during her second contact.

More concerningly, despite Sophia talking about threats that Daniel had made during both her applications, no action was taken.

5.2.35 The CMS's first submission to the draft report asserted that: "*is our judgement that, in this particular case, there was no evidence at any point that Sophia spoke to our caseworkers that she was under imminent threat of harm*". In explaining its approach, in its second submission, the CMS stated: "*CMS takes the safety of clients seriously and strives to mitigate any risks. Guidance and training require that case workers ask questions of the applicant in order to assess the severity of any issue and employ active listening techniques to ascertain if there is any immediate danger*".

5.2.36 While it is clearly important that call handlers can respond to immediate or imminent danger, the Review Panel felt that this focus is far too narrow. There is a robust evidence base about the risk of domestic violence in relation to both separation and arrangements around child contact[43]. There is also good evidence that the risk of homicide is higher when coercive control operates alongside financial abuse[44]. While Sophia may not have appeared to be at immediate risk when she contacted the CMS, that does not mean she was not at risk. Yet on both occasions, despite Sophia's disclosures about the threats Daniel had made, no assessment of risk was made. This is because there is no capacity within the CMS to undertake such an assessment beyond referring someone to an external service, or advising they contact the Police or offering to do so for them. What's more, Daniel was contacted almost immediately by the CMS with no consideration of his potential risk to Sophia. Again, this is because the CMS would only decide not to contact the other parent where there is immediate or imminent danger.

5.2.37 While the Review Panel acknowledged that the CMS has to follow due process, it should not be unaware of (or be unable to respond to) the imbalance of power that is present in a domestically abusive relationship. It is inexplicable that contact with an (alleged) perpetrator would take place

[43] Women's Aid (2016) *Nineteen Child Homicides*. Available at: https://www.womensaid.org.uk/child-first-research/ [Accessed: 31 January 2018].
[44] Websdale, N. (1999) *Understanding Domestic Homicide*, Boston, MA: North Eastern University Press.

without there being some process in place to identify and respond to domestic violence allegations first, particularly where specific threats have been disclosed. This point is not addressed by the CMS's IMR.

5.2.38 The Review Panel therefore concluded there were missed opportunities in the CMS's response to Sophia. In reaching that conclusion, while the contact in this case was with specific call handlers, it is important that DHRs do not single out a member of staff but rather consider the broader organisational context in which they operate. Looking beyond Sophia's case, the issue around the management of domestic violence disclosures could be relevant to anyone making a child maintenance application to the CMS.

Victim/survivors of domestic violence should be able to seek help in a range of everyday settings because every point of interaction is a potential opportunity for intervention and should not be missed. This must include child maintenance. The CMS should be able to more robustly respond to disclosures of domestic violence, including making direct referrals to independent specialist help and support, and ensuring that appropriate arrangements to manage risk are in place before contact with an alleged perpetrator is made. The Review Panel therefore made the following recommendation:

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.

5.2.39 Thirdly, with reference to staff training: The importance of training is illustrated in this case because Sophia was told by call handers that they were not experts on wider separation concerns. While the Review Panel accepted that call handers will not be experts, given the number of users likely affected by domestic violence and abuse, it would be reasonable for staff at the CMS to have adequate training on these issues, including financial abuse specifically.

5.2.40 In the CMS IMR, it is reported that the organisation's approach to conversations about domestic violence and abuse has recently been updated. Specifically, call scripts have been revised as follows:

- More directly enquire from the receiving parent whether they or their child/children have experienced domestic violence/abuse

- Talking through the various forms which this abuse might take
- Confirming that a report has been made to either the courts, the police or social services.

5.2.41 The CMS IMR goes onto note that: "*We are encouraging our people to be sensitive and sympathetic but not to attempt at any point to give advice or a personal opinion about domestic abuse. Where appropriate we encourage our people to signpost customers to additional services*".

5.2.42 The first of two recommendations in the CMS IMR related to this point:

- "*Updating our call scripts for our Applications caseworkers at the front end of the CMS business*".

5.2.43 Additionally, the CMS has rolled out a mandatory domestic violence training programme. This training package was commissioned internally in November 2016, piloted and evaluated in May 2017 and roll out began in March 2018.

5.2.44 These 2-hour coaching sessions are being led by Team Leaders and will be delivered to all caseworkers by 31 October 2018.

5.2.45 The second of two recommendations in the CMS IMR related to this point:

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

5.2.46 In June 2018, the CMS informed the chair that by the end of May 2018, 1567 (39.21%) staff had received the training, with the remaining 2,429 staff (60.79%) due to be trained by October 2018.

5.2.47 The chair received a copy of the training programme, including scripts for Team Leaders and handouts for staff. Disappointingly, the programme in its roll out and content appears to have significant weaknesses. Additionally, based on the evidence available to the chair, the training programme does not appear to have been developed within any direct input by a specialist domestic abuse service. Perhaps unsurprisingly, this means there are some significant flaws in the training programme.

5.2.48 Firstly, the training is delivered by in-house Team Leaders, who receive 'coaching guidance' but are not themselves specifically trained. This is

problematic as domestic violence and abuse is a challenging issue, and anyone responsible for training and supporting staff should have the skills and knowledge to do this adequately. For example, it is common practice in other organisations that have sought to cascade training across their teams that 'champions' are identified and undergo additional training to enable them to do this.

5.2.49 Secondly, the content covers:

- Statistics on domestic abuse
- Key messages around sensitive handling, taking appropriate action, protecting customers and not acting with bias
- Questions to ask users if staff hear anything that suggests the customer, or their dependents might be in danger
- Action to take where the caseworker believes the user to be in an abusive situation e.g. to contact the police immediately; to ask whether it is okay for CMS to contact the police where the customer is unable to do so; to signpost the customer to organisations who can support them etc.

5.2.50 However, the training does not substantively explore the potential impact of domestic violence and abuse in the context of a child maintenance or as a form of financial abuse (for example, considering Sophia's experience, exploring the impact of coercive control or the use of threats). While it includes some basic screening questions (e.g. "*what are you frightened of?*", "*who are you fearful of*?"), these are not related to practice (again, considering Sophia's experience, it is unclear how the training would equip a call handler to respond as she had disclosed a crime but did not indicate she was an 'immediate' risk).

Training requirements will vary depending on someone's role. Training may be about increased awareness, through to equipping professionals to respond effectively to a disclosure or enabling a team member or manager to act as a 'champion'. It is critical that agencies have a robust training strategy to ensure that knowledge about domestic violence and abuse is embedded across the workforce. The Review Panel therefore made the following recommendation:

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.

5.2.51 After reading the draft report, Cora was happy with the three recommendations that had been made in relation to the CMS. Commenting on the CMS response she said:

"*It seems so strange to me that for Sophia they* [the CMS] *didn't have anything (apart from a waiver) in place to help. I know they had to contact him* [Daniel] *but it was so quick. The way they dealt with this situation was wrong. There must be so many people in this situation, I just feel like they need to put in different strategies on how to deal with this better*".

GSTT

5.2.52 Sophia's contact with GSTT is discussed in relation to the impact of domestic violence and abuse on children, see 5.2.137 onward.

KCH

5.2.53 KCH had contact with Sophia in the early 2000s relating to the birth of Child A and later in relation to the birth of Child B. No social or safeguarding concerns were recorded at the time.

5.2.54 KCH also had contact with Sophia as her employer from July 2015 to the time of her death. Sophia was a well-liked and reliable member of staff, and there were no formal issues in relation to her employment.

5.2.55 Sophia had made disclosures to her manager, including Daniel's drinking, "*mind games*" and threats. She also talked about her financial struggles, including her concerns about seeking child maintenance.

5.2.56 It appears that these were dealt with sympathetically, with Sophia's manager providing practical support including changes to her working pattern, as well as reminders about the Police Officer on site.

5.2.57 Similarly, Sophia made disclosures to friends and colleagues including talking about a previous assault, and Daniel's other behaviours, including once following her home from work.

5.2.58 The following recommendations were made in KCH's IMR, which the Review Panel felt demonstrated an understanding of the opportunity to learn from this case and develop support for staff and their managers:

- *"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"*
- *"Standalone policy/ guidelines for supporting staff experiencing Domestic Abuse. Completion by September 2018".*

5.2.59 The Review Panel felt that Sophia's contact with her employer, albeit largely informal, illustrated the importance more generally of employers being able to support staff members affected by violence and abuse. The national VAWG strategy[45] describes employers as having a critical role in both identifying abuse and developing robust workplace policies to support employees who may be victims of violence, abuse or stalking.

5.2.60 With this in mind, as part of the DHR process, Review Panel members were asked whether their agency had a specific staff policy relating to domestic violence and abuse. Although the policies were not directly reviewed, after the third Review Panel meeting, agencies completed a template describing the current policy arrangements. The range of responses from within this small sample of agencies was striking, although perhaps not surprising:

[45] Home Office (2016) *Ending Violence against Women and Girls: Strategic 2016 – 2020*. Available at: https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020 [Accessed: 6 May 2018].

Agency	Staff Policy
CMG	The DWP has a departmental policy, which was last reviewed in March 2018
Croydon Health Services (CHS)	No specific policy. Staff experience addressed in 'Management of Domestic Abuse and Sexual Violence Policy' (2015)
Croydon Medical Centre	No staff policy
Croydon CCG	No staff policy but reviewing best practice following the request
Evelina London – GSTT	In process of compiling a GSTT wide domestic violence policy – this will include specific section on staff members who may be at risk or experiencing domestic violence
KCH	Recommendation made in IMR to develop an Employer Domestic Abuse Policy. This is currently being developed
Lambeth CCG	No staff policy
Lambeth Council (including Lambeth CSC and Housing)	No staff policy
Lambeth Medical Centre	Staff policy in place and last reviewed in 2018
MPS	The MPS Domestic Abuse toolkit has a specific section for staff who are victims or perpetrators of domestic abuse. The policy was last reviewed in September 2014. It is due to be reviewed in September 2018
NSPCC	Staff policy in place and last reviewed in 2017
Primary School	No policy in place. Head Teacher is I currently in discussion with Human Resources and Executive Headteachers regarding the need to implement a specific policy

Refuge IDVA Service at the Gaia Centre	Staff policy in place and last reviewed in 2016
Secondary School	No staff policy
Victim Support	There is a staff and volunteer domestic abuse policy and guidance; this is due to be reviewed in 2018

Local partnerships should ensure that their member agencies have policies in place, as well as identifying how they can individually and collectively promote the adoption of workplace policies within the public, voluntary and private sector. The Review Panel therefore made the following recommendations:

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.

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.

The (Croydon) Medical Centre - Croydon CCG

5.2.61 Daniel had very limited contact with the Medical Centre and no issues were identified and there were no opportunities to respond to domestic violence and abuse.

The (Lambeth) Medical Centre - Lambeth CCG

5.2.62 Sophia, Child A and Child B were seen regularly by GPs at the Medical Centre for a variety of health concerns, with timely and appropriate responses to their needs. The records show that the respective GP's who had contact with Sophia, Child A and Child B, managed their clinical presentation diligently.

5.2.63 Considering Sophia's contact specifically, it is of note that she saw many different GP's at the Medical Centre. Sophia presented with a series of apparently unrelated minor illness/elective care over a long period of time. Where a patient has on-going needs, there are benefits to the continuity of care within the practice. As Sophia had multiple contact with different GPs, this might have contributed to the extent to which there were no in-depth explorations of her domestic situation. In particular, there were disclosures by Sophia that could have triggered a direct enquiry about whether she felt safe at home, or more specifically, domestic violence:

- In June 2014, Sophia mentioned she was tired and had recently broken up with her partner
- Between January and December 2016, Sophia sought both physical and psychological support from GPs, as well as outlining the issues in her domestic circumstances
- On 7 June 2016, Sophia said she was having "*difficult*[y] *coping with everything*" during a phone appointment, explaining she had split with her partner, there were court proceedings and that her ex-partner had referred her to CSC
- When Sophia met a GP on the 10 June 2016 she again mentioned her domestic circumstances, referring to "*domestic hassle*".

5.2.64 Additionally, it does not appear that the Medical Centre was made aware by any other agency of explicit concerns around domestic violence and was not contacted by Lambeth CSC during its enquiries in 2016. However, the IMR for the Medical Centre identified that there were a number of letters or requests for information received which may, seen collectively, have suggested possible issues related to indicators of domestic violence. Again, Sophia's multiple contact with different GPs might have meant this was not identified.

5.2.65 The involvement of multiple GPs highlights one of the challenges of promoting a more consistent doctor-patient relationship within a modern primary care setting; such consistency could conceivably be beneficial towards identifying domestic violence and abuse and supporting a victim. If such consistency

cannot be achieved, as a minimum, this means training and procedures must be practice wide if they are to be effective.

5.2.66 Taken together, these issues demonstrate the importance for GP's (and other primary care staff) of being able to recognise indicators of domestic violence and abuse, as well as developing the skills of professional curiosity which are necessary to explore those indicators. Advancing the concept of professional curiosity may require the topic of domestic violence and abuse to be incorporated not only in formal training packages, but also in other experiential learning strategies open to primary care professionals, such as supervision and reflective practice.

5.2.67 Additionally, it is of note that the Medical Centre involved in this case had minimal reference to domestic violence and abuse within their Adult Safeguarding policy. Having a policy, underpinning any training or the use of professional curiosity, is important. The limited reference to domestic violence and abuse raises the question of how a GP or another member of the practice staff would understand their responsibilities towards domestic violence and abuse or would access information and guidance when managing a concern. A robust policy may be expected to contain baseline information in terms of organisational roles and responsibilities, referral mechanisms, resources and pathways, as well as guidance pertaining to Domestic Abuse risk. The Royal College of General Practitioners (RGCP) guidance for General Practice[46] outlines the key principles which could be covered in a practice domestic abuse policy.

5.2.68 The IMR for the Medical Centre acknowledges that clinical staff did not fully explore Sophia's domestic situation and made the following recommendation:

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

[46] Royal College of General Practitioners (2013) *Responding to domestic abuse: Guidance for General Practitioners*. Available at: http://www.safelives.org.uk/sites/default/files/resources/SafeLives_GP_guidance_manual_STG1_editable_0.pdf [Accessed: 6th May 2018].

5.2.69 The Review Panel additionally considered the question of the support locally to support primary care staff to undertake enquiry about domestic violence, or to access care pathways so patients can access help and support.

5.2.70 Between August 2011 and March 2017, Lambeth had a local IRIS (Identification & Referral to Improve Safety[47]) project. The IRIS project aims to increase health professional's awareness of domestic violence, as well as to support proactive enquiry where someone's presentation suggests domestic violence could be an issue. As a result of this project, the Medical Centre received one training session from IRIS on 16 September 2014, with 10 clinicians attending. While this is positive, clearly some time has elapsed since this training was last delivered.

A range of effective interventions can make it easier for primary care to respond to domestic violence and abuse. This should include ensuring that GPs (and other staff) have access to training, support and a referral programme to support them asking about and responding to domestic violence and abuse.

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.

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.

Lambeth CSC

5.2.71 With the benefit of hindsight, there is a significant divergence between the information in the Child and Family Assessment (concluded by Lambeth CSC's on the 8 August 2016, following the initial Section 47 enquiry) and the information known to other agencies.

5.2.72 To illustrate this, the following table summarises what was known to Lambeth CSC at the time. This is then cross referenced with what was known to the

[47] For more information, go to http://www.irisdomesticviolence.org.uk.

three agencies (MPS, the Gaia Centre and Child B's Primary School) that had substantive contact with Sophia and her family in the same period:

Lambeth CSC	MPS	The Gaia Centre	Primary School
The relationship was over	√	√	√
Non-Molestation Order and the Prohibited Steps Order in place	√ - but aware (from NSPCC report in June 2016) of a breach	√ - but aware of breaches	√
There had been one incident of physical abuse	√	√	√
Occasional incidents of verbal abuse	X – report in 2014, as well as report of harassment in 2016	X - verbal abuse which was getting worse and happening more often	√
Periods of amicable discussion particularly around contact arrangements for Child B	X – report in 2016 described "*arguing over childcare*"; Police Officers contacted Child B's school to ensure Daniel would not be able to take them out of school; Prohibited Steps Order in place	X – disclosed conflict over child contact and Daniel being drunk when he collected Child B from school; Prohibited Steps Order in place	X – had turned Daniel away with concerns that he was drunk; Prohibited Steps Order in place
No evidence that Child B or Child A were drawn into physically abusive exchanges	X – report in 2016 included description of "*arguing over childcare*"	X – disclosed at least once that Child B had witnessed psychological abuse	√
No evidence exerting dominance and control over	X – aware of harassment and threats "*you are dead*"	X – described a range of abusive behaviours, including physical abuse and	X

Sophia in her day to day life		intimidation, stalking, economic abuse and attempts to separate	

5.2.73 The divergence in what was known is striking. It shows that MPS, the Gaia Centre and Child B's Primary School had a range of different information which, if known to Lambeth CSC, would have enabled a clearer picture of the family situation. This in turn may have changed the outcome of Lambeth CSC's assessment.

5.2.74 In relation to the information known to Gaia Centre, this is particularly concerning because the Social Worker in this case was aware that a DASH RIC had been completed with Sophia. While the Lambeth CSC IMR states: "*it is not clear what conversations took place between Gaia and the Social Worker to share the risk assessment*", it was subsequently clarified that the Social Worker did not contact the Gaia Centre to discuss the DASH RIC.

5.2.75 The risk here is evident: One-off or apparently 'low level' incidents of domestic violence or physical injury may not meet the threshold for child protection procedures. However, no one agency has a full picture and such incidents need to be seen within the context of what else is known about the family. That means that, within the strictures of data protection, professionals must make timely and appropriate enquiries with other agencies in order to ensure that a parent is both engaged with a service (and receiving the support they need to keep any children safe) and that they have the fullest picture possible in order to make an assessment.

5.2.76 In this case, the Social Worker knew that Sophia was receiving support from a specialist service but did not gather all the relevant and up-to-date information from a key agency.

5.2.77 A further issue is that Social Worker in this case did not use the Barnardo's Risk Assessment Tool[48], which is required in local practice.

[48] Available at: http://www.barnardos.org.uk/Barnardos_Domestic_Violence_Risk_Identification_Matrix.pdf.

5.2.78 Neither of these issues was identified by the Team Manager who was supervising the Social Worker. Indeed, the Lambeth CSC IMR notes that the Team Manager should have asked the Social Worker to both contact the Gaia Centre and complete the Barnardo's Risk Assessment Matrix.

5.2.79 Had the Risk Assessment Tool been completed at the time, the risk would have been rated as Scale 1 or 'Moderate'. At the request of the chair, Lambeth CSC refreshed the Barnardo's Risk Assessment Tool to reflect the information known to other agencies at the time as described above. This was duly done. Lambeth CSC reported that, had there been a conversation between Lambeth CSC and the Gaia Centre (with consent of Sophia) and had the Social Worker completed the Barnardo's Risk Assessment Matrix, the level of risk would have been rated higher. The level of risk would have moved from Scale 1 or 'Moderate' to Scale 2 or 'Moderate to Serious'.

5.2.80 However, Lambeth CSC have been clear that, even if the risk had been rated at this higher scale, the outcome would not have made any difference. This is because Sophia had a stable nurturing relationship with her children and had already taken the actions that were available to her to protect herself and the children from ongoing exposure to domestic violence in the home.

5.2.81 Civil orders are discussed in more depth below (see 5.2.131). However, the focus on the steps that Sophia had taken is problematic. While the Social Worker commented in the analysis at the end of their assessment that Sophia had taken the appropriate action, it is clear that basis for this statement was limited. Indeed, the assessment had focused on the report by Daniel that Child A had hit Child B, rather than exploring issues more holistically. Indeed, multiple sources (in addition to any information from Sophia) were not explored. Examples include:

- Child A / Child B – the Barnardo's Risk Identification Tool was not completed, and Child A's Secondary School was not contacted
- Sophia – considering the previous history of abuse, including the report in April 2016, as well as the circumstances around the Non-Molestation Order and the Prohibitive Steps Order

- Daniel – While the Social Worker spoke with Daniel to explore his allegations that Child A had hit Child B, there was no exploration of the alleged domestic violence.

5.2.82 Additionally, as discussed above, the failure to liaise with the Gaia Centre meant additional information was not available. Had this been included it may have triggered a risk assessment around contact between Child B and their father.

5.2.83 This suggests that assumptions had been made about the presence or severity of domestic violence. Where assumptions are made, there may also be an increased risk of confirmation bias i.e. the tendency to search for or interpret information in a way that confirms one's preconceptions, leading to errors. In this case, as domestic violence was not seen as a significant issue, the Social Worker does not appear to have considered the full extent of the risk.

5.2.84 Arguably the risk of confirmation bias is demonstrated by the Lambeth CSC IMR itself. This observation relates to the incident in April 2016 when a MERLIN report was received from the MPS. Commenting on this, the IMR states that a decision at the time to take no further action was taken on the basis that: "*the parents had already separated, and Sophia had acted appropriately by reporting the matter to the police*". The Review Panel does not dispute that the referral itself may not have met the threshold for intervention by Lambeth CSC at the time. However, the Review Panel did challenge the assumption behind this statement in the IMR. While the statement may be true in relation to the actions that Sophia had (appropriately) taken, it does not address the risk per se. If actions taken by the victim are seen as the primary means by which professionals judge the likelihood of risk, then professionals are less likely to consider the actual source of the potential risk: the abuser. The absolute need to locate risk with the abuser is underlined by a recent American study which has reported that while Protective Orders are associated with lower rates of 'moderate' interpersonal violence, this association does not hold for more severe cases.

The authors in that study suggested that this may be related to the risk posed by the abuser and their intent[49].

5.2.85 Hester's Three Planet Model[50] may provide a useful framework for how the approaches of different agencies may contribute to this loss of focus. In this case, the identification that Sophia was experiencing domestic violence was reported to the MPS and also disclosed to the Gaia Centre (the domestic violence planet). However, the Lambeth CSC response (the child protection planet) focused on the welfare of the children. Hester describes this as: '*On the child protection planet . . . despite professionals identifying that the threat of violence comes from the man, it is the mother who is seen as responsible for dealing with the consequences and the violent man effectively disappears from the picture*[51].

5.2.86 A further feature of this case is that Sophia, albeit to different degrees and at different times, made disclosures around domestic violence but did not feel able to do so to any great extent with the Social Worker from Lambeth CSC.

5.2.87 In her contact with Lambeth CSC in June 2016 Sophia made general disclosures about domestic violence, emphasising that she had taken out a Non-Molestation Order and Prohibited Steps Order, however she did not say anything more specific, including sharing any concerns she had around Daniel or his behaviour.

5.2.88 One reason that Sophia may not have disclosed the extent of her experiences may have been because of the focus of the enquiry in June 2016. This started when Daniel made an allegation to the NSPCC that Child A had hit Child B. Reasonably, that meant the focus was on ensuring that Child B was safe. Sadly, we cannot know why Sophia did not make additional disclosures, but it is entirely reasonable to speculate that the enquiry felt intrusive, that she did

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[49] Messing, J.T., O'Sullivan, C.E., Webster, D.W., and Campbell, J. (2017) 'Are Abused Women's Protective Actions Associated With Reduced Threats, Stalking, and Violence Perpetrated by Their Male Intimate Partners?', *Violence Against Women,* 23(3), pp. 263–286.

[50] Hester, Marianne, *"The Three Planet Model: Towards an Understanding of Contradictions in Approaches to Women and Children's Safety in Contexts of Domestic Violence', The British Journal of Social Work*, Vol 41, Issue 5, U July 2011, pp 837-853.

[51] Hester, M. (2009) *The Three Planet Model,* Available at: *http://www.bristol.ac.uk/news/2009/6703.html* (Accessed: 3 February 2018).

not feel confident about making a disclosure and / or was wary of Lambeth CSC involvement in her life. In the context of Daniel's domestic violence and abuse, and if his allegation was an example of 'abuse of process', it would not be surprising if she had felt this way.

5.2.89 The Lambeth CSC IMR makes two recommendations, the first of which was accepted by the Review Panel as an appropriate response to some of the issues described above:

- *"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"*

5.2.90 However, the Review Panel felt the issues identified above in relation to the exploration of domestic violence were not fully addressed by this recommendation. In coming to this view, the Review Panel also noted the findings from the previously published SCR in relation to Child H.

Any organisation participating in a DHR needs to be able to ensure that the implications of any case specific learning are considered beyond the professionals and / or area involved in a case. This is in order that the organisation can be confident that the issues identified were either localised or, if they have a wider reach, this is identified with appropriate remedial action being taken. The Review Panel therefore made the following recommendation:

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.

5.2.91 The second recommendation made in the Lambeth CSC IMR was:

- *"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".*

5.2.92 Ensuring access to a Domestic Violence Perpetrator Programme (DVPP) is a key part of a CCR as it can help ensure perpetrators are held accountable and supported to change their behaviour. This also chimes with the increasing

focus nationally on the identification of those who use violence and abuse, with the national VAWG strategy[52] aiming to have an: *"embedded robust approach to tackling perpetrators through greater scrutiny of their motives and behaviour with a reduction in re-offending*". As a result, this recommendation was accepted by the Review Panel.

5.2.93 However, it was noted that there is already a Respect Accredited[53] community based DVPP in the borough. This is provided by the Domestic Violence Intervention Programme (DVIP)[54]. While men can self-refer, if they are involved with Lambeth CSC then places can be spot purchased. In delivering on this recommendation, Lambeth CSC therefore must consider its own contribution of resources, both when the threshold for ongoing involvement is met but also when it is not in order to enable earlier intervention.

5.2.94 More broadly, it is positive that Lambeth Council is taking proactive steps to further develop interventions with perpetrators, having been successful (along with Southwark and Lewisham Councils) in securing funding from Home Office VAWG Transformation Fund for a 'Prevention and Change' project that will focus on tackling domestic violence perpetrators. The project aims to ensure that the whole system is better geared towards managing perpetrators in partnership and provide an additional resource to existing enforcement activities. The priority outcome is to increase the safety and wellbeing of victims and associated children, and to prevent new and/or further victimisation and harm. The focus will be on how perpetrators are managed across the partnership, supported to change and/or held to account for their harmful behaviour. The project will provide interventions to 60 perpetrators per year across the three boroughs between 2018-2020. Additionally, as part of this project local training on working with perpetrators will be delivered.

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[52] Home Office (2016) *Ending Violence against Women and Girls: Strategic 2016 – 2020*. Available at: https://www.gov.uk/government/publications/strategy-to-end-violence-against-women-and-girls-2016-to-2020 [Accessed: 6 May 2018].

[53] The Respect Standard is designed to ensure safe, effective, accountable work with perpetrators of domestic violence and abuse. For more information, go to: http://respect.uk.net/what-we-do/accreditation/

[54] For more information, go to http://www.dvip.org.

5.2.95 In relation to this case specifically, Daniel would not have been able to access the 'Prevention and Change' project, as it targets serial and prolific offenders. More importantly, even if he could have accessed this project (or if he had been funded by Lambeth CSC to access the DVPP provided by DVIP), there is no evidence to indicate that either would have been considered.

5.2.96 This is because Daniel was not asked about his domestic violence and abuse by the Social Worker. This is despite the fact that the allegations in June 2016 could be seen as an example of abuse of process, and there were missed opportunities to explore his behaviour as part of the assessment undertaken by Lambeth CSC.

5.2.97 Consequently, while the Lambeth CSC recommendation is welcome, as proposed it is too limited. A DVPP cannot operate in isolation. Frontline professionals must be able to undertake early intervention in order to encourage an abuser to identify their behaviour as violent and abusive. Clearly, the nature and timing of any offer will vary and will also require those who use violence and abuse to be willing to access help and consent to it. Nonetheless, in the case of a professional like a Social Worker, who may have ongoing involvement with the family, it is important that they have the training and skills to be able to undertake appropriate interventions themselves, motivate someone to engage with a DVPP, or to work alongside a DVPP in order to encourage and sustain change. This is difficult work and there are clearly practical considerations in ensuring professionals are able to do this.

5.2.98 This underlines the importance of the staff working for Lambeth CSC to have had a direct conversation with Daniel. Given this conversation did not happen, there was a missed opportunity to address Daniel's behaviour. While the Lambeth CSC IMR notes that if the Barnardo's Risk Assessment Tool had been used, it would have promoted the Social Worker to address domestic violence with Daniel, it does not address how Social Workers are supported to do this in practice.

Practice, pathways and training in relation to the identification and response to violence and abuse must be sufficiently robust in order to ensure that perpetrators are held accountable. The Review Panel therefore made the following recommendations:

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.

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.

MPS

5.2.99 Issues in relation to the MPS's response to Sophia's report in 2016 are discussed above. However, a further issue appears to be the failure to take positive action in relation to Daniel on two occasions.

5.2.100 Firstly, after an unsuccessful arrest attempt on the 10 March 2016, there were no further attempts to arrest Daniel. The Police IMR addressed this issue directly, accepting that there was sufficient evidence to conclude a crime had been committed and to arrest and interview Daniel on suspicion of harassment. The IMR also notes that acting at this point may have provided assurance to Sophia that her experiences were taken seriously.

5.2.101 The Review Panel agreed that the MPS response was unsatisfactory. However, it concluded the underlying lack of follow up related to the ownership of the investigation, which has been discussed above, and which meant that an OIC was not identified promptly. If there had been an OIC with investigative responsibility, the Review Panel felt it is likely that further arrest attempts would have been made in line with MPS procedures. Therefore, no further recommendation is made in relation to this issue.

5.2.102 Additionally, despite the NSPCC sharing a report in June 2016 after Daniel had alleged that Child A had physically abused Child B, this does not seem to have been investigated. Again, the Police IMR addresses this issue, noting that it does not appear an enquiry was made to ascertain if Daniel had

breached the Non-Molestation Order. This issue is explored more from 5.2.131 onward below.

The Gaia Centre (run by Refuge)

5.2.103 The Gaia Centre appears to have had an effective working relationship with Sophia, engaging with her between April and June 2016. This contact appears to have been timely, and used appropriate tools, like the DASH RIC. It also meant Sophia was supported around a number of different issues.

5.2.104 There is learning for Refuge however. Firstly, there are some issues in relation to the use of the DASH RIC:

- The DASH RIC completed on the 12 April 2016 was scored at 13. The question about 'threats to kill' was marked 'no' even though Sophia disclosed that Daniel had said "*you are dead*". The actuarial risk score should therefore have been 14
- The actuarial threshold for the local MARAC is 15 ticks on the DASH RIC. This means that the DASH RIC completed with Sophia, regardless of whether the 'threats to kill' box had been ticked, would have been below the local actuarial threshold for referral. However, a decision could have made to refer on professional judgement. This does not appear to have been considered
- The Refuge Casework Management Policy requires risk and needs assessments to be reviewed every four weeks or earlier if there is a significant change. The Refuge IMR notes that when Sophia obtained a Non-Molestation order on the 20 April 2016, a risk review should have been undertaken. Even allowing for this oversight, the only review was on the 26 June 2016, and there should have been a review at the 4-week point.

5.2.105 Secondly, Sophia's case was also closed on 19 July 2016 without direct contact with Sophia, with the last contact having taken place on the 13 June 2016.

5.2.106 The IMR included a number of recommendations, which the Review Panel agreed addressed these issues:

- *"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"*
- *"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"*
- *"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".*

5.2.107 When discussing these recommendations, the Review Panel considered the wider learning for the local MARAC process. Nationally, 14 ticks on the DASH RIC is the recommended actuarial threshold for MARACs although local areas are, as Lambeth has done, able to set their own threshold. The local threshold of 15 ticks was set three years ago. There was a perception among agencies at the Review Panel that professionals do routinely refer to the MARAC on professional judgement, however, practice has not recently been reviewed to confirm this.

The MARAC is only as effective if professionals are able to identify high risk cases and refer appropriately, including on the basis of actuarial risk, professional judgement and escalation (or where there is a repeat). Local MARACs need to monitor referrals and the routes used by professionals. The Review Panel therefore made the following recommendation:

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.

5.2.108 There are four areas which were not addressed by these recommendations, which relate to the Gaia Centre's contact with the MPS and Lambeth CSC:

- While Refuge did contact the MPS in relation to the progress of the investigation following the April 2016 incident on one occasion, there does

not appear to have been any challenge in relation to the decision to close the investigation

- Refuge did not contact Lambeth CSC. Indeed, it does not appear that the health and social needs of Child A and Child B were specifically discussed with Sophia. Nor where these considered with reference to the local Threshold Chart[55], which is designed to help professionals to identify the best support for an individual child, young person and their family or carers dependent on need. If this had happened, it may have been that Refuge would have felt it appropriate to contact the local Integrated Referral Hub to discuss any concerns or speak with the other members of the professional network (such as the schools)
- After the 13 June, Sophia's Key Worker did not contact her to see what had happened in relation to the allegations made by Daniel against Child A. It is not possible to say what would have happened if contact had been made. However, if Sophia had spoken with her Key Worker, she might have talked about the progress of the allegations Daniel had made, including her meeting with the MPS and Lambeth CSC at Child B's primary school on the 15 June. This may have led to a discussion about any concerns she may have had, or an opportunity to advocate on Sophia's behalf, including challenging the decision of the MPS not to consider whether Daniel had breached the Non-Molestation Order
- Lastly, there is no explicit record that the Key Worker discussed with Sophia what to do after the Non-Molestation Order came to an end. It would have been appropriate to provide this advice as part of a 'safety netting' strategy, to encourage Sophia to seek further support if the

[55] Available at: https://www.lambethscb.org.uk/professionals/thresholds.

situation changed or got worse. This is discussed further below (see 5.2.131 onwards).

Specialist domestic violence will also often have a unique perspective on the experience of victim/survivors and play a critical role in the CCR to domestic abuse. It is therefore important that specialist domestic violence services address learning arising from DHRs and develop their responses. The Review Panel therefore made the following recommendation:

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.

Victim Support

5.2.109 Victim Support only had one contact with Sophia, when she declined support. The Victim Support IMR identified two issues with their involvement, firstly the timeframe for contacts[56], and secondly that the referrer (the MPS) was not notified that contact had been unsuccessful.

5.2.110 The Victim Support IMR set out the following recommendations which were accepted by the Review Panel:

- *"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"*
- *"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"*

[56] A delay of 14 days before the first call, thereafter nine days until the second call, and then seven days until the third attempt. First contact should be within 24 hours, second contact within 36 hours and third contact within 72 hours.

- *"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"*
- *"When changes are made to policy and procedure to bring them up to date, this needs to be accompanied by "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".*

Analyse organisations' access to specialist domestic abuse agencies.

5.2.111 Locally, agencies are aware of specialist domestic abuse services. Agency IMRs showed an awareness of how to access domestic abuse services, with specific examples of an agency (the MPS) providing information relating to local services on two occasions. Indeed, Sophia self-referred to the Gaia Centre after her contact with the MPS in 2016 (although it is not possible to know if this was directly as a result of the information provided to her).

5.2.112 However, as discussed further in this section of the report, there were issues in relation to referral pathways more broadly, including specific issues in relation to communication with and from the Gaia Centre.

Analyse the policies, procedures and training available to the agencies involved in domestic abuse issues.

5.2.113 Agencies have a range of policy, procedures and training in place in relation to domestic violence and abuse and these were described in each agencies' IMR.

5.2.114 There is significant learning in relation to the policies, procedures and training of CMS and Lambeth CSC, with additional learning for the Gaia Centre, the MPS and procedural changes for Victim Support, which are discussed in relation to each agency elsewhere in the analysis.

5.2.115 More widely, this case is an important reminder that professionals need to have the skills and confidence to respond appropriately to domestic violence and abuse, with access to robust policy and procedures to support a response. This is addressed specifically for a number of agencies throughout this section of the report.

Consider what might have helped or hindered engagement in services.

5.2.116 There are a number of issues that might have helped or hindered engagement in services, which have been explored elsewhere in this analysis.

5.2.117 Cora felt that Sophia would have been reluctant to be defined as a victim of domestic abuse. Sadly, it is not possible to know how Sophia would have described her experiences or felt about this term, although she clearly felt able to self-refer to the Gaia Centre. However, she did not tell Cora that she was accessing help. This suggests that Sophia may have felt uncomfortable talking about some aspects of her experiences to her family. Additionally, it seems likely that Sophia's confidence in talking about domestic violence (or her concerns about how she might be perceived) affected when and if she disclosed to professionals. For example, she told the Primary School, the Gaia Centre and (in 2016) the MPS. She also alluded to issues when speaking with her GP. However, Sophia clearly did not feel able to readily talk to Lambeth CSC, other health providers or the Secondary School.

5.2.118 The Safer Lambeth Partnership has a VAWG Strategy[57], which identifies preventing violence and abuse as a priority, including ensuring victims know where to go for help and advice. The Review Panel felt this focus was positive and while no further recommendation is made in relation to this issue, the partnership should be mindful of the learning from this review when implementing the strategy action plan.

[57] Safer Lambeth Partnership (2016) *Safer Lambeth Violence against Women and Girls Strategy*. Available at: https://www.lambeth.gov.uk/sites/default/files/ssh-safer-lambeth-vawg-strategy-2016-2020_0.pdf [Accessed: 6th May 2018].

5.2.119 An issue which has not been so far considered is Sophia's financial problems. Sophia disclosed these to a number of professionals, but it is unclear how effectively these were addressed.

5.2.120 Lambeth Housing had intermittent contact with Sophia in relation to rent arrears, although they had no information to indicate that domestic violence and abuse was an issue. Cora and her partner said that while Sophia was alive she and they made complaints about the condition of the property[58].

5.2.121 During the review, Lambeth Housing provided assurances about staff training, publicity material relating to specialist domestic violence service and established referral pathways with the Gaia Centre. However, the Review Panel noted that the advice Sophia received was issue specific i.e. it focused on the management of rent arrears, with no evidence that staff explored more broadly the cause. If this had been explored, it may have been an opportunity for Sophia to make a disclosure.

5.2.122 The Review Panel noted the developing national practice around housing. This includes Domestic Abuse Housing Alliance (DAHA)[59] which seeks to improve the housing sector's response to domestic abuse through the introduction and adoption of an established set of standards and an accreditation process. There may be an opportunity locally to build on the work of Lambeth Housing to date.

[58] There was no record of any complaint(s) about the property. It is not clear why this may have been the case, although Cora and her partner could not recall if they submitted a complaint or only made this verbally. If it was the latter, this may account for why no record exists.

[59] More information available at https://www.dahalliance.org.uk.

Housing providers are ideally placed to identify those carrying out domestic abuse and also those at risk, including children. It is important that staff working for Housing Providers have the skills to recognise domestic abuse at an early stage and help the victim access the right support quickly. The Review Panel therefore made the following recommendation:

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.

5.2.123 Additionally, Cora and her partner said that after her death, they discovered that Sophia had council tax arrears and had letters from bailiffs in relation to this.

5.2.124 Lambeth Council's Revenues and Benefits Service confirmed they had very little contact with Sophia regarding Council Tax unless she enquired about her balance or wanted a payment arrangement. As with contact relating to housing, the advice Sophia received in relation to her Council Tax was issue specific i.e. it focused on the management of arrears. There is no evidence that staff explored more broadly the cause, although the opportunity for them to do this was limited, given the infrequent contact with Sophia.

5.2.125 Locally, Lambeth Council commissions welfare advice on benefits and debt for local residents. Access to these services is through One Lambeth Advice[60], a freephone telephone service plus volunteer advisors in the council's customer centre and Citizens Advice in Streatham. On contacting One Lambeth Advice, clients are either given information to resolve their advice query or given an appointment at a local advice agency who will provide free advice casework (agencies referred to are Citizens Advice, Brixton Advice Centre, Centre 70, Lambeth Law Centre and the council's in-house welfare benefits advice service Every Pound Counts). Further support is available to council tenants who fall in to rent arrears, or residents entitled to Council Tax Support who get into arrears with Council Tax.

[60] For more information, go to: https://onelambethadvice.org.uk.

Nationally there is an increased awareness of the impact of financial and economic abuse. Raising awareness of domestic violence and abuse should be 'everyone's business' and embedded across a range of agencies in everyday settings in order to encourage help seeking. This must include organisations providing money advice. The Review Panel therefore made the following recommendation:

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

The following issues have also been identified as potentially pertinent to this homicide and organisations should include consideration of the following in their analysis where relevant:

a) Parental mental health and well-being

5.2.126 Sophia sought psychological support from her GP and this is discussed above from 5.2.62 onwards.

5.2.127 There is no evidence that Daniel sought psychological help from any agency. Specific consideration to help seeking by Daniel is discussed in the equality and diversity section (see 5.3).

b) Substance use

5.2.128 There is no evidence that Sophia had any substance misuse issues.

5.2.129 There is evidence that Daniel may have had an alcohol use issue, with Sophia making a number of disclosures that identified his drinking as a concern, which were also repeated by Cora. Additionally, on one occasion Daniel attended the Primary School while potentially drunk once and was seen drinking in the vicinity on another occasion. There is one report about his use of cannabis.

5.2.130 However, Daniel denied any issues and there is no evidence that Daniel sought support for alcohol or substance use from any agency. Specific consideration to help seeking by Daniel is discussed in the equality and diversity section (see 5.3).

c) Civil orders such as Non-Molestation / Prohibited Steps Orders

5.2.131 Sophia secured both a Non-Molestation Order and a Prohibited Steps Order. Positively, Sophia received advice and support around these Protective Orders from a number of different professionals, including the MPS, the Family Services Officer at Child B's Primary School, as well as the Gaia Centre.

5.2.132 However, a number of issues have been identified in relation to these Protective Orders. Firstly, there appears to have been issues in obtaining copies of the orders and inconsistent recording practices, as well as challenges in the responses to orders:

- The Gaia Centre – was aware of, and supported, Sophia to apply for both orders. However, there was no record of the length of either order, nor a record of the conditions of and / or a copy of the orders. Additionally, there does not appear to have been any 'safety netting' with Sophia, including discussing what to do if the situation changed or got worse, or when the order came to an end
- Lambeth CSC – the MPS informed Lambeth CSC that a Prohibited Steps Order was in place, while Sophia also told Lambeth CSC about the existence of both the Non-Molestation Order and Prohibited Steps Order, with this being noted in their assessment. However, Lambeth CSC had no record of the conditions of and / or a copy of these orders. Additionally, there was no specific consideration about these orders – including the risk posed by Daniel – beyond the determination that their presence was evidence that Sophia had taken steps to protect herself and the children
- MPS – Intelligence reports were created in relation to both orders, in line with MPS policy on how to record Judicial Orders. The MPS also shared details of the Prohibited Steps Order, but the Non-Molestation Order was not mentioned in the MERLIN report that was received by Lambeth CSC. Additionally, when this information was shared, only the details of Child B were shared, and the report did not include any details of Child A.

5.2.133 Secondly, there were differences in professional understanding around protective measures in relation to children where both the victim and the abuser have Parental Responsibility[61]. For example, when Sophia requested that the Primary School did not release Child B to Daniel's care (before a Prohibited Steps Order was in place), staff correctly indicated they would have to respect his Parental Responsibility and release Child B to his care. The exceptions to this are where an order in place, or if there is a concern such as an adult being under the influence of a substance. Yet, the MPS advised the Primary School on the 11 April 2016 (again before a Prohibited Steps Order was in place) that they should not release Child B from school to anyone other than Sophia.

5.2.134 Thirdly, there was inconsistent practice in relation to education providers. The Primary School was aware of both the Non-Molestation Order and Prohibited Steps Order and their response is discussed below. In contrast the Secondary School was not informed of any of the concerns that had led to Sophia's applications for, or indeed the existence of, any orders. Both are discussed further below (see 5.2.137 onward).

5.2.135 Fourthly, although the NPSCC demonstrated good awareness of the potential of a breach of a Non-Molestation Order (when Daniel told them he was in contact with Sophia when he rang to alleged that Child A had hit Child B in June 2016), it is striking that this did not lead to any response by agencies locally. This is summarised in relation to the MPS response below (see 5.2.99 onward) as well how the allegation may itself be an example of 'abuse of process' (see 5.1.9 onward).

5.2.136 Fifthly, all agencies involved in this case noted that copies of orders were not always available to agencies. In this case, the MPS had copies of orders but Lambeth CSC and the Gaia Centre did not.

[61] All mothers and most fathers have legal rights and responsibilities as a parent - known as 'parental responsibility'. Parental responsibility was first defined in the Children Act 1989 (Section 3) as, "all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property.

Practice, pathways and training in relation to the identification and response to violence and abuse must be sufficiently robust in order to ensure that perpetrators are held accountable. While the local partnership has a responsibility for addressing this issue, there is also a national context as the systems underpinning the use of Protective Orders like Non-Molestation and Prohibited Steps Orders are fragmented. The Review Panel therefore made the following recommendations:

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.

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.

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.

d) The impact of domestic violence and abuse on children.

5.2.137 It is highly likely that both Child A and Child B would have witnessed (directly or indirectly) domestic violence and abuse. As noted in the wider discussion around domestic violence (see 5.1) Cora also described how Daniel used the children to abuse.

5.2.138 The Review Panel is also aware of reports of direct harm, with Daniel reported by Cora to have used physical chastisement on Child A. Additionally, there are examples of concerns noted about Daniel's relationship with the children; on one occasion education staff noted that Child A "*appeared worried/scared when collected by their step dad*", while staff at GSTT had noted that Child B was lacking in "*… confidence when speaking and Father spoke negatively about them"*.

5.2.139 There is a good evidence base about the potential for adverse impacts on children growing up in a domestically abusive home environment, including how this can affect both behaviour in school and impact on their development.

5.2.140 Considering local services, there was extensive contact with Child A and Child B, in particular by health and education providers.

5.2.141 In relation to health providers, the response of Sophia, Child A and Child B's GP is discussed above.

5.2.142 GSTT provided a range of services to Child A and Child B. These services related to the children's respective health and development needs, and interventions were appropriate. The GSTT IMR notes that there were some issue in relation to non-attendance at appointments, but these did not show any particular pattern and professionals did not identify any concerns at the time. Indeed, it appears that Sophia was actively engaged, taking pro-active steps to secure additional support for her children. This was also evident in Sophia's contact with both the Primary and Secondary Schools, which is discussed below.

5.2.143 The GSTT IMR also addresses the non-disclosure of domestic violence. While Sophia made no disclosures, GSTT acknowledges that there is no documented evidence that Sophia was asked about possible domestic violence. At the time, routine enquiry was being embedded into practice and so staff were not necessarily routinely enquiring or recording where they did so.

5.2.144 As a result, the GSTT IMR made the following recommendations, which were welcomed by the Review Panel:

- *"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"*
- *"Develop a Trust domestic abuse strategy".*

5.2.145 The Review Panel discussed the repeated contact related to the assessment of both children, as well as Sophia's extensive contact with health providers but the absence of any domestic violence disclosure. Managing behaviour issues also overlapped with both schools. While this contact appears to have been appropriate, it was noted that Sophia's experience of navigating this pathway (in order to secure the appropriate help and support for her children) was likely to have been taxing.

5.2.146 The Primary School had contact with first Child A and then Child B. It appears that this contact was appropriate and focused on their educational attainment, with an awareness of both children's development. While the Primary School's contact with both Child A and Child B was largely in relation to their behaviour and needs, with Child B this expanded to include some information on Sophia's circumstances and her concerns about Daniel. In responding to these concerns the Primary School was able to support Sophia, including through the work of the Family Support Officer.

It is beyond the scope of this DHR to review the wider experience of Child A and Child B. However, it may be that further consideration is required to be assured that the local care pathway in relation to a learning difficulty is working as well as it should. The Review Panel therefore made the following recommendation:

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.

5.2.147 There was one significant contact with Daniel, when he was turned away from school because of concerns that he was drunk. On the same day Sophia made a disclosure about separation and domestic violence. The Primary School did not make a referral to Lambeth CSC on this occasion as Child B was absent from school when Daniel visited. The rationale provided by the Primary School for this was that: Child B was not thought to be at risk of significant harm; when school staff asked Daniel to leave the school premises, he did so; and Sophia was notified of Daniel's visit.

5.2.148 The Review Panel discussed this. It was agreed that the response on the day was appropriate. However, it was felt that given what the school knew, having also had a disclosure about separation and domestic violence on that same day, that contextually a referral should have been made to Lambeth CSC. No specific recommendation is made in relation to this, as the Review Panel felt this learning could be addressed as part of the LSCB Performance and Quality Assurance Sub Group's response to Recommendation 15.

5.2.149 The Primary School identified some issues with the response on the day of Sophia's murder. While After School staff supported Sophia to meet a friend to walk home, they were not able to contact a member of the Senior Leadership Team and / or the Family Services Officer. While this is unlikely to have changed the outcome, it does identify a procedural issue. The Primary School made the following recommendation in its IMR which addresses this issue:

- *"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".*

5.2.150 An additional issue that was noted is that on the evening of the homicide three members of school staff were walking aware from the primary school and noticed Daniel. The Primary School IMR notes that: "*the staff member did not think anything of the sighting and the three members of staff continued on their routine home*". In describing this contact, it is relevant to note that Daniel was not behaving in a way that would suggest any immediate concern, that none of the staff had direct contact with Child B and nor did the staff have any knowledge of any previous issues around Daniel and concerns. The Primary School reported that while information on the Non-Molestation Order would have been shared as necessary with the Senior Leadership Team, Family Support Officer, Office Staff and with the class team, it would not have been shared with school staff more widely.

5.2.151 The Review Panel discussed this. It agreed that the Primary School's response was appropriate in light of the *current* practice locally.

5.2.152 However, the Review Panel felt that current practice should be reviewed. As has already been discussed in this review, Protective Orders do not reduce risk per se. Nonetheless, they are important. Yet, as this case demonstrates, when Protective Orders in place, that information is often only available to specific staff and / or there is an expectation that a victim 'activate' the order themselves by reporting breaches. There is an opportunity to consider whether information about Protective Orders could be made more widely available so that their enforcement becomes core business for a wider range of professionals and agencies. For example, in the case of the Primary

School, that might have meant routinely briefing all staff that a Protective Order was in place. Clearly there are issues to consider in this regard, including victim consent and working with a victim to identify those places where they think they are at risk and therefore which agencies could take a more proactive role. Staff would also need access to clear guidance, procedures and training.

5.2.153 A striking feature of this case is that Child A's Secondary School did not have any knowledge of the domestic violence, either as a result of disclosures or through information sharing by other agencies. This meant, critically, that they were unaware of the Non-Molestation Order and, it appears, the Section 47 enquiry.

This review has already made recommendations relating to guidance, procedures and training around Protective Orders (Recommendations 22 and 23). In delivering these recommendations, there is an opportunity for the Safer Lambeth Partnership to explore local approaches so that the responsibility for the enforcement and activation of Protective Orders become core business for a wider range of professionals and agencies as part of the CCR.

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.

5.2.154 A focus on Child A at this point highlights a specific issue in this case. As noted above, Lambeth CSC's assessment of the case was not holistic, while the Gaia Centre did not use the local Threshold Chart to consider risks to the children. Of particular concern was that at no time did professionals appear to identify that Child A might have been at an increased risk in the context of domestic violence and abuse, specifically as they were a step child of Daniel. Nor was the Secondary School notified of the concerns about domestic violence and abuse. This is also relevant to the assessment of risk to Sophia, as there is an established evidence base relating to the increased risk of

intimate partner homicide if there is a stepchild in the home (her biological child, not his)[62].

It is critical that evidence about risk is reflected in policy, procedures and training to ensure that practitioners are able to respond appropriately. The Review Panel therefore made the following recommendation:

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.

5.2.155 Additionally, there is little in relation to Daniel in this health / education contact. Bar some specific contacts, which are discussed elsewhere in this analysis, the Review Panel concluded that it was unlikely that anything specific could have been done in this regard. The issue of the invisibility of fathers is addressed in the wider literature and has not been explored further in this review.

5.3 Equality and Diversity:

5.3.1 The Review Panel identified the following protected characteristics of Sophia and Daniel as requiring specific consideration: sex and race.

5.3.2 *Race:* Sophia was White British. Although it is impossible to know, trying to understand Sophia's perspective, it is likely that her cultural context affected both her perception of her experiences, and also the help and support she felt she could access. In particular, her sister Cora talked about how Sophia likely "*didn't want to be thought of as a victim of domestic violence".* With that in mind, it is positive that that Sophia felt able to access the Gaia Centre and contact the MPS. Yet, at the same time, it is striking that she felt unable to discuss her experiences with a number of other agencies. Despite the considerable increase in the awareness of domestic violence, stigma

[62] Campbell, C., Glass, N., Sharps, P., Laughon, K and Bloom, T. (2008) 'Intimate Partner Homicide: Review and Implications of Research and Policy', *Trauma, Violence and Abuse,* 8(3), pp. 246-269.

continues to have the potential to be a potent barrier to help seeking. These issues are addressed elsewhere in the analysis.

5.3.3 Daniel was Black Caribbean. During his interview, he referred to his father's traditional beliefs and attitudes but did not identify any particular issues that might have affected either his own behaviour or help seeking. While this has not been explored further as a result, since the Windrush generation arrived in the 1950s, Lambeth has been home to the UK's biggest black community. A 2014 report by the Black Health and Wellbeing Commission[63] noted that, particularly for people of Caribbean descent, there are inequalities in mental health and wellbeing locally. The same report made a number of recommendations to address these issues.

5.3.4 *Sex:* As discussed above (see 1.4), sex is a risk factor in domestic violence, with women being disproportionality affected by domestic homicide. A further consideration in relation to sex is Daniel's approach to help seeking (it appears he did not seek help even when advised to do so), and also identification by agencies (in part he absented himself, but he was also largely absent in agency considerations).

5.3.5 In relation to the other protected characteristics:

5.3.6 *Age*: Although age was not identified by the Review Panel as having a particular impact in this case, Sophia was in her early thirties at the time of her death. A Home Office analysis of DHRs[64] found that the among both women and men the highest proportion of domestic homicides was among those aged 30 to 50.

5.3.7 *Disability:* No information was presented in relation to disability relating to either Sophia or Daniel and the Review Panel concluded this Protected Characteristic had no impact on the response either Sophia or Daniel

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[63] Lambeth Black Health and Wellbeing Commission. (2018) *From Surviving to Thriving*. Available at: https://www.blackthrive.org.uk/lambeth-black-health-and-wellbeing-commission-report [Accessed: 27 June 2018].

[64] Home Office. (2016) Domestic Homicide Reviews: *Key Findings from Analysis of Domestic Homicide Reviews*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf [Accessed: 31st January 2018].

received or the homicide itself. However, there were issues relating to the needs of Child B and Child A. There are discussed elsewhere in the analysis.

5.3.8 *Gender reassignment:* Not relevant to this review.

5.3.9 *Marriage and Civil Partnership:* No information was presented in relation to Marriage and Civil Partnership and the Review Panel concluded this Protected Characteristic had no impact on the response either Sophia or Daniel received or the homicide itself.

5.3.10 *Pregnancy and Maternity:* No information was presented in relation to Pregnancy and Maternity and the Review Panel concluded this Protected Characteristic had no impact on the response either Sophia or Daniel received or the homicide itself.

5.3.11 *Religion or Belief:* No information was presented in relation to Religion or Belief and the Review Panel concluded this Protected Characteristic had no impact on the response either Sophia or Daniel received or the homicide itself.

5.3.12 *Sexual Orientation:* Sophia and Daniel were in a heterosexual relationship. No information was presented in relation to Sexual Orientation and the Review Panel concluded these had no impact on the response either Sophia or Daniel received or the homicide itself.

6. Conclusions and Lessons To Be Learnt

6.1 Conclusions

6.1.1 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.

6.1.2 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.

6.1.3 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.

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

6.2 Lessons To Be Learnt:

6.2.1 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.

6.2.2 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 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.

6.2.3 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 relation to: 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.

6.2.4 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 DHR 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.

6.2.5 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.

6.2.6 Sophia reached out for help to the MPS. Yet procedural issues likely comprised Sophia's confidence in the MPS. This is unacceptable. These issue 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.

6.2.7 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).

6.2.8 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.

6.2.9 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.

6.2.10 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.

7. Recommendations

7.1 IMR Recommendations (Single Agency):

7.1.1 The following single agency recommendations were made by the agencies in their IMRs. They are described in section three following the analysis of contact by each agency and are also presented collectively in **Appendix 2**. These are as follows:

CMS

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

7.1.3 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

7.1.4 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.

7.1.5 Develop a Trust domestic abuse strategy.

KCH

7.1.6 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.

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

Lambeth CSC

7.1.8 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.

7.1.9 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

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

MPS

7.1.11 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.

7.1.12 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

7.1.13 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

7.1.14 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.

7.1.15 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.

7.1.16 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

7.1.17 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.

7.1.18 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.

7.1.19 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.

7.1.20 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.

7.2 Overview Report Recommendations:

7.2.1 The Review Panel has made the following recommendations, which are also described in section three as part of the analysis and are also presented collectively in **Appendix 3**.

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.

7.2.2 **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.

7.2.3 **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.

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

7.2.5 **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.

7.2.6 **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.

7.2.7 **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.

7.2.8 **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.

7.2.9 **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).

7.2.10 **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.

7.2.11 **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.

7.2.12 **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.

7.2.13 **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.

7.2.14 **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.

7.2.15 **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.

7.2.16 **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**.**

7.2.17 **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.

7.2.18 **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.

7.2.19 **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.

7.2.20 **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**.**

7.2.21 **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.

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

7.2.23 **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.

7.2.24 **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.

7.2.25 **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.

7.2.26 **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**.**

7.2.27 **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.

7.2.28 **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.

Appendix 1: Domestic Homicide Review Terms of Reference

This Domestic Homicide Review (DHR) is being completed to consider agency involvement with Sophia and Daniel following the homicide of Sophia.

The DHR is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with Sophia and Daniel, from 2008 (when the relationship is believed to have begun) to the end of May 2017 (the date of Sophia's death). Where there is agency involvement with either party prior to 2008 to summarise this, and review any issues pertinent to the DHR.
2. To identify the involvement of each individual agency, statutory and non-statutory, with Child B and Child A. To summarise this and review any issues pertinent to the DHR.
3. To establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
4. To 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.
5. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
6. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
7. To contribute to a better understanding of the nature of domestic violence and abuse.
8. To highlight good practice.

Role of the DHR Panel, Independent Chair and Community Safety Partnerships

9. The *Independent Chair* of the DHR will:
   a) Chair the DHR Panel.
   b) Co-ordinate the review process.
   c) Quality assure the approach and challenge agencies where necessary.
   d) Produce the Overview Report and Executive Summary by critically analysing each agency involved in the context of the established terms of reference.

10. The *Review Panel* will:
    a) Agree robust terms of reference.
    b) Ensure appropriate representation of their agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
    c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
    d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.

e) Agree and promptly act on recommendations in their organisations IMR Action Plan.
f) Ensure that the information contributed by their organisation is fully and fairly represented in the Overview Report.
g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
   - The purpose of the review has been met as set out in the ToR;
   - The report provides an accurate description of the circumstances surrounding the case; and
   - The analysis builds on the work of the IMRs and the findings can be substantiated.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) On completion present the full report to the Safer Lambeth Partnership.
j) Implement their organisation's actions from the Overview Report Action Plan.

11. Community Safety Partnerships (CSPs)
The *Safer Lambeth Partnership* has commissioned this DHR and will be the lead CSP, and will take responsibility for:

a) Translating recommendations from Overview Report into a SMART Action Plan.
b) Submitting the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
c) Forwarding Home Office feedback to the family, Review Panel and STADV.
d) Agreeing publication date and method of the Executive Summary and Overview Report.
e) Notifying the family, Review Panel and STADV of publication.

As Daniel lived and worked in Croydon, the *Safer Croydon Partnership* will be an associate CSP and will support the review process by:

a) Nominating a Single Point of Contact to be a member of the Review Panel.
b) Facilitating the engagement of other Review Panel members from Croydon as appropriate.
c) Support the translation of any recommendations from Overview Report into a SMART Action Plan where they relate to Croydon and takes responsibility for progressing these.

Definitions: Domestic Violence and Coercive Control

12. The Overview Report will make reference to the terms domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

    "*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.*
    Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and

capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

Equality and Diversity

13. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Sophia and the Daniel (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider (e.g. armed forces, carer status and looked after child) - the Review Panel identified that the protected characteristic of sex requires specific consideration in this case (Sophia was female and Daniel is male).
14. Consideration has been given by the Review Panel as to whether either the victim or the perpetrator was an 'Adult at Risk' – definition in Section 42 the Care Act 2014: "*An adult who may be vulnerable to abuse or maltreatment is deemed to be someone aged 18 or over; who is in an area and has needs for care and support (whether or not the authority is meeting any of those needs); Is experiencing, or is at risk of, abuse or neglect; and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*" The conclusion is that neither Sophia or Daniel were 'Adults at Risk' based on the information known to professionals at the time. However, Lambeth Council - Adults and Public Health will be represented on the Review Panel to ensure that issues in relation to Adults are Risk are considered.
15. *Expertise:* The Review Panel did not identify a requirement for additional representatives to act as an expert/advisory panel member to ensure appropriate consideration of the identified characteristics; however, it was agreed this would be kept under review.
16. If Sophia and Daniel have not come into contact with agencies that they might have been expected to do so, then consideration will be given by the Review Panel on how lessons arising from the DHR can improve the engagement with residents and communities. If required, the Chair of the DHR will make the link with relevant interested parties.
17. The Review Panel agrees it is important to have an intersectional framework to review Sophia and Daniel life experiences. This means to think of each characteristic of an individual as inextricably linked with all of the other characteristics in order to fully understand one's journey and one's experience with local services/agencies and within their community.

Parallel Reviews

18. There is an inquest into the death Sophia and the panel will ensure the DHR process dovetails with the Coroner Inquest.
19. As there are children in this case, the Review Panel noted that issues may be identified that relate to how agencies work together to safeguard and promote the wellbeing of children and young people. Where such issues are identified, the Chair of the Review will ensure that these are given appropriate consideration within the scope of the DHR and, for any other matters, that a link is made to the Local Safeguarding Children Board (LSCB) and its Serious Case Review Sub-group.
20. It will be the responsibility of the Chair of the Review to ensure contact is made with any other parallel process if these are identified during the DHR process.

[Criminal trial disclosure dealt with in paragraph 51 below]

Membership

21. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
22. The following agencies are to be on the Review Panel:
    a) Guy's and St Thomas' NHS Foundation Trust (GSTT) (Community Services, Health Visiting).
    b) Kings College Hospital NHS Foundation Trust (KCH) (Emergency Department, Maternity Services, also as the employer of Sophia).
    c) Lambeth Clinical Commissioning Group (CCG) (also acting as the link to the General Practitioner(s) for Sophia, Child B and Child A).
    d) Lambeth Council – Adults and Public Health.
    e) Lambeth Council – Children's Services.
    f) Lambeth Council – Neighbourhoods and Growth (including Violence Against Women and Girls Team and Housing Services).
    g) Local domestic violence specialist service provider - The Gaia Centre / Refuge IDVA service.
    h) Metropolitan Police Service (MPS) (Specialist Crime Review Group, Borough Commander or representative and Senior Investigating Officer (for first meeting only)
    i) National Probation Service (NPS).
    j) NHS England (NHSE).
    k) Primary School.
    l) Secondary School.
    m) South London and Maudsley NHS Foundation Trust (SLAM) (Mental Health and Substance Misuse Services).
    n) Victim Support.

23. Daniel lived in another local authority area - Croydon. The following organisations will be invited to be on the Review Panel:
    a) Croydon Clinical Commissioning Group (CCG) (acting as the link to the General Practitioner(s) for Daniel).
    b) Croydon Council – Place Department, Safety Division.
    c) Croydon Health Services NHS Trust (Emergency Department).

24. The Review Panel Members from Lambeth Council – Children's Services and GSTT will ensure good cross communication with the LSCB (see paragraph 19), as they are both members of the Board and sit on the Serious Case Review Sub-group.

Role of Standing Together Against Domestic Violence (Standing Together) and the Panel

25. Standing Together have been commissioned by the Safer Lambeth Partnership to independently chair this DHR. Standing Together have in turn appointed their DHR Associate James Rowlands to chair the DHR. The DHR team consists of two Administrators and a DHR Manager. The DHR Administrator will provide administrative support to the DHR and the DHR Team Manager will have oversight of the DHR. The manager will quality assure the DHR process and Overview Report. This may involve

their attendance at some panel meetings. The contact details for the Standing Together DHR team will be provided to the panel and you can contact them for advice and support during this review.

Collating evidence

26. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.
27. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Sophia, Daniel and / or Child B and Child A:
    a) Croydon Health Services NHS Trust (Emergency Department).
    b) Guy's and St Thomas' NHS Foundation Trust (GSTT) (Community Services, Health Visiting).
    c) Kings College Hospital NHS Foundation Trust (KCH) (Emergency Department, Maternity Services, and as Sophia's employer).
    d) Lambeth Clinical Commissioning Group (CCG) (acting as the link to the General Practitioner(s) for Sophia, Child A and Child B).
    e) Lambeth Council – Children's Services.
    f) Lambeth Council – Neighbourhoods and Growth (Housing Services).
    g) Local domestic violence specialist service provider - The Gaia Centre / Refuge IDVA service.
    h) Metropolitan Police Service (MPS).
    i) Primary School.
    j) Secondary School.
    k) Victim Support.

28. Information will also be sought from the following organisations, who may be requested to complete a short report, a chronology or an IMR, depending on their level of contact:
    a) Croydon Clinical Commissioning Group (CCG) (acting as the link to the General Practitioner(s) for Daniel).
    b) Child Maintenance Service (CSA).
    c) London Ambulance Service (LAS).
    d) NSPCC ChildLine.

29. Further agencies may be asked to completed chronologies and IMRs if their involvement with Sophia, Daniel and / or Child B and Child A becomes apparent through the information received as part of the review.

30. Each IMR will:
    - Set out the facts of their involvement with Sophia, Daniel and / or Child B and Child A:
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

31. Agencies that have had limited or 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 Sophia, Daniel and / or Child B and Child A in contact with their agency.

Key Lines of Inquiry

32. In order to critically analyse the incident and the agencies' responses, this review should specifically consider the following points:
    a) Analyse the communication, procedures and discussions, which took place within and between agencies.
    b) Analyse the co-operation between different agencies involved with Sophia, Daniel and the wider family, specifically Child B and Child A
    c) Analyse the opportunity for agencies to identify and assess domestic abuse risk, including during any contact with Sophia, Daniel and / or Child B and Child A in relation directly to domestic abuse and / or other needs and issues.
    d) Analyse agency responses to domestic abuse issues.
    e) Analyse organisations' access to specialist domestic abuse agencies.
    f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.
    g) Consider what might have helped or hindered engagement in services.

33. The following issues have also been identified as potentially pertinent to this homicide and organisations should include consideration of the following in their analysis where relevant: parental mental health and well-being, substance use; civil orders such as Non-Molestation / Prohibitive Steps Orders; and the impact of domestic violence and abuse on children.
    As a result of this analysis, agencies should identify good practice and lessons to be learned. The Review Panel expects that agencies will take action on any learning identified immediately following the internal quality assurance of their IMR.

Development of an action plan

34. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs. The Overview Report will make clear that agencies should report to Safer Lambeth Partnership on their action plans within six months of the Review being completed.
35. The Safer Lambeth Partnership to establish a multi-agency action plan for the implementation of recommendations arising out of the Overview Report, for submission to the Home Office along with the Overview Report and Executive Summary. The Safer Croydon Partnership will support the translation of any recommendations from Overview Report into a SMART Action Plan where they relate to that area.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

36. The review will sensitively attempt to involve the family of Sophia in the review, once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement with the support of the Police Family Liaison Officer.
37. The Review Panel discussed the involvement of children in the DHR at the 1st Panel Meeting and decided this would be inappropriate given their age and additional support needs. As the children are 'Looked After Children' any contact with the children will be facilitated through Lambeth Children Services in the first instance.
38. Daniel (alleged perpetrator) will be invited to participate in the review, following the completion of the criminal trial.

39. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.
40. The Review Panel discussed involvement of other informal networks of the victim and alleged perpetrator and agreed it was proportionate to the DHR to seek the widest possible engagement. As the Police have identified a range of witnesses as part of the criminal enquiry, in the first instance the chair will review this information to identify who to approach. This will include friends and colleagues.

Media handling

41. As part criminal proceedings, the Police have a media strategy, and this will be shared with the Review Panel for information.
42. Any enquiries related to the DHR from the media and family should be forwarded to the Safer Lambeth Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Safer Lambeth Partnership will make no comment apart from stating that a review is underway and will report in due course.
43. The Safer Lambeth Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

44. 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.
45. 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.
46. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.
47. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email. Please use the password provided to you by the Standing Together team. Agency representatives in should be reminded that they should remove the password and only share appropriate information to appropriate front line staff in line with the DHR Confidentiality Statement and the specific Terms of Reference.
48. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.
49. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

50. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

51. The sharing of information by agencies in relation to their contact with the victim and/or the [alleged] perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles': The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) outlines data protection issues in relation to DHRs (Par 98). It recognises they tend to emerge in relation to access to records, for example medical records. It states 'data protection obligations would not normally apply to deceased individuals and so obtaining access to data on deceased victims of domestic abuse for the purposes of a DHR should not normally pose difficulty – this applies to all records relating to the deceased, including those held by solicitors and counsellors'.
    b) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with DHRs and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply. Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
        - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
        - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
        - partial redaction of record content.

    c) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety and protecting the rights or freedoms of others (domestic abuse victims).
    d) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
        i) It is needed to prevent serious crime
        ii) there is a public interest (e.g. prevention of crime, protection of vulnerable persons)

52. As there are criminal proceedings ongoing, the police are bound by law to ensure that there is fair disclosure of material that may be relevant to an investigation and which does not form part of the prosecution case. Any material gathered in this DHR process could be subject to disclosure to the defence, if it is considered to undermine the prosecution case or assisting the case for the accused.
53. The DHR Chair will discuss the issues of disclosure in this case with the police Senior Investigating Officer.
54. The chair, police and CPS will be minded to consider the confidentiality of material at all times and to balance that with the interests of justice.

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Appendix 2: Single Agency Recommendations and Action Plan

CMS

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
Updating our call scripts for our Applications caseworkers at the front end of the CMS business.						
Implementation of coaching on domestic abuse for all our caseworkers by end October 2018 – which covers the points set out in section 8 above.						

GSTT

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
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.						
Develop a Trust domestic abuse strategy.						

KCH

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

Lambeth CSC

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
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.						
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

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

MPS

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
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.						
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

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 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.						

The Gaia Centre (run by Refuge)

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
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.						
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.						
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

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
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.						
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.						
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.						
When changes are made to policy and procedure to bring them up to date, this needs to be accompanied by “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.						

Appendix 3: DHR Recommendations and 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
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	National					
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	National					
Recommendation 3: The UK Government to include abuse of process in the statutory definition of domestic violence and abuse and the associated statutory guidance	National					
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.	Regional					
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	Regional					

investigation so that these are resolved promptly, and the safety of victims is prioritised						
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	Local					
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	Regional					
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).	National					
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	National					

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	National					
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	Local					
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	Single Agency					
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	Local					
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	Local					

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	Local					
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	Local					
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	Local					
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	Local					
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	Local					

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

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						
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	Local					
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	Local					

Appendix 4: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ASD	Autistic Spectrum Disorder
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic
BOCU	(MPS) Borough Operational Command Unit
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CAHMS	Child and Adolescent Mental Health Service
CCR	Coordinated Community Response
CCG	Clinical Commissioning Group
CAIT	(MPS) Child Abuse Investigation Team
CMO	Child Maintenance Options
CMS	Child Maintenance Service
CRIS	(MPS) Crime Recording System
CSC	(Lambeth) Children's Social Care
CSP	Community Safety Partnership
CSU	Community Safety Unit
DASH RIC	Domestic Abuse Stalking and Harassment Risk Identification Checklist
DVPP	Domestic Violence Perpetrator Programme
DWP	Department for Work and Pensions
DHR	Domestic Homicide Review
FLO	(MPS) Family Liaison Officer
GP	General Practitioner
GSTT	Guys and St Thomas' NHS Foundation Trust
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
IO	(MPS) Investigating Officer
IIO	(MPS) Initial Investigating Officer
IRIS	Identification and Referral to Improve Safety
IT	Information Technology
KCH	King's College Hospital NHS Foundation Trust
LSAB	Lambeth Safeguarding Adults Board
LSCB	Lambeth Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Conference
MOPAC	Mayor's Office for Policing and Crime
MPS	Metropolitan Police Service
NCDV	National Centre for Domestic Violence
NSPCC	National Society for the Prevention of Cruelty to Children
OIC	(MPS) Officer in Charge
RGCP	Royal College of General Practitioners
SCR	Serious Case Review
SCRG	(MPS) Specialist Crime Review Group
SEN	Special Education Needs
SIO	(MPS) Senior Investigating Officer

SLAM	South London and Maudsley NHS Foundation Trust
SLT	Speech and Language Therapy
STADV	Standing Together Against Domestic Violence
TAC	Team Around the Child