# SAFER HILLINGDON PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

# EXECUTIVE SUMMARY

## Report into the homicide of Lottie

## March 2015

**Independent Chair and Author of Report: Della Fallon**

**Associate Standing Together Against Domestic Violence**

**Date of Completion: July 2017**

# Contents

# 1. Executive Summary

## 1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Hillingdon Partnership (SHP) Domestic Homicide Review (DHR) Panel in reviewing the homicide of Lottie who was a resident in their area.

1.1.2 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: Lottie (victim), Bert (perpetrator), Henry, Marge, Betty, Dean, Tina, Stanley, Dolly, Fred and Len.

1.1.3 At the time of her murder, Lottie was twenty-five years old and a single parent. She was white, British. She was the intimate partner of Bert, the perpetrator.

1.1.4 Bert was twenty-three years at the time of the murder. He was also white, British.

1.1.5 Criminal proceedings were completed in May 2016 and the perpetrator was sentenced to a minimum of fifteen years imprisonment.

1.1.6 The process began with an initial meeting of the Community Safety Partnership (CSP) on the 8th July 2015 when the decision to hold a DHR was agreed. All agencies that potentially had contact with the victim and perpetrator prior to the murder were contacted and asked to confirm whether they had involvement with them.

## 1.2 Contributors to the Review

1.2.1 The approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that were identified to have had contact with Lottie and/or Bert. It was also considered helpful to involve agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. Twenty-seven agencies were identified in the initial scoping undertaken by the CSP and at the first panel meeting.

1.2.2 Twenty-three IMRs were received. They all included chronologies and analysis of each agency's contacts with the victim and/or perpetrator over the Terms of Reference time period from 1st June 2009 to the date of the homicide.

1.2.3 Both Lottie and Bert used several aliases. Agencies were asked to check their records for contact with any of these names.

1.2.4 IMRs were received from:

a) Central and North West London NHS Foundation Trust, Mental Health Services

b) General Practice for Lottie – two practices

GP 1 registered 1/5/12

GP 2 registered 5/11/12 (same as GP 3 below)

c) General Practices for Bert – five practices

GP 1 registered 1/6/09

GP 2 registered 21/3/13

GP 3 registered 8/4/14

GP 4 registered 24/6/14

GP 5 registered 25/11/14

d) Greenbrook (provider of Hillingdon Urgent Care Centre)

e) Hillingdon Hospital

f) London Borough of Hillingdon, Children's Social Care Services

g) London Borough of Hillingdon, Independent Domestic Violence Advocacy Service

h) Metropolitan Police

i) Thames Valley Police

j) National Probation Service, London Division

k) School (attended by Lottie's daughter, Betty)

l) London Borough of Hillingdon, Education

m) Victim Support

n) London Borough of Hillingdon, Homeless Prevention Team

o) Hestia

p) Care UK (provider of out of hours GP services)

q) London Ambulance Service

r) Central and North West London NHS Foundation Trust, community services

1.2.5 Agencies who reviewed their files and provided information to the Review Panel but no IMR:

a) Leeds Teaching Hospital.

1.2.6 Agencies who reviewed their files and notified the Review Panel they had no contact with either Lottie or Bert were:

a) Leeds Children's Social Care

b) Leeds and York Partnership NHS Foundation Trust

1.2.7 Agencies who reviewed their files and were known to have contact but were unable to retrieve details were:

a) Together (mental health provider working with probation)

b) The panel was unable to identify the GP practices Lottie was registered with between June 2009 and May 2012.

1.2.1 The IMRs were written by authors independent of case management or delivery of the service concerned. Twenty-three services had involvement with the victim of sufficient duration, which required IMRs to be submitted. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Lottie and/or Bert and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received.

1.2.2 This Review has followed the statutory guidance for DHRs (2013) issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004. On notification of the homicide, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The chronologies were combined and a narrative chronology written by the independent chair.

1.2.3 <u>The Review Panel Members</u>

1.2.4 Agency members not directly involved with the victim, perpetrator or any family members, undertook the IMRs. The members of the panel are listed in **Appendix 3.**

1.2.5 Agency representatives were of an appropriate seniority and professional background. Attendance at meetings was good although, because of the length of the process, some representatives were replaced.

1.2.6 In recognition of the specific health needs of both Lottie and Bert, the panel membership included a psychiatrist with drug and alcohol expertise and a senior manager with general adult mental health expertise.

1.2.7 The Review Panel met a total of eight times, with the first panel meeting on the 8th July 2015 and the final meeting on 22nd November 2016.

1.2.8 <u>Contact with the family</u>

1.2.9 Following Bert's sentencing, the Independent Chair met with several members of Lottie's family on 26th May 2016. On 8th November 2016, the Independent Chair held an additional meeting with a family member. At both meetings the family was supported by an advocate from AAFDA. The draft DHR report was shared with the family at a further meeting on 9th March 2017. Following the Hillingdon CSP meeting on the 28th March 2017, one recommendation was revised. The full DHR report, including the action plan, was shared with the family on the 17th July 2017.

1.2.10 Bert and Bert's family were also approached and invited to contribute to the review. The independent chair met with Dolly, Bert's mother, on the 23rd June 2016. Bert's brother declined to engage. Bert also chose not to participate in the review.

1.2.11 The Chair of the Review wishes to thank everyone who contributed their time, patience and cooperation to this review.

## 1.3 Chair of the DHR and Author of the Overview Report

1.3.1 The Chair of the Review and author of the Overview Report was Della Fallon, an associate DHR Chair working with Standing Together Against Domestic Violence (STADV), an organisation dedicated to developing effective, coordinated community responses to domestic violence. Della has spent her entire career working in the field of mental health, in service development, commissioning and more recently as a senior independent director of an NHS Foundation Trust. She is currently the chair of the Epsom Health and Care Board; a first tier tribunal member (mental health); and a lay representative with Health Education England, Kent, Surrey and Sussex. Della has no connection with Hillingdon or any of the agencies involved in this case.

1.3.2 Della Fallon has no connection with the London Borough of Hillingdon or any of the agencies involved in this case.

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

## 1.4 Terms of Reference for the Review

1.4.1 The full Terms of Reference are included in **Appendix 2**.

1.4.2 The review was conducted in Hillingdon as this was where Lottie was murdered. Both Lottie and Bert lived in Hillingdon for many years and had attended schools in the borough as children. In 2014 Lottie lived briefly in Slough. For this reason, the agencies involved with the review were predominantly Hillingdon based, but Thames Valley Police was also represented. The Review Panel were asked to review events from 1st June 2009 up to the homicide. This date was chosen because there was a reference to a MARAC referral for Lottie in late 2009. Agencies were also asked to summarise any relevant contact with Lottie or Bert prior to 2009.

## 1.5 Summary of Chronology

1.5.1 At the time of her murder, Lottie was twenty-five years old, unemployed and a single parent. Her seven-year-old daughter was in the care of her parents and both families were living in Hillingdon. She had been in a relationship with Bert for approximately eighteen months.

1.5.2 At the time of the murder, Bert was twenty-three years old and unemployed.

1.5.3 Metropolitan Police: both Lottie and Bert were known to the police.

1.5.4 In 2009 and 2010, Lottie came to the attention of police as a victim of domestic related incidents on five occasions, but none of these involved Bert. On 11th February 2010, Lottie was referred by the police to the IDVA and MARAC.

1.5.5 Between 2012 and 2013 there was further contact with the police because of domestic incidents involving Lottie's parents, harassment by others and burglary. In March 2013, Lottie was cautioned

for common assault following an incident involving her mother. On 5th November 2013, Lottie was arrested for child neglect.

1.5.6 On 1st June 2012, Bert was convicted and sentenced to 27 months imprisonment following an unprovoked attack on a motorist. He was released on licence on 17th December 2012.

1.5.7 Between 2014 and 2015, the police had contact with Bert on four occasions for incidents of domestic abuse involving Lottie. During that time he also came to the attention of the police for two incidents related to assaults on his younger brother and an assault on a minicab driver.

1.5.8 On 10th February 2014, the first recorded incident of domestic abuse occurred. Lottie called the police because of threats by Bert. A skeleton DASH risk assessment assessed her as being at standard risk.

1.5.9 On 4th July 2014, Bert called the police and disclosed hitting Lottie. Both Lottie and Bert subsequently denied the assault. Lottie was assessed as standard risk.

1.5.10 On 13th July 2014, Lottie called 999 four times in the early hours of the morning. Police forced entry and found her asleep, holding a knife and with visible injuries. During one call she disclosed domestic abuse. She was assessed as medium risk.

1.5.11 On 26th November 2014, Lottie called the police after Bert gained entry to her flat. She disclosed previous violence from Bert and was assessed as standard risk.

1.5.12 On 26th December 2014, Bert was identified as the sole suspect in the assault of a minicab driver. He was wanted for this crime at the time of Lottie's murder, although the Metropolitan Police subsequently discontinued the outstanding arrest.

1.5.13 Thames Valley Police: both Lottie and Bert were known to the police.

1.5.14 Bert came to the attention of Thames Valley Police on two occasions in 2013, relating to robbery and kidnapping. He was not charged for either.

1.5.15 On 24th October 2013, police were called by the ambulance service to a hotel in Slough. Bert had self-harmed and he was taken by police to a health centre. A woman, believed to be Lottie, was present.

1.5.16 On 8th November 2014, police were called to same hotel by a member of staff following sounds of things being broken and shouting. Police found considerable damage to the room and Bert and Lottie were arrested on suspicion of criminal damage. The case against Lottie was dropped. Bert failed to attend for charging on the 19th December 2014 and attempts to trace him were unsuccessful. On the 11th May 216, Bert was charged with criminal damage and resisting arrest and sentence to six weeks imprisonment.

1.5.17 Independent Domestic Violence Advocacy Service, HIDVA; Lottie was in contact with the service between January 2010 and July 2014. In January 2010 she was referred to MARAC. There were two face-to-face contacts with Lottie in relation to Bert and one risk assessment was recorded. The final contact with Lottie was by telephone on the 20th July 2014.

1.5.18 Hestia, Domestic Abuse Floating Support Service; their only contact with Lottie was on 14th March 2012.

1.5.19 National Probation Service: Bert was first known to probation in May 2012 while on bail for the assault on a motorist. He was convicted and sentenced to 27 months imprisonment. On 17th December 2012 he was released on licence and referred to MAPPA. On 13th February 2013 his MAPPA status was reduced from level 2 to level 1. On 31st January 2014, Lottie's address was assessed as suitable for licence supervision. On 18th February 2014 he was recalled to custody following the incident involving Lottie on 10th February 2014. He was released from prison on the 21st June 2014. There was no further contact with probation after this date.

1.5.20 Central and North West London NHS Foundation Trust (CNWL); mental health services. Both Lottie and Bert were known to CNWL mental health services. Lottie was discharged from their care in December 2014, but Bert was still in receipt of services at the time of the murder.

1.5.21 Lottie's first contact was on the 10th January 2013 following an overdose. Following care by the Home Treatment Team, she then had several appointments with the Assessment and Brief Treatment Team throughout 2013 and 2014. On 27th March 2014 she disclosed domestic abuse.

1.5.22 Bert had a longer history of contact with mental health services and a diagnosis of dissocial personality disorder and emotionally unstable personality disorder. In May 2010, aged seventeen, he was admitted as an inpatient to an adolescent unit. On three occasions Bert presented to Accident and Emergency (A and E) and made threats against others. On occasions he presented to mental health services and asked to be admitted as an in-patient. Between 2011 and 2014 he was seen sporadically by CNWL community services. He was admitted informally in September 2014. He was last reviewed on the 19th February 2015.

1.5.23 Central and North West London NHS Foundation Trust (CNWL); community health services. Lottie and her daughter were well known to the CNWL community health services. In the early years they were seen by the health visiting service and in March 2012, when Betty started school, they were transferred to the school nursing service.

1.5.24 On 11th February 2014, Betty disclosed domestic violence to the school nurse. The school shared the disclosure with children's social care that day. The school nurse regularly assessed Betty. The school nurse attended core group and case conference meetings. It was noted that Lottie rarely attended the meetings but her parents mostly did. The final core group meeting was held on the 4th March 2015.

1.5.25 Greenbrook Healthcare, Hillingdon Urgent Care Centre: Bert presented to the service on five occasions between October 2013 and September 2014 requesting treatment for physical injuries, medication following his release from prison, and mental health issues. The service had no contact with Lottie.

1.5.26 Hillingdon Hospital NHS Foundation Trust; both Bert and Lottie attended the hospital.

1.5.27 All of Bert's attendances preceded his relationship with Lottie. Between 2009 and 2011, Bert presented to A and E on six occasions for mental health issues, an overdose and injuries following acts of violence. In March 2012 Bert presented to A and E on two consecutive days, 29th and 30th, making serious threats against others. The psychiatric liaison team assessed him. Bert's final attendance was on the 5th September 2013, when he presented with injuries sustained in a fight.

1.5.28 In December 2012 and January 2013, Lottie attended A and E having taken overdoses.

1.5.29 Lottie's final recorded attendance was on 10th October 2014 when she attended an outpatient appointment and disclosed having been a victim of domestic violence.

1.5.30 Care UK, Out of hours GP Service; Bert had contact with the service on three occasions. The final contact was on 24th September 2013 when he presented with a worsening of his mental health problems.

1.5.31 London Borough of Hillingdon, Housing; Lottie was well known to the service. In January 2013 she presented with Betty, fleeing domestic violence from an unknown perpetrator, but not Bert. After staying in a refuge she was accommodated in a two-bedroom house.

1.5.32 On 7th July 2014 she asked to be rehoused after being assaulted by Bert. She was placed in several B&Bs before moving to the hotel in Slough on 20th August 2014.

1.5.33 On 13th November 2014, Lottie was offered and accepted a one-bedroom flat in Hillingdon on a temporary basis. Later that month she reported feeling concerned about her safety there. She was directed to the IDVA service.

1.5.34 On 20th February 2015, Lottie requested a move back to her previous address.

1.5.35 Bert had limited contact with housing. He approached housing on 21st June 2014, the day he was released from prison. He was provided with interim accommodation on the 25th June 2014 although it appears that he didn't ever stay there. He attended again on the 12th November 2014 but was not offered accommodation.

1.5.36 London Ambulance Service; had four recorded contacts with Lottie.

1.5.37 The first three contacts preceded her relationship with Bert. On 21st December 2012 they attended and Lottie was recorded to have taken an overdose. A safeguarding referral for Betty was made. On the 10th January 2013 they again attended following an overdose and a safeguarding referral was made for Lottie.

1.5.38 The final contact was in March 2015 following the fatal stabbing.

1.5.39 Victim Support; during the review period, they received nine referrals for Lottie. The first was in 2010 when Lottie was being supported by the IDVA. The following six were for non-domestic incidents and, on each occasion, Lottie declined support.

1.5.40 During 2014, the Metropolitan Police referred Lottie to Victim Support following the second incident of domestic violence on 4th July 2014, when Lottie was risk assessed and referred on to IDVA, and again following the third on 13th July 2014 when they confirmed the IDVAs involvement and closed the case.

1.5.41 General Practitioners; from May 2012 to March 2015, Lottie was registered with two practices. She has a history of non-attendance but occasionally attended requesting mental health referrals and prescriptions.

1.5.42 Bert was registered with five practices. He was a frequent attender, often making emergency appointments and attending the same day. Between 25th November 2014 and March 2015, Bert attended GP 5 on seven occasions. His final contact was in March 2015 when he asked for a prescription as advised by the community mental health team.

1.5.43 The School; became aware of the relationship between Lottie and Bert in February 2014 when Bert started collecting Betty from school. On 11th February 2014, staff noticed that Bert's hands were heavily bandaged. It was the same day that Betty disclosed that Lottie and Bert had been fighting. Social services were informed and Bert was recalled to prison shortly after.

1.5.44 From June 2014 onwards, Betty was cared for by her grandparents. Lottie was next seen at school in January 2015 when she denied the incident the previous year.

1.5.45 Education, London Borough of Hillingdon; had some limited contact with Lottie because of Betty's poor school attendance.

1.5.46 Children's Social Care, London Borough of Hillingdon; Lottie and Betty were known to Children's Social Care from before 2009 due to concerns about Lottie's intoxication.

1.5.47 Betty was allocated a social worker in November 2009 who was actively involved with Lottie over the years.

1.5.48 Following Lottie's arrest for child neglect on the 5th November 2013, Betty was placed in her grandmothers care. Betty disclosed to her social worker that Bert and Lottie had argued that day and Bert had broken a window.

1.5.49 On the 29th November 2013, Lottie and Bert signed a written agreement about the care of Betty and she was returned to Lottie's care. The following month probation notified children's social care of a potential risk to Lottie and Betty because of people pursing Bert.

1.5.50 From 16th December 2013, Betty was managed by children's social care as a child in need. Lottie and Bert's engagement with the plan was noted to be poor.

1.5.51 Betty's disclosure about the incident of domestic violence on the 10th February 2014 was shared by the school with children's social care. Probation was notified and Bert was recalled to prison.

1.5.52 On the 10th March 2014, Betty was placed on a child protection plan. There were on-going concerns about Betty and, at some point in spring 2014, Betty moved to live with her grandparents. She was living with them at the time of Lottie's murder.

1.5.53 There was on-going contact with children's social care and Lottie, and they were notified by the IDVA of the third incident of domestic abuse on the 13th July 2014.

1.5.54 On 26th September 2014 Lottie called to discuss having Betty returned to her care. In November 2013 a risk assessment of Bert was planned. It is not clear when it started but, on in March 2015, it was recorded to be underway.

## 1.6 Conclusions from the Review

1.6.1 Bert subjected Lottie to physical violence and coercive control.

1.6.2 Given the severity and frequency of domestic violence was escalating, which had also included violent assaults by Bert on his brother, and latterly an assault on a member of the public, it is reasonable to conclude that further serious violence could have been predicted. It could not have been predicted with certainty whom the victim would be, but the risks to Lottie were elevated because they were intimate partners.

1.6.3 The services provided to Lottie were not effective in keeping her safe. What cannot, however, be concluded is whether, had the services been better coordinated, her needs been escalated, realistic and practical alternatives offered, and fewer opportunities missed, Lottie could have engaged effectively with agencies to ensure her safety and prevent her murder.

## 1.7 Issues Raised by the Review

1.7.1 This was the second domestic homicide in Hillingdon in 2015; both resulted in DHRs. There were some common themes across both.

1.7.2 Weaknesses in the borough's strategic overview, governance and operational response to domestic violence were identified.

1.7.3 A number of missed opportunities by agencies to intervene were identified.

1.7.4 Gaps in the provision of domestic abuse specialist support service were indicated and there was no clear commissioning strategy to meeting the needs of both victims and perpetrators. There was a lack of focus by some services on those victims at highest risk of harm.

1.7.5 Both Lottie and Bert had high levels of contact with statutory services and agencies. However, no one developed a good working relationship with Lottie and really understood the complexities of her life. Generally there was a lack of curiosity about Lottie and her circumstances, and a lack of awareness among many professionals about domestic violence generally and coercive control specifically. As a result, some agencies were unrealistic in their expectations of Lottie, both in the plans they developed and also by expecting her to be proactive in seeking support. Overall, there was no clear approach to working with someone, like Lottie, who often didn't engage well with professionals and services.

1.7.6 Some agencies worked in a silo. Only a few agencies were aware of the relationship between Lottie and Bert, and there were significant gaps in some agencies recording and sharing of information. Communication and cooperation within and between agencies was sometimes poor.

1.7.7 Very few risk assessments were done and different agencies used different tools. Despite this, there was clear evidence available to some agencies that Lottie was at high risk of harm yet, after 2010, Lottie was never successfully referred to MARAC or adult safeguarding.

1.7.8 The elevated risk of violence resulting from the combination of mental health issues and substance misuse, sometimes called the toxic trio, wasn't widely understood. There is a need to review the local planning and provision for perpetrators with substance misuse and personality disorders. It was also clear that some agencies were unaware of the referral pathway and criteria for referral to MAPPA.

1.7.9 At that time, the pursuit of offenders of domestic violence wasn't given the priority that it should have been. Aside from being recalled to prison, Bert was not held to account for the abuse that he perpetrated. There are no specialist resources for perpetrators available within Hillingdon currently. A partnership approach to perpetrators is needed. There was also a lack of planning and management of Bert's release from prison following his recall for non-engagement and domestic violence, which increased the risks to Lottie.

## 1.8 Recommendations from the Review

1.8.1 Review Panel Multi agency recommendations

1.8.2 SHP to conduct a rigorous borough wide review of Hillingdon's strategic overview and operational response to domestic violence. This review must address:

a) the effectiveness of the SHP, specifically the effectiveness of the governance and strategic leadership that the partnership provides for domestic abuse.
b) the effectiveness of the Domestic Violence Forum and related sub-groups,
c) the strategic direction and priorities for Hillingdon,
d) the gap between the strategy and delivery of the strategic aims by all agencies.

1.8.3 SHP to ensure that all partner agencies conduct an internal review of their domestic violence/abuse policies and procedures in relation to how they identify, risk assess, refer and respond appropriately to victims, particularly those who don't engage and/or are subject to coercive control, and make changes as appropriate. This must include reviewing referral pathways to multi-agency forums (MARAC, MAPPA and Safeguarding) and ensuring that they are clearly identified and utilised.

1.8.4 SHP to review the partnership approach to perpetrators of domestic abuse and produce recommendations for change based on the learning from the two recent DHRs.

1.8.5 SHP to undertake a needs assessment and review of existing domestic abuse specialist support services (including the management of IDVA), and develop a comprehensive commissioning strategy that meets the needs of both victims and perpetrators and includes a focus on prevention and early intervention.

1.8.6 SHP to review the use of the CAADA DASH risk identification checklist in Hillingdon agencies including: the purpose of DASH completion, the adoption of DASH consistently across agencies and in front line practice, the use of DASH as an on-going risk identification tool, and the arrangements for sharing of risk information outcomes between agencies involved with the same client. A multi-agency task and finish group should be established in order to develop a multiagency protocol regarding the risk assessment of victims of domestic violence.

1.8.7 SHP to establish a task a finish group in order to develop a multiagency protocol on information management including creating a common information record and sharing information on victims and perpetrators of domestic violence.

1.8.8 SHP to review the effectiveness of the information available to the public about the appropriate action to take if they have concerns about the risk of domestic violence against a person, to enable the police and other agencies to intervene positively.

1.8.9 SHP to seek assurance from partner agencies that they are compliant with the NICE guidelines on domestic violence and abuse; multi agency working, by local agencies.

1.8.10 SHP to review provision for perpetrators of domestic abuse released from prison and develop a plan to include the provision of suitable housing, access to primary health care, access to mental health services and prescribed medication.

1.8.11 SHP to ensure that the new MASH arrangement addresses the information sharing needs of schools and education services about cases of domestic abuse.

1.8.12 SHP to ensure that all partner agencies agree a policy on the reallocation of domestic violence cases when a conflict of interest exists or there is a failure to develop a workable relationship with the client.

1.8.13 SHP to review the multiagency training strategy including:

(a) Front-line and professional staff awareness of the dynamics of domestic abuse, especially coercive control and non-engagement. This must include consideration, in partnership with Hillingdon CCG, of commissioning IRIS or a similar domestic violence programme designed specifically for primary health care teams including General Practice, the Out of Hours service and the Urgent Care Centre.

(b) Front line and professional staff's skills in safe enquiry and disclosure, and the specific challenges of working with victims of coercive control and poor engagement.

(c) Ensuring front-line and professional staff are aware of the heightened risks associated with domestic abuse, mental ill health, and drug and alcohol misuse.

(d) Audit safeguarding children's training (and take up across the multi-agency partnership) to ensure that domestic violence is appropriately addressed.

(e) Audit adult safeguarding training (and up take across the multi-agency partnership) to ensure that domestic violence is appropriately addressed

1.8.14 Review Panel Single Agency Recommendations

1.8.15 **Recommendation – London Borough of Hillingdon Children's Social Care**

a) Hillingdon Children's Social Care to ensure that they assess and take appropriate steps to address the abusive behaviour of perpetrators who come within the remit of their service.

b) Hillingdon Children's Social Care to ensure that domestic violence dynamics are actively addressed during supervision.

c) Hillingdon Children's Social Care to introduce standards for record keeping.

For these three recommendations to be regularly reviewed in supervision, and for a dip sample audit to take place six months after changes have been made, with the results reported to the SHP.

1.8.16 **Recommendations – Metropolitan Police**

a) Metropolitan Police to audit the effectiveness of mechanisms in place to prioritise and actively pursue outstanding offenders of domestic abuse.

b) Metropolitan Police to audit the effectiveness of arrangements for increasing the number of prosecutions using evidence based prosecutions.

c) Metropolitan Police to dip sample compliance with the Victim's Charter to ensure that victims of domestic abuse are regularly updated on progress.

1.8.17 **Recommendation – Metropolitan Police and Thames Valley Police**

a) Metropolitan and Thames Valley Police to audit compliance with investigative expectations and supervision of allegations of domestic abuse.

b) Metropolitan and Thames Valley Police to review the arrangements for ensuring that all relevant information is gathered before conducting arrest attempts in relation to domestic violence in another forces area. This should be subject to dip sampling to ensure compliance.

1.8.18 **Recommendation – Hillingdon Hospital NHS Foundation Trust**

a) Hillingdon Hospital to improve the arrangements for sharing safeguarding concerns between Accident and Emergency, liaison psychiatry, and all other departments within the hospital, including outpatients. Success measures should be identified and audited.

1.8.19 **Recommendations – Hillingdon CCG**

a) Hillingdon CCG to provide assurance to SHP that CNWL's action plan arising from the Internal Investigation Report has been implemented. The action plan will be monitored by the CCG using the Goodall Safeguarding meeting. An update on the action plan should be provided within six months of the DHR being approved by the Partnership. Further updates to be determined by the Partnership.

b) Hillingdon CCG to oversee the implementation of NICE guidelines on Antisocial Personality Disorders: prevention and management, and to evaluate the effectiveness of local provision for people with personality disorders.

c) Hillingdon CCG to share the findings and learning from this DHR with Hillingdon GP practices, Out of Hours Service and Hillingdon Urgent Care Centre.

d) Hillingdon CCG to work with Hillingdon health service providers to ensure that all information systems enable the flagging of high risk victims of domestic abuse.

e) Hillingdon CCG to ensure that all Hillingdon GP practices, the Out of Hours Service and the Hillingdon Urgent Care Centre develop policies that ensure staff are aware of the issue of domestic violence, how to identify and assess people at risk, how to identify and assess perpetrators of domestic violence, what services are available locally and the referral pathway.

f) Hillingdon CCG to consider commissioning IRIS or a similar domestic violence programme designed specifically for primary health care teams.

1.8.20 **Recommendation – London Borough of Hillingdon Housing**

a) Hillingdon Housing to review the local housing procedure and develop guidance on specific considerations when accommodating perpetrators of domestic abuse.

1.8.21 **Recommendations – Hillingdon IDVA**

a) HIDVA to focus support on high risk cases and review repeat victims and audit to ensure the risk levels are being reduced.

b) HIDVA to actively manage their case load and communicate the status of cases to other agencies. This should be subject to regular audit.

c) HIDVA to ensure proactive and timely support for victims when known perpetrators are due to be released from prison. This should be overseen in supervision.