# NEWHAM COMMUNITY SAFETY PARTNERSHIP

# DOMESTIC HOMICIDE REVIEW

## Overview Report into the death of Angela

## June 2015

**Independent Chair and Author of Report: Nicole Jacobs**

**CEO, Standing Together Against Domestic Violence**

**September 2017**

# 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 domestic homicide review examines agency responses and support given to Angela, a resident of Newham prior to the point of her murder at her home in June 2015. Angela was found stabbed in her home and her adult son, William, was convicted of her murder.

1.1.3 The review considered agencies' contact and/or involvement with Angela and William from 1991 until the date of the homicide.

1.1.4 In addition to agency involvement, the review also examined 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 for the residents of Newham.

1.1.5 The key purpose of undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. 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 be reviewed and changed in service design and delivery 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 friends of Angela for their loss of a dear sister, friend, neighbour and co-worker and thanks them for their contributions and support of this process.

## 1.2 Timescales

1.2.1 The Newham Community Safety Partnership (CSP), in accordance with the 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide

Review. The Home Office were notified of the decision in writing on 15th November 2016.

1.2.2 Standing Together Against Domestic Violence (STADV) was commissioned to provide an independent chair for this DHR and the first date of the review panel was 16th December 2016. The completed report was handed to the Domestic and Sexual Violence Partnership Board and then to theCommunity Safety Partnership on 4th December 2017 and due to further clarification made by LBN, it was resubmitted by the chair on 1st March 2018.

1.2.3 Home Office guidance states that the review should be completed within six months of the initial decision. The review was delayed due to the criminal trial which concluded in late 2015 and the review was commissioned in late 2016.

## 1.3 Confidentiality

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

1.3.2 This review has been suitably anonymised in accordance with the 2016 DHR guidance. The specific date of death has been removed and only the independent chair and Review Panel members are named.

1.3.3 To protect the identity of the victim, the perpetrator and family members, the following anonymised terms have been used throughout this review:

1.3.4 The victim: Angela

1.3.5 The perpetrator: William

1.3.6 These pseudonyms were agreed by Angela's sister and in discussion with panel.

## 1.4 Equality and Diversity

1.4.1 The Chair of the Review and the Review Panel considered 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 Angela was an older woman who was planning her upcoming retirement. Her adult son lived at home and was financially dependent on her. The panel discussed in some depth how this may have

impacted on her perceptions of services as well as her perceived options for help. This has been included in the analysis section.

1.4.3 No additional equality issues were identified during the course of the review.

1.4.4 *Sex*: Sex should always require special consideration. Recent analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing most victims and males representing the majority of perpetrators.[1] This characteristic is therefore relevant for this case; the victim of the homicide was female and perpetrator of the homicide is male.

## 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 Angela and William's circumstances, 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 was comprised of agencies from Newham, as the victim and perpetrator lived there for many years and were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.5.3 At the first meeting, the Review Panel shared brief information about agency contact with the individuals involved, and as a result, established that the time period to be reviewed would be from 1991 to the date of the homicide. This was the time period when there are first indications of William seeking help for smoking which panel members felt may have been linked to possible cannabis use. In addition, there was little information provided in the initial scoping and so the panel agreed that it would be prudent to ensure a longer period of time to gather as much information as possible.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the "generic issues" as set out in 2016 Guidance and identified and considered the

[1] "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.

"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.

following case specific issues such as substance misuse and links to mental ill health and adult child to parent violence.

1.5.5 A Consultant Forensic Psychologist at East London NHS Foundation Trust (ELFT) was invited to be part of the review due to his expertise in mental ill health and links to substance misuse even though he had not been previously aware of the individuals involved.

## 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.

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 2016 statutory guidance for Domestic Homicide Reviews 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 approach adopted was to seek Individual Management Reviews (IMRs) for all organisations and agencies that had contact with Angela or William. A

total of ten agencies were contacted to check for involvement with the parties concerned with this review.

1.6.7 The Metropolitan Police Service (MPS) had little contact with Angela or William and therefore supplied a detailed letter which outlined their investigation of the homicide and two contacts with William in 2000 and 2005 for possession of cannabis.

1.6.8 *Independence and Quality of IMRs:* The IMRs were written by authors independent of case management or delivery of the service concerned. Most IMRs received were comprehensive and enabled the panel to analyse the contact with Angela or William, and to produce the learning for this review. Where necessary, further questions were sent to agencies and responses were received. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the terms of reference for this review.

1.6.9 The General Practice provided GP records, there was little comment or analysis from the practice provided. The Lead GP for Safeguarding in Newham agreed to review the records in order to provide the chair and panel with their viewpoint of how William's cannabis use in particular was addressed. The chair thanks the GP for taking the time to undertake this task to help enhance the learning from this panel. The chair would also like to thank the Consultant Forensic Psychiatrist from the East London Foundation Trust (ELFT) who also helped the chair and the panel understand the information presented from a mental health perspective.

1.6.10 *Documents Reviewed:* In addition to the four IMRs, documents reviewed during the review process have included a summary of learning from previous DHRs in the area done by the Community Safety Partnership and STADV and Home Office DHR Case Analysis. Panel members from criminal justice agencies referred to the following reports in their panel discussions: Court report, Police statement, Post Mortem report, Probation Pre-Sentence report and assessment.

## 1.7 Contributors to the Review

1.7.1 The following agencies and their contributions to this Review are:

| | |
|---|---|
| Change, Grow, Live (CGL) which is the current provider of substance misuse services commissioned by the London Borough of Newham | Contribution- IMR and Chronology |

| | |
|---|---|
| Woodgrange Medical Practice | Contribution- medical notes |
| Newham University Hospital | Contribution- IMR and Chronology |
| Barts Health Acute Trust | Contribution- IMR and Chronology |
| Metropolitan Police Service (MPS) | Detailed letter |

## 1.8 The Review Panel Members

1.8.1 List Panel Members

| **Name** | **Job title, Organisation** |
|---|---|
| Phillipa Uren | Safeguarding Coordinator, Barts Health |
| Rob Carrick | DSV Commissioning Officer, London Borough ofNewham (LBN) |
| Justin Roper | Associate Director of Quality, Newham Clinical Commissioning Group (CCG) |
| Janette Clarke | Safeguarding Lead, East London Foundation Trust (ELFT) |
| Dr JB Berman | Consultant Forensic Psychiatrist, East London Foundation Trust (ELFT) |
| Tony Pape | Senior Safeguarding Officer, London Borough of Newham (LBN) |
| Mandy Oliver | Senior Safeguarding Adults Advisor I Safeguarding, Mental Capacity and DOLs Team, LBN Adult Social Care |
| Karen Bohan | Senior Safeguarding Adults Advisor I Safeguarding, Mental Capacity and DOLs Team, London Borough of Newham (LBN) Adult Social Care |
| Allison Hamer | Detective Superintendent, Metropolitan Police Service (MPS)/SCRG |
| Allison Buchanan | Domestic and Sexual Violence Commissioner, London Borough of Newham (LBN), Adults Services Commissioning |
| Neil Matthews | A/Supt, Newham Metropolitan Police Service (MPS) – left panel early in process and replaced temporarily with Sean Yates who attended 1 panel meeting only |
| Piers Adamson | Service Manager, Change Grow Live (CGL) |
| Sinéad Dervin | Senior Mental Health Commissioning Manager, Health in the Justice System NHS England |
| Karen Ingala-Smith | CEO, NIA Project |
| Greg Tillet | Head of Newham National Probation Service (NPS) |
| Anju Ahluwalia | North East Area Manager, Victim Support |

1.8.2 Independence and expertise: Agency representatives had an appropriate level of knowledge, management and independence to represent their service or agency on the panel.

1.8.3 The Review Panel met a total of 3 times, with the first meeting of the Review Panel on the 16th December 2016. There were subsequent meetings on 20th April 2017 and 13th October 2017.

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

## 1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 Initially, Newham CSP notified Angela's sister in writing of their decision to undertake a review on 9th December 2016.

1.9.2 The chair of the Review and the Review Panel acknowledged the important role that Angela and William's family could play in the review. From the outset, the Review Panel decided that it was important to take steps to involve the family, friends, work colleagues, neighbours and the wider community.

1.9.3 As William was Angela's only child and she did not have a current partner, her older sister was notified that a DHR was being commissioned via a letter sent from the London Borough of Newham on 9th December 2016. This letter outlined the purpose of the review, identified the points at which family members could participate in the review if they wished and introduced the independent chair.

1.9.4 The early contact with Angela's sister was greatly aided by the fact that she was already supported by AAFDA (Advocacy After Fatal Domestic Abuse)[2]. The independent chair subsequently contacted the sister of Angela through AAFDA who had established a trusting relationship with Angela's sister and had supported her prior to the DHR commencing so that she fully understood the scope, purpose and how to participate in the DHR. She also understood the terms of reference for the review and reviewed the final report.

1.9.5 The independent chair met with Angela's sister on 6th January 2017 and met her subsequently at a conference held by AAFDA and contacted Angela's sister both via the AAFDA advocate and directly by phone and

2 AAFDA specialise in guiding families through Inquiries including Domestic Homicide Reviews and Mental Health Reviews, and we assist with and represent on Inquests, Independent Police Complaints Commission (IPCC) inquiries and other reviews. For more information go to http://aafda.org.uk

text. The chair would like to thank both AAFDA and Angela's sister for their input and support and for reviewing the final draft of this report.

1.9.6 The independent chair also met with Angela's next door neighbour and friend as well as her long-time friend with whom she shared an interest in animal welfare.

1.9.7 The independent chair spoke on the phone to William's father who now spends some of the year abroad. Due to ill health and his time away from the UK, he wished only to be kept informed via William of this review. He regularly visits William in prison.

1.9.8 The independent chair contacted but was unable to meet Angela's colleagues from work. Colleagues at work were very distressed by the news of her death and communicated with her wider network of family and friends to ensure they could contribute to a memorial bench in the work's garden in her name.

1.9.9 The comments and input of all friends and family members are included throughout this report.

## 1.10 Involvement of Perpetrator and/or his Family:

1.10.1 On 13th June 2017 William was sent a letter from the independent chair with a Home Office leaflet explaining DHRs and an interview consent form to sign and send back. He sent back the signed consent form on 21st June 2017.

1.10.2 The independent chair met William in prison on 3rd August 2017. His comments are included throughout this report as necessary.

## 1.11 Parallel Reviews

1.11.1 There were no parallel reviews of this case.

1.11.2 *Criminal trial:* The criminal trial concluded in late 2015. The Senior Investigating Officer attended the first panel meeting and provided information to the panel that was presented at trial.

## 1.12 Chair of the Review and Author of Overview Report

1.12.1 The chair and author of the Review is Nicole Jacobs, the CEO of Standing Together Against Domestic Violence (STADV). Nicole has received training from her predecessor at Standing Together, Anthony Wills and attended the Home Office training on DHRs in 2013. She has over 20 years of experience working in the domestic violence and

abuse sector and has chaired five DHR reviews and has led in the work related to dissemination of findings of all the STADV-chaired DHRs with the Child and Women Abuse Studies Unit at London Metropolitan University, published in 2016.

1.12.2 Nicole has no connection with Newham Community Safety Partnership (CSP) or any of the agencies involved in this case.

1.12.3 Standing Together Against Domestic Violence (STADV) is a UK charity bringing communities together to end domestic abuse. STADV 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.

1.12.4 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.

### 1.13 Dissemination

1.13.1 The following recipients have received or will receive copies of this report:

- Panel members listed in this DHR Overview Report
- Angela's sister and her support workers at AAFDA
- Standing Together Against Domestic Violence DHR Team

# 2. Background Information (The Facts)

### 2.1 The Homicide

2.1.1 Angela was a hardworking friend, mother, colleague and community member who felt passionately about the care and wellbeing of animals. She was the mother to William, a 37 year old street cleaner who worked in a neighbouring London borough. Angela worked for many years as an assistant at the Royal London Medical Library. They lived together in their family home in the London borough of Newham. Angela and William's father had divorced when William was young and she had taken on the care of William as single parent.

2.1.2 Angela reported sick for work a few days before she was found murdered, saying she had food poisoning. On the same day, William also failed to attend work and was shown as absent without leave.

2.1.3 A couple of days later, and on the day after her 65th birthday, Angela was found deceased at her home address by an emergency gas engineer, who had accessed the property to investigate a suspected gas leak which had been reported by the neighbour. She was found to have multiple stab wounds. It was concluded that she had been murdered the day before, which had been her birthday.

2.1.4 The cause of the gas leak was in the kitchen of the property. All four control knobs on the gas cooker had been turned to the fully on position and a lighter had been left in the microwave in an apparent attempt to trigger a fire or explosion.

2.1.5 Angela's adult son, William, was not present at the address and was quickly identified as a potential suspect for the murder and was circulated as wanted on the Police National Computer (PNC).

2.1.6 The next day, William was arrested by officers from the Port of Tilbury Police in Essex. He made an unsolicited comment upon arrest, saying: *"It's my mum, I have done something bad to my mum".*

2.1.7 The post-mortem was conducted by Home Office Pathologist at East Ham Mortuary. The cause of Angela's death was recorded as multiple incised stab wounds.

2.1.8 The case was investigated under Operation Launcells by the Homicide and Serious Crime Command and William was charged with the murder of Angela in mid-June 2015. He was charged with murder and two further offences that he had committed following the murder of his mother.

2.1.9 The further offences happened when William fled to Essex after the murder of his mother, and before he was arrested. He broke into a shed and stabbed a man sleeping in the shed. He was subsequently charged with the murder of his mother and the attempted murder of another person.

2.1.10 *Criminal trial outcome*: In late 2015, William was found guilty at Chelmsford Crown Court of murder, arson with intent to endanger life and attempted murder.

2.1.11 William's defence was largely based on an argument that he had experienced a psychotic episode and two differing accounts of his mental health were presented at trial in conflicting psychiatric reports.

2.1.12 In late 2015, he was sentenced to (counts 2 & 3 to run concurrently to count 1):

1. Murder - Life imprisonment with a minimum tariff of 21 years;
2. Arson with intent to endanger life – 5 years 6 months;
3. Attempted murder – 8 years 6 months.

## 2.2 Background Information about Angela and William

2.2.1 Angela was a white British woman, aged 65 who was born in Cornwall and moved to London when she was a baby. She was married at the time William was born but had divorced and was a single mother from the time William's was a small child. She worked at a Medical Library where she was a valued and beloved member of staff. Angela was dedicated to the welfare of animals and had formed some of her close friendships with others because of fundraising and activities related to animal welfare. Her friends and neighbours remember her leaving food out for foxes and food for the birds. She sponsored programmes to support horses and orangutans. One friend described her by saying, "The word 'no' did not figure in her vocabulary." She was proactive and took an interest in a wide range of events and activities. If a friend suggested an activity or event, Angela was always enthusiastic to make it work.

2.2.2 Angela was an assertive person. She could ask neighbours to help her in the back garden or suggest that they clean up or address work needed in their shared or overlapping space. One friend remembers her offering a local homeless man some work to paint her fence. She had noticed him and his dog at the station and thought that he may like to be offered some work to do. Her friend believes that her motivation may well have been to help his dog by helping him.

2.2.3 She was also private and cautious. She was not likely to attend a party or gathering where people were unknown to her. She enjoyed her close circle of friends and was most active when they would do things together, but not in wider social groups. When her friends invited her to anything, she was always careful to ask who else may be there and would sometimes decline if there were people in attendance who she did not know.

2.2.4 She was nearing retirement and she had spoken to her friends about her travel plans. She had a good friend who had lived in Belgium and asked her if they could travel there together once she was retired. She also planned to volunteer at the Theatre Royal and a charity shop for animal welfare.

2.2.5 William is a white British man who was aged 37 at the time of the murder. He lived at home with his mother and he worked as a street cleaner for 9 years up until the time of arrest. William recalled that he smoked cannabis regularly from the age of 16 -18. He could not

recollect the exact age he began. He described his cannabis habit as dependent on his income. He often smoked from his pay day until mid-week when he would run out of money to be able to buy any more cannabis. William acknowledged that his mother knew about his cannabis use and they spoke from time to time about how to address or stop his drug use.

2.2.6 Angela spoke to certain friends about her concerns regarding William's cannabis use. She had a close friend who had worked in a drug dependency unit and Angela asked her friend for support and advice. She spoke to her friend about a time when William had sought help and was attending counselling. This was in the year before the murder and it aligns with William's recollection of help seeking to address his drug use.

2.2.7 William describes himself as someone who lacks self-confidence and to escape he would smoke cannabis and play video games. At the time of murder, he would play on an Xbox for several hours per day. His routine was to wake up, smoke cannabis, play video games and then go to work in the afternoon. He played Minecraft, Call of Duty and Battlefield and often played with other people via the internet. This took up most of his time out of work and he describes becoming increasingly drawn in to hours of video games in the time before the murder. He had a small number of friends but he did not see them often.

2.2.8 William confirmed that for a period of 2 years, he moved away from the family home but returned because it was hard to sustain independent living.

2.2.9 William explained that at aged 30, he considered attending college with ambitions in relation to nursing or infection control. He stated that he found that he could not juggle both coursework and working which was disappointing to both him and his mother.

2.2.10 William described his relationship with his mother as one of relative harmony. He said they had some minor disagreements but they got along on a daily basis. Their weekday routine was such that they only overlapped in the house for a couple of hours each day due to their differing schedules.

2.2.11 William's description of a lack of conflict between him and his mother is reflected in the interviews with the friends and family of both Angela and William. Angela's neighbour did not recall hearing anything through their adjoining walls except for occasionally hearing Angela raise her voice at William. When she spoke with Angela over the garden fence, she would often speak about William and occasionally complain if she had asked him to do something and he had not done it. None of these things raised concern for their neighbour.

2.2.12 Friends and family often visited the family home. Angela's sister visited once or twice a week. Friends and family describe coming to the house and being greeted by William who was often playing video games but would stop, and politely greet the visitor and then often go back to what he was doing. Angela did not describe or disclose to friends and family interviewed for this review that she had experienced conflict, violence or discord with William.

2.2.13 Angela recruited William to help at her work from time to time which seemed to work well and William got to know her co-workers and would sometimes go to dinner with Angela and her colleagues.

2.2.14 However, William admitted that both he and Angela wanted William to move out. He spoke that they were both frustrated with the fact that his finances were such that he could not live independently of her. She spoke to her close friend about her plans for retirement and her future about changing her will. She expressed concern to her friend that perhaps William would not be able to keep up the house and therefore she was considering leaving it to a charity. There is no indication that she had communicated that to others or to William.

# 3. Chronology

## 3.1 Chronology from 1991 to 2015

3.1.1 Neither Angela or William had substantial interactions with services. Only four services were able to find records which indicated contact with them. From accounts from William and also family and friends, they had a regular pattern and routine to their day to day life that extended over years.

3.1.2 Both Angela and William sought medical care for routine and minor ailments. They both visited the GP and would attend follow up or referral appointments to other health care trusts. They also reported crime and were victims of crime reported to the Police. William reported his bike stolen and Angela reported disturbances on her street on several occasions.

3.1.3 In 1991, Angela was seen at Barts Health Care Trust because she was referred by her GP for headaches. She stated that she did not have specific stress or anxieties but that she was divorced and was a single parent. She noted that her teenage son was currently having an assessment to determine if he was dyslexic. There is no evidence that this was ever diagnosed.

3.1.4 In 1992, William was seen by Barts Health Care Trust for convulsions/fits which were deemed to be possibly related to his video games. He was diagnosed with generalised non-convulsive epilepsy. He was given medication and it was noted that Angela was concerned about his lack of concentration.

3.1.5 There was regular follow up and medication review until 1996 when William was discharged from regular follow ups as he had not had further fits and, in 1999, it was recorded that he withdrew from his medication completely for fits.

3.1.6 William did not recall these assessments or this period in much detail stating that his memory was not very good.

3.1.7 In 2000, William was found in possession of a small amount of cannabis by his employer. Police attended and William was arrested. He fully admitted his offence and was given an adult caution.

3.1.8 In 2004, William was stopped and searched by Police and found to be in possession of herbal cannabis. William admitted the offence and was not arrested but given a formal warning.

3.1.9 In 2007, William called the police to report that he had been robbed by a group of males. Police attended and completed a crime report but following investigation, no suspects were identified and the matter was closed. In the same year he sought help in relation to smoking cessation. He was prescribed nicotine replacement patches by his GP.

3.1.10 In 2009 and 2011, William's smoking habit was noted due to his complaints of cough and asthma reviews. In 2013 during a similar review, the first note of cannabis use is mentioned in his medical notes.

3.1.11 In 2014, William was seen by the GP and there is a notation about cannabis use. The GP writes that William has recently given up a 15-year habit of smoking cannabis and cigarettes. William was given smoking cessation advice and was referred to Barts Healthcare Trust to review his high blood pressure. He stated that he had stopped cannabis use and had developed headaches which is why he sought advice from his GP.

3.1.12 Throughout the years 2011 to 2015 there were times when William also reported to nurses and the GP that he had stopped smoking. The extent of his smoking and drug use was uncertain to medical services.

3.1.13 In 2013, William described going to Amsterdam with friends and smoking cannabis there which had an unusual effect on him. At his trial, this was presented in more detail with descriptions of him feeling that something had infected or taken over in his body. In talking to the

chair of the Review, he did not present this detail but he referred to this trip as a turning point in his feeling unwell. He went so far as to say that he felt that trip was the cause of "why I am here today."

3.1.14 In 2014, William sought help for his cannabis use. William describes having a "first breakdown" in early 2014 and he went to a Police station that he walked past on his way to work and said that he needed help. He cannot recall what he said but he recalls feeling unwell and confused and believes he asked for help. He recalls being told to leave. He then spoke to Angela and told her that he wanted to stop smoking cannabis. She took him to Drug and Alcohol Service for London (DASL) which was one of five commissioned drug and alcohol services in Newham at that time.

3.1.15 William recalls going to DASL every two weeks for a period of 3-5 months and spoke enthusiastically about the support he received there. He explained that he had a 1 to 1 session with someone who was an ex-user himself who William trusted, and helped William feel confident that he could stop. William reported that he stopped his cannabis use for the period of time he was engaged with the drug and alcohol service.

3.1.16 NOTE: Two providers of substance misuse services used the same building during this time. One was called DASL and one was called ELFT. William recalls being supported by DASL but it may have been ELFT as service users often thought of these services as one in the same and referred to the building in general as DASL. As there are no records to verify which service supported William, this report will refer to it as "William's drug and alcohol service".

3.1.17 In 2014, drug and alcohol services were recommissioned by Newham Council and the contracts with DASL and ELFT and three other services were not renewed. An organisation called CRI (later called Change, Grow, Live) took over the contract.

3.1.18 William reports that he was told by his support worker that the council had stopped funding the service. William was distraught by this and it was one of the first things he mentioned during his interview with the chair of the Review. His impression was that his drug and alcohol service lost its funding and closed. He did not recall anyone speaking to him about the newly commissioned service, CRI, or how his support could continue past the closure of his current service. In his mind, the service closed and he did not know where to find further support. William reports that although he had stopped his cannabis use during his time with his drug and alcohol services, that in the weeks after his last contact, he resumed smoking cannabis.

3.1.19 In 2015, William returned to Barts Healthcare Trust as his blood pressure was still high. He was prescribed medication.

3.1.20 When William attended a subsequent appointment at Barts Healthcare Trust in relation to his blood pressure, he asked his friend's mother to attend with him. This was six weeks prior to the murder of Angela. William can recall asking his friend's mother to attend for her general support, and not for a particular reason. He recalls sitting in the appointment and thinking to himself, "I need to be sectioned off." He recalls wanting to ask for help but he was not sure what to say. He said to the medical staff, "I'd like to speak to your supervisor" but then he did not know what to say after so the conversation with medical staff was vague and did not result in any specific support being requested or offered. He remembers his friend's mother asking him later why he had done that but he replied that he did not know.

# 4. Overview and Analysis

## 4.1 Domestic Abuse/Violence

4.1.1 Considering the government definition above, information gathered by the police as part of the murder investigation, information provided by agencies and by family and friends, it is clear that William murdered his mother but that any ongoing pattern of coercion or control was unknown to their wider family and friends.

4.1.2 This case exemplifies the findings from analysis by Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* "(June 2016) which points out the need to separately analyse murders related to intimate partner violence and adult child to parent violence.

4.1.3 There is a significant dearth of research about adult child to family violence. While it is acknowledged that it is a gendered crime, more research is needed in the areas of risk identification, assessment and management of cases.

4.1.4 The Carers Trusts define a carer as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction who cannot cope without their support. While Angela was not assessed as an official carer of William, one could argue that their relationship verged on a carers relationship. He was financially dependent on his mother and he often required help and guidance from her and those close to the family would have questioned if William could have lived independently.

4.1.5 William had never been assessed or diagnosed with mental ill-health and while a diagnosis of psychosis was presented at trial but not upheld by the jury and judge, William describes feeling mentally unwell from 2013 onwards which is a common feature on the case analysis report done by Sharp-Jeffs.

4.1.6 Similarly, while William asserted that his cannabis use was a contributing factor to his ill health, the panel did not view it as a cause or excuse for the murder of Angela.

4.1.7 In summary, while there are lessons to be learned in this review, it is not felt that this murder of Angela could have been foreseeable and there are no specific points at which failures led to her death.

## 4.2 Analysis of Agency Involvement:

4.2.1 **Metropolitan Police Service (MPS):** had limited contact with William. He should not have been offered a second caution for cannabis possession in 2004 as per MOJ guidance which state one should not be offered a second caution for the same type of offense[3]. In 2014, William recollects approaching the police for help before attending his drug and alcohol service. His recollection of this event was that he felt unwell but was not sure why so he would have appeared confused or unsure in his interaction with the Police. It may have been that taking some time to understand and direct William to services would have been useful. William responded well at that time to suggestion in terms of help seeking. He followed his mother suggestion to seek help at the drug and alcohol service shortly after. It may have been an opportunity to point out to William where to go or who to speak to if feeling anxious or unwell but it is unclear what exactly was said to the Police and therefore any criticism of the Police in this instance would be unwarranted.

4.2.2 **GP services:** Ultimately the extent to which William used cannabis and the degree to which it was a problem for him or others was never established by the GP service. There are mixed messages in medical notes which indicate smoking where it may have been more accurately described as cannabis use. This may be because William described cigarette smoking instead of cannabis. There are times when William reports that he had stopped smoking and times when his smoking or that his use of cannabis had resumed. In 2013, there was a missed opportunity to code the cannabis use and when the GP could have explored further the use of cannabis and highlighted to the

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416068/cautions-guidance-2015.pdf

substance misuse lead for GPs. Again, there is a similar missed opportunity in 2014 as well. It may be that the exploration of cannabis use was missed because William generally presented as well or with specific complaints such as high blood pressure. There is no indication that the GP spoke to William about the make up of local drug and alcohol services and William seemed to have little knowledge of how to access services other than his direct experience at DASL. In addition, there is no indication of communication between DASL and the GP service.

4.2.3 **London Borough of Newham:** At the transition of commissioned services, there was oversight for the continuity of services provided to current service users. A full plan was in place, however, for communicating and consulting with service users. Commissioners:

- Attended service user forums to inform of change.
- Produced posters to be placed in all services and checked these were on display.
- Held consultation events with service users.
- Ensured that service users were part of the evaluation process when tendering for new providers.
- Requested that keyworkers share details of the new service with clients and also requested that they reconsented service users to be transferred to the new service.
- Advertised the new service to other stakeholders to increase knowledge of the new provider. This included contacting the following; GP's, Pharmacies, Dentists, Criminal Justice Partners, Major Employers, Libraries, Community Centres, Jobcentre, Workplace, Social Care services, Community Groups, Homelessness and housing services, DSV services, Religious organisations etc.
- Held launch events for the service and advertised these launch events with the Newham Magazine – which is distributed to every household in the borough.

ACOUNT (Advisory Council on Opening up New Treatment) was a locally based service user group. This group represented people in treatment at that time. The group were kept up to date with all plans so that these could be circulated to all service users.

4.2.4 In any change of commissioned services, there should be time to allow for a smooth transition so that care of vulnerable service users is maintained and that there is a plan for communication to service users about the change. William reports that, despite the efforts of LBN, he was told inaccurate information by his support worker who at the time would likely have been feeling uncertain about the transition

arrangements and who may well have had personal concerns about his role and how and if it would continue. While there is credible information from CGL employees present during the time of the transition of services that CGL drafted and disseminated bulletins and updated and hosted a service user consultation event, it is not as clear how this communication was handled by each of the five services which were decommissioned during this time.

4.2.5 CGL "inherited" a smaller caseload than they anticipated when they took over the contract (some 550 service users) and then had a large influx of service users within the first year of operation which CGL believe may have been due to the decommissioned services discharging a high number of service users prior to the transfer. There was local news coverage where one of the five decommissioned services criticised the change in services although the London Borough of Newham clearly asserts in the same article that continuity and services would continue via CGL. The actions outlined in 4.2.3 make it unlikely that there was systematic confusion in communication with service users but William was clear that he was told that the service supporting him was shutting down due to "council spending cuts". That is not the reason why LBN decommissioned services. They consulted service users who informed council they found the system of five providers difficult to navigate. The other concern that service users raised was that they were being assessed on more than one occassion when transferring between the agencies. These were the primary reason LBN moved from five providers to one.

4.2.6 CGL recognised improvement was required in their mobilisation planning. For example, at the time of this transition when the continuity of service to William as a service user was possibly lost, CGL did not have any outreach and re-engagement workers in post as they were still being recruited. These two posts were built into the original model but when CGL took the contract over in July 2014, no one matched these roles via TUPE. Therefore, these posts could only be recruited for after 1st July 2014. CGL drafted in workers from other sites in their wider organisation but the function of the outreach and re-engagement work did not commense immediately. Had people been in the outreach and re-engagement posts from the beginning, they could have supported the Recovery Workers earlier in the contract to re-engage service users not attending appointments. Organisations can recruite during implementation periods but they may be unclear as to which posts are required until the TUPE process is over. CGL recognised that recruiting faster to vacant positions during implementation periods could be achieved with more management support and oversight and understanding of the logistical challenges in cooperation with the support provided by the local authority commissioner.

4.2.7 Newham should continue to ensure that all transitioning services have a communication and transition plan in place which is fully monitored and implemented. In this case, William was influenced by the statements made by an individual worker. A potential way to mitigate the possibility for misinformation is to ensure written information is given to service users so that any transition in care is clearly articulated and not left to the individual case worker to communicate on behalf of the service.

4.2.8 **Change, Grow, Live:** According to CGL records, William was not contacted for 6 weeks after CGL took the contract. William does not recall this contact as his last recollection was his drug and alcohol worker worker explaining that their service was closing. It may be that William did not recognise CGL and therefore did not respond if CGL contacted him. In any case, due to the large TUPE transfer, it took most staff at CGL some time to get on top of their caseloads and begin contacting all service users on their caseload.

4.2.9 Since August of 2014, CGL instituted two policies which would increase the likelihood of engagement. CGL now uses a re-engagement pathway which ensures that more than one attempt would be made to contact a service user through more than one means before case closure. Equally, if service users are not attending the service, CGL employs a Missed Appointments Matrix as guidance to ascertain risk. These policies and practices are both now in place and being used operationally by CGL.

4.2.10 In addition, at the time William's case was discharged, there was no discharge checklist process in place. This is a process whereby a line manager will only sign off a discharge in the event of all aspects of the checklist being completed. This was implemented at CGL Newham Rise in November 2015.

4.2.11 CGL also has a communication plan in place for GPs which has improved the likelihood of coordination of care as required.

4.2.12 CGL recognised the need to improve mobilisation planning after the challenges in mobilisation of the Newham contract as well as other implementations delivered. A National Implementation Manager was appointed to help oversee and improve this process and to create an Implementation Toolkit. It was specifically identified in the internal review of mobilisation in Newham that with larger integrated treatment systems, a greater level of management support was required in the early months to support the implementation process.

4.2.13 It is impossible to say if these changes and new tools, now in use, had been in place in July and August 2014, would have generated successful contact with William and possibly lead to a successful intervention

4.2.14 What can be said is that those systems are in place now, there are 1000 service users currently in treatment with CGL Newham Rise and at the end of February 2017, the average time a CGL Newham Rise service user went without face-to-face contact with the service was 17 days (this is 5 days better than the national average). That is a sign of positive engagement with the service as it exists today.

4.2.15 Angela sought advice from her friends regarding William's cannabis use and she was proactive when William approached her for help in 2014 in relation to wanting to seek help. Angela did not access and does not appear to have been offered or know about how she may have contacted services to seek advice. CGL offers support and advice to the family of their service users and the promotion of this service should be more widely advertised and known. It is possible that the best place for Angela to have known about this is via the GP surgery.

4.2.16 The current CGL Newham Rise staff team is comprised of approximately 50 people. This includes a multi-disciplinary staff team of doctors, nurses, management, front line staff and volunteers. Safeguarding Training at CGL is a mandatory course and 100% of the staff team have completed the CGL core Safeguarding training. The Safeguarding Lead and rest of the management team have completed additional training via CGL and the London Borough of Newham around domestic abuse and information from these trainings are disseminated to the wider staff team.

4.2.17 Currently, an Independent Domestic Violence Advisor (IDVA), employed by Victim Support co-locates at CGL once a week. This is a new initiative that is in its early stages, however the IDVA has a work plan to act as a champion and will be running surgeries where CGL staff members can discuss cases with the IDVA and she will support creating plans and making onward referrals to ensure risk is monitored and managed.

4.2.18 These training and multi-agency improvements are welcomed as it is clear that CGL service users will often require support in relation to domestic abuse either as a survivor of abuse or a perpetrator of abuse.

## 4.3 Equality and Diversity:

4.3.1 The Review Panel identified the following protected characteristics of Angela and William as requiring specific consideration for this case; gender and the age of Angela.

4.3.2 The panel discussed in some depth how Angela's age may have impacted on her perceptions of services as well as her perceived options for help. As William was an adult child living at home, Angela

had limited understanding of the help he may or may not have been seeking at any given time and she would not have been a part of his discussions with his GP. While William had every right to privacy in these settings, it appears that Angela struggled to find information and support which may have helped her make sense of the possible support or intervention William needed.

4.3.3 Race / Nationality; religion and belief; disability; sexual orientation; gender reassignment; marriage / civil partnership; pregnancy and maternity: the panel believed these had no impact on the response Angela or William received.

# 5. Conclusions and Lessons to be Learnt

## 5.1 Conclusions (key issues during this Review):

5.1.1 'Domestic violence is a complex social problem. It harms the whole of society. The outcomes are the responsibility of all the agencies with a remit for health, social care and crime.[4]' The adult child to parent violence which sits within this broader definition require more time, attention, research and development of practice. An understanding of risk factors for adult children who are dependent on their parent(s) financially, emotionally or due to substance misuse of mental ill-health requires much more awareness raising and proactive encouragement for early help and support.

5.1.2 It is clear from the review that this homicide was neither predicatble for foreseeable from the information provided and the review carried out. Therefore, the review has identified some lessons to be learnt from the review but these would not have directly impacted upon the outcome of this case.

## 5.2 Lessons to Be Learnt:

5.2.1 **Prioritising information to aid help seeking**: It is possible that William's use of cannabis for a period of approximately 20 years and the effect on him was not fully understood by him, his family, friends or GP services. It is possible that both he and Angela did not consider help was needed for a substantial period of those years. William only took steps for help seeking in 2013, although he had sought more general

[4] Wills, A. and Standing Together Against Domestic Violence, 'In Search of Excellence: A Guide to Effective Domestic Violence Partnerships , 2013, p.3.

advice from the GP in previous years. It is possible that the GP practice could have explored his cannabis use further, but he had stated he had stopped its use at the appointment and had been engaged with DASL. Whether at the GP or drug and alcohol services, empowering patients and service users with information about where and how to seek help is an important aspect of their service.

5.2.2 **Commissioner practice in transition of services:** Commissioners of services should consider additional steps they can take to be certain that service users are provided with clear and accurate information when there is a change in service structures or a transition in commissioned services.

5.2.3 **Awareness of adult child to parent violence:** Although there has not been evidence this was the case for Angela, it is true that a significant minority of DHRs are adult child to parent homicides. Providers of community health services, substance misuse services and mental health services should be increasingly aware of adult child to parent violence and the gendered nature of these crimes and consider the risks to parents or family members of their adult service users, especially when living together and when the service user is financially dependent on them. In these circumstances, parents should be provided with information and support to ensure they feel confident and understand local service provision and can be encouraged to seek support in their own right if necessary.

5.2.4 **Importance of re-engagement pathways for substance misuse services:** Effective and systematic re-engagement pathway/process and discharge checklist within substance misuse services are critical.

5.2.5 **The importance of confidential services for families and carers affected by others' substance misuse**: CGL Newham Rise has a small team of experienced workers who specialise in engaging with families, carers and substance misusing parents. They offer carers' support groups, confidential support and advice, carers assessments, drug and alcohol awareness, 1 to 1 counselling and key work sessions, coffee mornings, courses and an evening clinic. Input from this team and linkages to domestic abuse services would be of mutual benefit to ensure that service users and front-line workers are fully aware of the possible support for them.

5.2.6 **The importance of training links in Newham in relation to domestic abuse:** CGL has internal training on domestic abuse for its staff team. In addition, the London Borough of Newham clearly promotes on its website the training offered to all services in the borough. This includes a course on Recognising and Responding to Domestic Abuse and another course on Intervention and Ways of Working.

5.2.7 **Learning from this review and other DHRs in Newham:** A prior DHR AB in Newham where a son killed his father cited lessons learned that the family did not have a point of contact with the team who were supporting the perpetrator (in this case, mental health services) who they could share their concerns with. There was no awareness of the family of carers' support available. The case highlighted the importance of ensuring that carers, and health care providers are properly linked together to ensure that individuals are supported.

5.2.8 The London Borough of Newham is commended for promoting learning and training from DHRs but for also providing links to each DHR on their website, alongside a combined action plan and learning summary.

# 6. Recommendations

## 6.1 Overview Report Recommendations:

6.1.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Newham Community Safety Partnership within six months of the review being approved by the partnership.

6.1.2 **Recommendation 1: Adult Safeguarding Board-** Improved awareness and training around risk identification, management and access to support for adult child to parent violence and to ensure this is linked with increasing levels of adult children who will live at home as outlined in the London Poverty Profile Report[5].

6.1.3 **Recommendation 2: Adult Safeguarding Board-** As with a previous DHR (Newham AB), review support, information and training related to these findings should be made for carers when mental health, substance misuse services or domestic abuse is present.

6.1.4 **Recommendation 3: London Borough of Newham Commissioning Services-** Consider if individual communication to all existing service users should be embeded when there is a significant change to commissioned services or when there is a transition to a newly commissioned service and consider any improvements that could be made to provide assurance that all services in transition abide by

[5] https://www.trustforlondon.org.uk/documents/272/LPP_2017_full_report.pdf

agreed practice and procedures specified in commissioning and mobilisation plans.

6.1.5 **Recommendation 4: Community Safety Partnership:** Further understanding of the services available for parents or family whose adult child is accessing substance misuse and promote an increase awareness of the commissioned services for families provided by CGL.

6.1.6 **Recommendation 7: CCG**: Consider increased awareness raising in relation to GP's understanding of the impact of long term cannabis use and promotion of CGL services in Newham.

6.1.7 **Recommendation 6: Home Office:** Support the dissemination of findings in relation to DHRs and recognise the required cost implications for local government to address changes and improvement of practice required.

# Appendix 1: Domestic Homicide Review Terms of Reference

## Domestic Homicide Review Terms of Reference: Case of Angela

This Domestic Homicide Review is being completed to consider agency involvement with Angela and William following the death of Angela in early June 2015. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

**Standing Together Against Domestic Violence and DHR's Mission**

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

STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 50 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

STADV through their Domestic Homicide Review (DHR) work aim to:

- Raise the status of the victim and the victim's family;
- Hold perpetrators to account and
- Allow agencies and communities to learn lessons from the homicides and to work on improving their own Coordinated Community Response to Domestic Abuse.

**Purpose**

1. DHRs place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel,

until the panel agree what information should be shared in the final report when published.

2. To review the involvement of each individual agency, statutory and non-statutory, with Angela and William during the relevant period of time: **January 1991 to June 2015**. To summarise agency involvement prior to **1st January 1991.**

3. To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.

4. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

5. To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.

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

7. To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.

8. On completion present the full report to the Newham Community Safety Partnership.

**Definitions: Domestic Abuse and Coercive Control**

9. The Overview Report will make reference to the terms domestic abuse and coercive control. The Review Panel all agree that domestic abuse is not only physical violence but a wide range of abusive and controlling behaviours. The Review Panel understand and agree to the use of the cross-government definition as a framework for understanding if domestic abuse was experienced by the Victim in this DHR.

The cross government definition of domestic violence and abuse (amended March 2013) 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.

**Ethnicity, Equality and Diversity**

10. The Review Panel will consider all protected characteristics of both Angela and William (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation)
11. The Review Panel identified the following protected characteristics of Angela and of William as requiring specific consideration for this case; age and gender.
12. The Review Panel agrees it is important to have an intersectional framework to review Angela and William's 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.
13. The Review Panel membership includes the local domestic violence service NIA, and the Chair may consult with Solace Silver Project (service tailored to needs of women over the age of 55) to ensure the Review Panel are providing appropriate consideration to the identified characteristics.

**Membership**

14. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Agency representatives

must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

15. The following agencies are to be on the panel:
    - ELFT
    - Bart's Health
    - NHS England
    - Police
    - Probation Service
    - London Borough of Newham Adult Social Care Safeguarding Governance Officer
    - CGL
    - NIA
    - Mental Health Trust
    - CCG
    - London Borough of Newham Adult Social Care (DSV Commissioner)
    - Mental Health Clinician

16. Expertise: The Review Panel recognise that particular issues in this case are substance misuse and mental health and therefore a Mental Health Clinician will be invited to act as an expert on this area to advise the Review Panel.

17. Parallel Reviews: There are no parallel reviews.

18. Role of Standing Together Against Domestic Violence and the Panel:
    STADV have been commissioned by Newham CSP to independently chair this DHR. STADV have in turn appointed their CEO Nicole Jacobs to chair the DHR. STADV DHR team consists of two Administrators and a Manager. STADV DHR team Administrators Tosca Tizzano and Sheila Wesa will provide administrative support to the DHR and the STADV DHR Team Manager Gillian Dennehy will have oversight of the DHR. The STADV Manager may at times attend a panel meeting as an observer. STADV DHR Manager will quality assure the Overview Report before it is sent to the Home Office. STADV DHR team will liaise with the CSP around publication. The contact details for all on the STADV team will be provided to the panel.

**Collating evidence**

19. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted, and secure all relevant records.

20. Chronologies **and** Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with Angela and William during the relevant time period:
    a) GP in relation to both MH and PH
    b) Newham Change, Grow, Live (CGL) drug and alcohol service in relation to MH
    c) Barts Health in relation to MH

21. Chronologies to be completed by any agency that had contact between 1991 and June 2015. Chronologies only to be completed by:
    a) ELFT
    b) Barts Health in relation to PH
    c) Police (and letter to replace IMR)

22. Further agencies may be asked to complete chronologies and IMRs if their involvement with Angela and William becomes apparent through the information received as part of the review.

23. Each IMR will:
    a) Set out the facts of their involvement with Angela and/or William;
    b) Critically analyse the service they provided in line with the specific terms of reference;
    c) Identify any recommendations for practice or policy in relation to their agency;
    d) Consider issues of agency activity in other areas and review the impact in this specific case.

24. Agencies that have had no contact should attempt to develop an understanding of why this is the case and how procedures could be changed within the partnership which could have brought Angela and William in contact with their agency.

**Analysis of findings**

25. In order to critically analyse the incident and the agencies' responses to Angela and William, 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 Angela and William and their wider family.

c) Analyse the opportunity for agencies to identify and assess domestic abuse risk.
d) Analyse agency responses to any identification of domestic abuse issues.
e) Analyse organisations' access to specialist domestic abuse agencies.
f) Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues.

*As a result of this analysis, agencies should identify good practice and lessons to be learned. The 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**

26. 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 the Community Safety Partnership on their action plans within six months of the review being completed.

27. Community Safety 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.

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

28. Sensitively attempt to involve the family/friends/neighbours of Angela 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 an AAFDA advocate.
29. Invite William to participate in the review, following the completion of the criminal trial.
30. Co-ordinate family liaison to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

**Media handling**

31. Any enquiries from the media and family should be forwarded to the Community Safety Partnership who will liaise with the chair. Panel members are asked not to comment if requested. The Community Safety Partnership will make no comment apart from stating that a review is underway and will report in due course.

32. The Community Safety Partnership is responsible for the final publication of the report and for all feedback to staff, family members and the media.

## Confidentiality

33. 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.
34. 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.
35. 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 to be password protected.

## Disclosure

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

37. The sharing of information by agencies in relation to their contact with the victim and/or the perpetrator is guided by the following:
    a) 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).
    b) 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)

# Appendix 3: Action Plan (will be done by Newham)

| 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 |
|---|---|---|---|---|---|---|
| Adult Safeguarding Board - **-** Improved awareness and training around risk identification, management and access to support for adult child to parent violence and to ensure this is linked with increasing levels of adult children who will live at home as outlined in the London Poverty Profile Report | Local level | Training will be reviewed and training packages designed to reflect this recommend ation | LBN | A task and finish group has been called in order for all parties to agree their actions in relation to this plan. This has been set for 7th December 2018 | Targe dates to be set at the Task and Finish Group on the 7th December | TBC |
| Adult Safeguarding Board- As with a previous DHR (Newham AB), review support, information and training related to these findings should be made for carers when mental health, substance misuse services or domestic abuse is present. | Local level | Carers should be included in information related to support they can receive | LBN | As above | As above | As above |
| London Borough of Newham Commissioning Services- Consider if individual communication to all existing service users should be embeded when there is a significant change to commissioned services or when there is a transition to a newly commissioned service and consider any improvements that could be made to provide assurance that all services in transition abide by agreed practice and procedures specified in commissioning and mobilisation plans. | Local level | Liaise with commission ers around communicati ons plans for service users to check that it is robust and actions plans are proportionat e and effective | LBN | As above | As above | As above |

| | | | | | | |
|---|---|---|---|---|---|---|
| Community Safety Partnership: Further understanding of the services available for parents or family whose adult child is accessing substance misuse and promote an increase awareness of the commissioned services for families provided by CGL. | Local level | To ensure that family support is promoted in substance misuse services | LBN | As above | As above | As above |
| CCG: Consider increased awareness raising in relation to GP's understanding of the impact of long term cannabis use and promotion of CGL services in Newham. | Local level | CCG to consider how training and awareness raising for GP's and practices can be increased | LBN | As above | As above | As above |
| Home Office: Support the dissemination of findings in relation to DHRs and recognise the required cost implications for local government to address changes and improvement of practice required. | National | | Home Office | | | |