DOMESTIC HOMICIDE REVIEW

London Borough of Ealing Community Safety Partnership

REPORT INTO THE DEATH OF C MOON

December 2013

Author of Report: N Jacobs

Date Completion: January 2016

THE EXECUTIVE SUMMARY

Outline of the incident

1.1.1 At 7:00 am on the 29th of December 2013, Police were called by Mr AA to the home he shared with his wife Mrs C Moon and their nine year old daughter Miss M. On the call to the Police, Mr AA stated that Mrs C Moon was dead. He described injuries to her face and chest.

1.1.2 When the Police arrived, they found several blood-stained knives on the floor of the kitchen, one of which had a broken blade tip with the handle missing. Mrs C Moon had large, deep lacerations to the neck and right arm, multiple stab wounds to both breasts and to her back.

1.1.3 The Police found that Mrs C Moon's father was present. Mr AA had called Mrs C Moon's father before he called the Police. Mr AA openly admitted that he had killed his wife stating that they were arguing about Mr AA's belief that she was having an affair with someone at work. Police arrested Mr AA and he was subsequently charged with murder.

1.1.4 **Post mortem:** A post mortem concluded that Mrs C Moon had multiple incised wounds, widely distributed to the back of the body, front of the body and both arms and one leg which suggested a dynamic interaction between the two people. It concluded that the cause of death was shock and haemorrhage as a result of stab wounds to the neck and chest.

1.1.5 **Criminal prosecution:** Mr AA was convicted of murder in July 2014 with a sentence of 22 years. Mr AA's defence centred on manslaughter which was rejected by the jury. Mr AA sought an appeal which was denied.

1.1.6 The Panel would like to express its sympathy to the family of Mrs C Moon for their loss and to thank them for their contributions and support for this process.

The review process

1.2.1 These circumstances led to the commencement of this domestic homicide review (DHR) at the instigation of the London Borough of Ealing Community Safety Partnership. The initial meeting was held on the 23rd May 2014 to consider the circumstances leading up to this death.

1.2.2 The DHR was established under Section 9(3), Domestic Violence, Crime and Victims Act 2004 and was conducted in accordance with Home Office revised guidance.

1.2.3 The purpose of these reviews is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply those lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.2.4 This review process does not take the place of the criminal or coroners courts, nor does it take the form of a disciplinary process.

Terms of Reference

1.3.1 The purpose of this review is to establish how well the agencies worked both independently and together and to examine what lessons can be learnt for the future.

1.3.2 The Terms of Reference looked at the time from the point of marriage between Mr AA and Mrs C Moon and prior to the birth of their daughter.

1.3.3 Throughout this report, the term 'domestic abuse' is used to identify incidents or a pattern of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional), between adults who are or have been intimate partners or family members.

Panel membership

1.4.1 Panel membership consisted of:

- Ealing Safer Communities Team
- Metropolitan Police Critical Incident Advisory Team
- Metropolitan Police, Ealing
- Rise Drug and Alcohol Service
- NHS Ealing Clinical Commissioning Group
- Victim Support
- Ealing Council Children's Social Care
- Ealing Hospital NHS Trust (now London North West Healthcare NHS Trust)
- Ealing Council Pupil Access and Welfare
- Ealing Council Drug and Alcohol Strategy

- London Probation Trust
- NHS England

Independence

1.5.1 The Independent Chair of the DHR is Nicole Jacobs, CEO of Standing Together Against Domestic Violence, an organisation dedicated to developing and delivering a coordinated response to domestic abuse through multi-agency partnerships. She has conducted domestic abuse partnership reviews for the Home Office as part of the Standing Together team that created the Home Office guidance on DV partnerships, 'In Search of Excellence'. She has worked in the field of domestic abuse intervention for 20 years. She has no connection with Ealing Council or any of the agencies involved in this case. Standing Together currently employs the Ealing MARAC Coordinator. In this case, there were no MARAC referrals.

Methodology

1.6.1 Mrs C Moon was born overseas and knew Mr AA as a child. She grew up in the UK and married Mr AA overseas in 2002 and returned to the UK on her own. After following immigrations processes, Mr. AA joined his wife in the UK in 2004. They lived in Greenford, then with Mrs C Moon's father for two years and ultimately in Ealing where the homicide took place.

1.6.2 Initial enquiries were made with a request for a 'Summary of Involvement' (SOI) from a wide range of agencies.

1.6.3 Based on the response from the SOI, Individual Management Reviews (IMRs) were requested from those organisations and agencies that had contact with any member of the family. It was also considered helpful to involve those agencies that could have had a bearing on the circumstances of this case, even if they had not been previously aware of the individuals involved. This would include those agencies that, if the response to this type of incident were completely effective, would have had some contact with either party.

1.6.4 It is worth noting that the daughter of Mr AA and Mrs C Moon was registered in a different GP practice and therefore two IMRs were sought from two different GP practices.

1.6.5 IMRs were provided by:

- Metropolitan Police
- Gifford Primary School
- Ealing Community Services, Ealing Hospital NHS Trust
- Ealing Hospital Acute Maternity Services
- Greenford Road Medical Centre

- Goodcare Practice, Grand Union Village Health Centre
- Ealing Council Children's Social Care

1.6.6 Additional information was sought from the employer of Mrs C Moon and Mr AA as well as their freeholder, Genesis Housing.

1.6.7 The Panel would like to thank everyone who contributed their time and expertise to this review.

1.6.8 The trial of Mr AA began in July 2013, seven months after the homicide in December and four months after the DHR commenced. This required a pause in panel meetings until after the trail was finished and an initial application for appeal was sought and denied. The Panel waited for the trial to complete so that those interviewed for this process would have discharged their responsibilities as witnesses. After a respectful time, the Chair contacted family members to seek further input and involvement in this review. Further time was required to ensure that the family had time to review the finding and full overview report.

1.6.9 The IMRs were undertaken by agency members not directly involved with the perpetrator, victim or family members and who did not have line responsibility for those who did.

Contact with family and friends

1.7.1 Contact with family and friends are of the utmost importance to the Chair and the panel members. It was clear from the first panel meeting that there was little involvement from services and that to adequately learn lessons from this tragedy, the input and views of family members would be essential.

1.7.2 The Family Liaison Officer (FLO) passed the Chair's letter explaining the purpose of the DHR and the Home Office and AAFDA leaflet to the father of Mrs C Moon. He represented his other three adult daughters and was actively involved at the trial, attending every day and actively speaking with Police Officers. Mrs C Moon came from a very close-knit family who are keen to support this review but who are also focused on Mrs C Moon's right to privacy. Subsequently, the father of Mrs C Moon met with the Chair three times over the course of 2015/16.

1.7.3 The family was invited and did comment on the final report before it was published.

1.7.4 The family have requested this report does not highlight their country of origin as there have been local press reports there related to this homicide.

1.7.5 The family have selected the pseudonyms used in this report.

1.7.6 Contact with the perpetrator has been sought but no response has been received at the time of this report. The prison service has confirmed receipt of letters and information from the Chair to Mr AA. Contact will be attempted again before the final report is published.

Equalities

1.8.1 The panel has considered the protected characteristics as defined by the Equality Act 2010 – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. The panel did not feel that these issues had a material bearing on the circumstance of this case or the subsequent review. Mr AA and Mrs C Moon were born overseas. It is possible that understanding of and trust in statutory services would have been influenced by their country of origin but Mr AA had lived in the UK for just under 10 years at the time of the homicide and Mrs C Moon had lived in the UK since childhood. They were both employed and integrated into UK society in many ways.

KEY ISSUES ARISING FROM THE REVIEW

2.1.1 Mrs C Moon had known Mr AA since childhood and spent many years committed to settling into married life with him in the UK. Her family reported that she stopped her university studies to earn money so that she could show financial stability to support his entry to the UK.

2.1.2 The first documented incident related to domestic abuse was a call to the Police in 2005 when Mrs C Moon was heavily pregnant with their daughter. This was not disclosed to the wider family and formal allegations were not made.

2.1.3 It appears that Mr AA's traditional views regarding what Mrs C Moon was and was not able to do as his wife were well known to her wider family. He was known to be jealous from early in the marriage. Her sisters and brother-in-law described situations in 2007 and 2008 when Mr AA would get jealous if any other man showed attention towards Mrs C Moon when they were out. However Mrs C Moon did not disclose and the wider family were not fully aware of the risk Mr AA posed to her or of a pattern of physical violence prior to her disclosure to them of a serious incident with a knife in July 2013 which was not reported to the Police.

2.1.4 There was an escalation of jealous and controlling behaviour and physical violence to Mrs C Moon in the year and a half before the homicide. This began with disclosures to Mrs C Moon's father, GG, that Mr AA was monitoring Mrs C Moon's use of social media in June 2012. Five months later there were disclosures by Miss M at her school. Several months later in April 2013, Mrs C Moon's sister reported seeing bruising to Mrs C Moon's neck. Three months later, Mrs C Moon disclosed to her father and sister that she had been threatened with a knife by Mr. AA. Another four months later she disclosed to her sister about Mr AA's monitoring of her phone and, again, her sister saw bruises to her neck. During this time Mr AA discussed his jealousy with his brother-in-law and threatened violence to Mrs C Moon's co-worker as well as to Mrs C Moon.

2.1.5 Amidst this escalation there was a key intervention by Gifford Primary School and Ealing Council Children's Social Care which, by the account of her father, terrified Mrs C Moon that she would potentially lose her daughter.

2.1.6 In the context of a time that Mrs C Moon felt she could not speak about her concerns of abuse to statutory agencies or services for fear of losing her daughter, the violence and controlling behaviour escalated. It is reasonable to think that Mrs C Moon would have thought that seeking any formal help via any service or professional outside of the family could well have resulted in further assessment by Ealing Council Children's Social Care. Considering the description by the school, work colleagues and her own family that she was private regarding her home life, Mrs C Moon may well have felt she had no viable options for support.

2.1.7 There was a lack of sharing of information and joined up working between the School, Community Health Services and Ealing Council Children's Social Care at the time of the disclosure by Miss M in November 2012. This led to missed opportunities to offer support to Mrs C Moon and Miss M and to help establish confidence in these systems that they would be there to help Mrs C Moon and her daughter.

Who might have helped?

2.1.8 Anyone and everyone can help another identify that they are suffering abuse and assist them. Friends, family, employers and professionals need to be able identify signs of abuse, be confident to 'ask the question', and respond sensitively and effectively. To do this, family and friends need to understand domestic abuse and where to go for help and information. Employers and professionals need training and information. All need to understand how domestic abuse might present itself, the dynamics of abuse that make it hard for victims to identify what is happening and act to protect themselves, and to understand how perpetrators often present themselves, and then how to respond (referral and support). The link to specialist support can come from family and friends, employers, statutory agencies and health professionals. Below we review the engagement of family, employers and health professionals.

The importance of family.

2.1.9 Over the course of Mrs C Moon's relationship with Mr AA, the family were involved and often socialised with the family. They were aware of early jealousy but had increasing concerns in the year and a half prior to the homicide. Mrs C Moon's family encouraged her to seek help from the Police at various times. They also confronted and spoke to Mr AA about some of his behaviour. As such, they were a support to Mrs C Moon.

2.1.10 There were times when the family debated if they should contact the police on Mrs C Moon's behalf but they took the practical approach that she would have to substantiate the allegations and left the decision to her. It would have been clear to Mrs C Moon that they would have supported her.

2.1.11 The family agreed with Mrs C Moon's fears about Ealing Council Children's Social Care. They shared her view that Miss M could well have been taken from the

family due to concerns reported to her school in late 2012. This would have reinforced Mrs C Moon's judgement about the overall situation.

2.1.12 In this case, Mrs C Moon's family and Mrs C Moon herself might have benefitted from public information that described the different types of abuse and that abuse tends to get worse without an intervention of some type. We do not know what information Mrs C Moon had access to or whether she knew about specialist services related to domestic abuse and their independence from statutory services.

The importance of employers to understand domestic abuse

2.1.13 There is no indication that Mrs C Moon disclosed the abuse she was suffering to her work. There may have been private, informal conversations about Mr AA's jealously regarding who she was speaking to at work or her use of social media but it was not at a level at which co-workers would have sought to intervene formally or seek help from management.

2.1.14 Work was likely a source of independence and individuality that Mrs C Moon highly valued. As such she was a well-liked and reliable employee who performed well.

2.1.15 The workplace can be a source of support and an opportunity to find or explore possible sources of support. However, victims are often concerned to disclose or seek support from work for fear of repercussions.

The need for support from GP services

2.1.16 Neither GP surgery had contact with Mrs C Moon or other members of the family that raised concerns regarding domestic abuse. Therefore there are no recommendations arising for GP services from this review. However, it is noted that there were opportunities for services, specifically Children's Social Care (CSC) to communicate directly with GP services when child protection concerns were being investigated, both during pregnancy and in 2012.

2.1.17 Key learning for General Practice from other cases and DHRs remains relevant in this case. It is important that GPs and General Practice staff have and then maintain the competencies, training, knowledge and skill at the levels described in the RCPCH – Safeguarding children and young people: roles and competences for health care staff -Intercollegiate Document (Third edition: March 2014).

2.1.18 Understanding the potential impact of domestic violence is a core competency requirement for all safeguarding training levels detailed in the Intercollegiate Document.

2.1.19 Safeguarding training requirements are broader than safeguarding children. Awareness, training and resulting competencies are required to encompass areas such as vulnerable adults, domestic violence, learning disability, disabled children and working with families who are difficult to engage.

2.1.20 Having a working knowledge and understanding of local arrangements, resources and DV assessment tools is also recognised as being an important element in GP services effectively engaging with multi agency working. Maximising the opportunities for those suffering abuse to disclose and get help.

Responses to disclosure of abuse to Police

2.1.21 There was one disclosure to Police in 2005 when Mrs C Moon was heavily pregnant. When the police arrived Mrs C Moon did not make an allegation and Mr AA appeared asleep. The Police referred to Ealing Council Children's Social Care and also the Police Community Safety Unit reviewed the case and contacted both parties. A DV flag was also made for their address. This early and partial disclosure was dealt with well.

Response from Ealing Community Services – Ealing Hospital NHS Trust as part of London North West Healthcare NHS Trust

2.1.22 There was some lapse in health visitation in Miss M's early years. The current plan for follow-up which has been started in some quadrants is that parents will be invited to clinic (by appointment in some quadrants) when the baby is 4 weeks, 8-12 weeks, 3-4 months, 6-8 months, 1 year and 2 ½ years. This will be part of the new policy which is being developed at present and will include a plan for follow-up by the health visiting team if the parents do not attend.

2.1.23 In line with the Healthy Child Programme (HCP) Ealing Integrated Care Organisation NHS Trust will be introducing standard contacts to all children by the health visitor at 9 ½ months and 2 ½ years. This is still in the development stage.

2.1.24 In November 2012, when Miss M disclosed abuse at school, good professional practice would expect that the school nurse would have contacted the social worker to discuss the outcome of the social worker's assessment and to find out what future plan the social worker had for the family. This would have enabled the school nurse to decide on her own plan for further follow-up.

2.1.25 The documentation in RIO for follow-up is ambiguous and does not state clearly what the plan was. The statement below recorded in the RIO records indicates that there was no clear plan of action by the school nurse.

2.1.26 The record documented by the school nurse should have given a clear history of which parent Miss M had alleged to have hit her. 'Your records should be accurate and recorded in such a way that the meaning is clear.' (Nursing and Midwifery Council, Record Keeping Guidance for Nurses and Midwives 2009).

2.1.27 The record did not give a clear plan of action about how the school nurse would follow-up once the information was received by the social worker. The plan should have included:

- A planned liaison with the social worker.
- A planned liaison with the school teacher or lead for safeguarding in school.
- A plan to offer a health assessment in school with the mother present.

2.1.28 health assessment with the mother would have given the school nurse the opportunity to discuss any issues at home and to explore any domestic violence or abuse going on at home.

2.1.29 The liaison with the social worker and school and the health assessment would have enabled the school nurse to find out whether the father was living at home at

the time. It would also give the opportunity to find out the details of the father to link to the child and mother under the family management in RIO.

2.1.30 A health assessment would also have given the school nurse the chance to listen and include 'the voice of the child' in her assessment.

2.1.31 Research shows that another risk factor linked to domestic violence and abuse is that there may be a history of behaviour problems or unexplained injuries in children (How to Deal with and Recognise Patients Who Are Victims of D.V., Domestic Violence London 2014). A health assessment would have provided an opportunity to explore this.

2.1.32 The RIO alert system enables users to see immediately when accessing the RIO record that there is an area of concern for the client. Once the school nurse had been informed that Miss M had disclosed physical abuse an alert should have been placed on the record of the child and the parents.

2.1.33 Good record keeping practice would have included writing the liaison with the social worker onto the mother's records. It appears that the mother was put on the RIO system after she had died and that the family members were linked by the Specialist Health Visitor in the Multi-Agency Safeguarding Hub at that time

2.1.34 There is clear guidance relating to multi-agency and targeted support in the universal partnership plus offer. It states, "to work in partnership with partner agencies in the provision of intensive and multi-agency targeted packages of support where additional health needs are identified" (Department of Health 2014 and in Maximising the school nursing team contribution to the public health of school-aged children: Guidance to support the commissioning of public health provision for school aged children 5-19).

2.1.35 Placing the family in the universal partnership plus caseload would indicate that the family were receiving multi-agency on-going work/support by the school nurse. This case may then have been highlighted to bring to safeguarding supervision by the school nurse of safeguarding supervisor. There is no evidence that this family were brought to supervision by the school nurse.

2.1.36 Safeguarding Training is provided by Ealing Hospital NHS Trust as required by the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document 2014. Level 3 training for the School Nurse was appropriately up to date for level 3 at the time of the liaison with the social worker in 2012.

2.1.37 The safeguarding policy in place at the time of the liaison with the social worker was the Ealing Hospital NHS Trust ICO (Integrated Care Organisation) Safeguarding Children Policy and Procedures, 2011

Primary School

2.1.38 The school's referral to social care on 13th November 2012 was appropriate as there was a risk of significant harm. The matter was also correctly recorded in a pupil child protection file. There was no mention in Leyla's disclosure, or school's perception of the family that indicated actual or suspected domestic violence.

2.1.39 The DfE and Pan London child protection referral procedures were followed by school.

2.1.40 There is some discrepancy in recording between the school and Ealing Council Children's Social Care as to whether it was the school administrator or the school's Safeguarding lead who made the referral. There seemed to be a lack of curiosity with the Safeguarding lead as to what was happening with the assessment of Miss M's situation. For example there is no indication that enquiries were made regarding the referral made from the school.

2.1.41 Ealing Council Children's Social Care should have let the school know the response and outcome of the referral. There also seems to have been a long

delay in social care acting on the referral with the full assessment not taking place for three months.

2.1.42 Replying to referrers is expected within existing child protection guidance and procedures. The feedback from Ealing Council Children's Social Care would have indicated that there was no further social care involvement and school had no further incidents or concerns to suggest a need to challenge that decision.

Ealing Council Children's Social Care

2.1.43 There was not a sharing of information about the non-crime domestic incident in the 8th month of pregnancy to the midwifery team from Ealing Council Children's Social Care.

2.1.44 As the referral did not include any disclosure or alleged offences it may be reasonably argued that this was an appropriate response. It may be hypothesised that contact with the victim may have provided an opportunity to explore whether or not there was on-going domestic abuse. This would have required the agreement of Mrs C Moon as the assessment of the manager was that the statutory threshold for intervention was not met.

2.1.45 At that time the London Child Protection Procedures 2003, 2nd Edition was in place. In addition to Working Together to Safeguard Children1999, this provided the guidance on practice for all London Boroughs.

2.1.46 In terms of the assessment made as a result of Miss M's disclosure at school in November 2012, the assessment did not sufficiently address the concerns and because of the time lapse it is unlikely that the concerns would be substantiated. There was insufficient rigour and challenge to the parents about the detail of Miss M's allegation – the position of the parents was taken at face value; physical punishment and the meaning of Miss M's stomach aches was not explored. Neither parent was seen alone which may have been indicated as the allegations related to both of them. Family members were not involved in the assessment process. The assessment is completed based upon the screening enquires in ECIRS and one home visit. It may be argued that had a section 47 child protection been undertaken there would have been more opportunity to make enquiries without parental consent. Outside of an s47 enquiry the parents would have been able to refuse permission to speak to the GP or any family members. The challenge here is that procedural guidance at that time did not indicate that the s47 threshold was met (section 6.4.4 LCPP 4th edition 2011).

2.1.47 Given the age and developmental stage of Miss M, it would be unrealistic to have expected her to substantiate the allegations made nearly 3 months earlier. It could be speculated that the allegations were discussed with her by one or both parents in the intervening period which could have effectively prevented Miss M from speaking openly. Records do not indicate that Miss M was asked about why she did not want to be at school, why she had stomach aches, or the allegations of physical abuse.

2.1.48 The Ealing Council Children's Social Care had recently re-organised into ECIRS and six locality teams in July 2012. There was a period of adjustment to new roles and processes being imbedded. Referrals and contacts increased at that time as did the number of s47 enquiries and children subject to Child Protection Plans. In addition, the service had recently implemented the single assessment process (CFA) which replaced the Initial and Core Assessments.

2.1.49 At the time of the assessment, Northolt Locality Team were under significant pressure; caseloads were high and there was work being undertaken by the Senior Manager responsible for the locality service to address he timeliness and quality of response within the team, particularly in relation to child protection referrals.

2.1.50 Since then the quality of CFAs has improved significantly and all are completed within the required 45 working days. There is a new management team in place with strong leadership. Additional management capacity within frontline locality teams has been enhanced to ensure timely decision-making and supervision.

2.1.51 ESCB and West London Alliance (WLA) training on domestic abuse has been revised and updated since 2012. A new course focussing on the impact of domestic abuse upon children has been delivered by ESCB. The ESCB training makes specific reference to physical symptoms in children that may be manifestations of anxiety such as stomach and headaches as this is a noted feature. WLA provides specialist training to social workers who seek to focus on a particular area of child protection.

2.1.52 Recent developments in practice at Ealing Council Children's Social Care include:

- Co-located service in Ealing with Domestic Violence Intervention Project (DVIP) support and consultations to social workers in working with perpetrators, weekly Violence Prevention Programme (VPP) and women's support worker for partners or ex-partners of men on VPP.
- VAWG strategy in development commissioned by Safer Ealing Partnership.
- Establishment of VAWG strategic group.
- MARAC now independently co-ordinated by Standing Together against Domestic Violence.
- Use of Barnyards DV Matrix training delivered to all CSC staff in 2011/12.
- Training on domestic violence for schools programme developed and delivered by Health Improvement Team since 2012.
- ESCB training programme includes; Domestic Violence as a Serious Child Protection Issue, Domestic Violence; the impact upon children and MARAC training. These are open to all agencies.
- Domestic Violence & Relationship Abuse Project (DVRAP) pilot delivered and managed by Victim Support.

Recording and transmission of information between professionals

2.1.53 The learning from this DHR was that while each of the statutory actors worked within their guidance and carried out their responsibilities, there was little proactive communication between the school, Ealing Council Children's Social Care and Ealing Community Services. There was little curiosity about how the assessment process was progressing and the possibility that Mrs C Moon was suffering domestic abuse and whether or not she should be offered support or, at a minimum, be informed of the existence of specialist services.

Good Practice

2.1.54 Much of the good practice in this report reflects what would be expected of professionals involved presented with such circumstances.

2.1.55 Early interaction with the Police was proactive and despite the fact that Mrs C Moon did not wish to make a formal allegation, the fact that the Police referred to Ealing Council Children's Social Care and there was a follow-up by the Community Safety Unit and a domestic violence flag put on the address is good practice.

2.1.56 The school was also proactive by taking Mr AA's comments seriously and by following policy regarding safeguarding referrals.

CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

3.1.1 Every professional that Mrs C Moon saw had the opportunity to ask her about his home life and the abuse that she suffered. In a coordinated community response (CCR), all parties are aware of domestic abuse and its dynamics. They know the indicators of abuse and the risk factors, their role in the coordinated effort and how to act to help victims. The CCR closes the gaps between services. The professionals who dealt with members of this family each did their specific job, but without an understanding of their role in the coordinated community response to domestic abuse. The care pathways to help and without a broader understanding of their response to screen for domestic violence and address barriers to seeking help.

3.1.2 **Preventability-** Mrs C Moon's reluctance to talk about the abuse, possibly based on fear of the consequences, limited the opportunities to help. Such reluctance – which is common in victims of abuse – heightens the importance of the responses when disclosure were made. The only advice Mrs C Moon appears to have been given by her family was that she report to the police. Given the fact that she feared the involvement of Ealing Council Children's Social Care, she would not have been likely to seek help outside of the family. In these circumstances it is not clear that this homicide could have been prevented.

Recommendation 1: The Community Safety Partnership via the VAWG Strategic Group launch publicity and awareness-raising for family, friends and victims or make use of national campaigns and efforts to raise awareness in the community.

- Providing information about where victims, family and friends can go for advice and to talk about their options and
- Address the role of Children's Social Care to support non-abusing parents

Recommendation 2: The Community Safety Partnership via the VAWG Strategic Group provide guidance and support for employers and unions to develop employment policies that address domestic abuse, ensuring that

employees are asked about domestic abuse and supported to address this before instigating disciplinary actions.

Recommendation 3: LNWHT should be assured if professionals undertaking a new birth visit ask routine and follow-up questions around domestic abuse. Evidence of risk assessment and any required support details.

Recommendation 4: All staff at LNWHT are trained to use the new assessment tool for domestic abuse.

Recommendation 5: LNWHT should ensure their DV policy is in line with NICE guidance and refers to creating an environment for disclosing DV and abuse. Consider IDVA for acute settings.

Recommendation 6: LNWHT should be assured around school nurses and health visiting Record keeping skills.

Recommendation 7: LNWHT should ensure safeguarding children level 3 training is inclusive of DV and recommendation from this DHR.

Recommendation 8: LNWHT should review of internal processes for creating alerts on electronic records in relation to domestic abuse.

Recommendation 9: The Community Safety Partnership via the VAWG Strategic Group to provide support for Safeguarding leads within Ealing schools on The DffE and Pan London child protection referral procedures and best practice related to domestic abuse.

Recommendation 10: The LSCB ensure that training to be delivered for school safeguarding leads which include equipping schools with the knowledge/skills to understand the risks associated with domestic abuse contained in the CAADA Dash and Barnados DV Tools. This may be part of the LSCB training programme but it should be documented that all school Safeguarding leads have undertaken the LSCB module on domestic abuse.

Recommendation 11: The Community Safety Partnership undertake audits and quality assurance measures to ascertain if recommendations from this DHR have been embedded in practice.

Recommendation 12: Ealing Council Children's Social Care produce good practice in domestic abuse guidance for social care staff. Development of training for social work managers on risk management and decision making in domestic abuse cases.