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EALING COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Mrs C Moon

December 2013

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Associate Standing Together Against Domestic Violence

Date completed: May 2016

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Introduction

Outline of the incident

1.1 In 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.

1.2 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.

1.3 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.

1.4 **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 was concluded that the cause of death was shock and haemorrhage as a result of stab wounds to the neck and chest.

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.

1.6 The Review 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

1.7 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.

1.8 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.

1.9 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 abuse victims and their children through improved intra and inter-agency working.

1.10 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

1.11 The full Terms of Reference are included in **Annex 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.

1.12 This DHR was conducted in Ealing, so 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.

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

Panel membership

1.14 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

1.15 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 17 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

1.16 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 2004. They then returned to the UK. They lived in Greenford, then with Mrs C Moon's father for two years and ultimately in Ealing where the homicide took place.

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

1.18 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.

1.19 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.

1.20 IMRs were provided by:

- Metropolitan Police
- Green End 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

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

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

1.23 The trial of Mr AA began in July, 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.

1.24 Other delays to the completion of this DHR were caused by correspondence to the perpetrator via the prison, ensuring the family had sufficient time to participate in the DHR and that all panel members had signed off recommendations in the report post the final panel meeting.

1.25 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

1.26 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.

1.27 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 in March 2015, June 2015 and July 2015. He demonstrated to the Chair that he spoke to all his daughters and he also saw his granddaughter on a regular basis. In between meetings with the Chair, he would speak to them and forward their comments to the Chair.

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

1.29 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.

1.30 The family have selected the pseudonyms used in this report. Pseudonym has also been provided for the primary school of Miss M.

1.31 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

1.32 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 society in many ways.

The Facts

The Death of Mrs C Moon

2.1 In December 2013, Mr AA called the police to attend his home that he shared with his wife Mrs C Moon and their daughter Miss M.

2.2 He reported that his wife, Mrs C Moon, was dead and disclosed that that there had been an argument which ended up with them fighting. He described his wife as bleeding from the chest and face.

2.3 The operator could hear someone else present which would turn out to be Mrs C Moon's father, GG.

2.4 Police and London Ambulance Service arrived at the address and the front door was opened by GG who directed them to the kitchen. He also directed them to Mr AA, standing nearby with blood stains on his feet and left hand and said, "It was him."

2.5 Mr AA said to officers, "I did it. I called you. I killed her." He was arrested for suspicion of attempted murder and subsequently for suspicion of murder. He made an unsolicited comment between cautions where he stated, "I killed her. She was getting text messages from men at work. We both work for (named place of employment). We argued and she went to the kitchen and picked up a knife and said she would kill herself so I took it and killed her."

2.6 GG had been called to the home by Mr AA prior to the police being called.

2.7 Miss M, eight years old at the time, was found sleeping in her room.

Background

Mr AA

2.8 Mr AA was born overseas and grew up in the same village as Mrs C Moon. Their families were friends. Mr AA married Mrs C Moon in 2002 and came to the UK at that time.

2.9 Mr AA was employed by the Royal Mail and worked as a postman in Wembley. He had a good employment record and there was nothing of note related to his conduct at work.

Mrs C Moon

2.10 Mrs C Moon was the oldest of four daughters of GG and his wife (deceased). GG moved to the UK in 1980 and worked as a successful professional. His family remained in their country of origin while the children were educated. They joined him in the UK in 2000.

2.11 Mrs C Moon remained in contact with Mr AA who she knew from childhood. When she returned to her county of origin in 2002 to visit an ailing family member, she married Mr AA.

The relationship between Mr AA and Mrs C Moon

2.12 Having married abroad in 2002, Mr AA entered the UK in 2004. Both Mr AA and Mrs C Moon gained work with the same employer, working in different locations, in different roles and with different schedules to each other.

2.13 In 2005, Mrs C Moon gave birth to their daughter, Miss M.

2.14 After living in a rented flat, then with Mrs C Moon's father GG for two years, Mr AA and Mrs C Moon obtained a mortgage for their flat in Ealing in 2007.

Information from Mrs C Moon's family

2.15 Mrs C Moon was deeply loved by her family and friends. Mrs C Moon's family described her as a hardworking, loving and a committed parent and family

member. In line with comments made from co-workers, Mrs C Moon is consistently described as both kind and private.

2.16 Mrs C Moon had married Mr AA in 2002 without the knowledge of her family. This did not cause a rift in the family but there was some dissatisfaction that their marriage had not been agreed or planned in line with tradition.

2.17 Mrs C Moon had worked hard to bring Mr AA to the UK in 2004. She was a committed spouse who showed determination to work out the logistics which would allow Mr AA to come to the UK in 2004, two years after their marriage.

2.18 Family members described Mr AA as having traditional views of marriage and the role of women within marriage. They described him as demanding and not wanting his wife to "be free."

2.19 Incidents of domestic abuse perpetrated on Mrs C Moon were known within the family but they were also limited. There are few specific incidents known.

2.20 In July 2013, Mrs C Moon called her father to say that Mr AA had held a knife to her neck and said, "I can slaughter you if I want." At the time, they lived opposite a police station and GG encouraged his daughter to go to the police. Mrs C Moon also rang her sister who advised the same. Mrs C Moon did not report the incident to the police. When family members visited the couple, they appeared reconciled. They felt Mrs C Moon would have worried about harm to Mr AA or putting him in a difficult situation.

2.21 The incident in July 2013 was the first-time family members were aware of physical abuse. They knew of disagreements within the relationship prior to this time but did not have any overriding concerns. For example, GG described no problems related to domestic abuse occurring during the two years the couple lived with him.

2.22 The family often socialised at the home of Mr AA and Mrs C Moon and felt they had an open communication with Mrs C Moon about her day to day life.

2.23 In retrospect, the family remember some complaints from Miss M, the daughter of Mr AA and Mrs C Moon, who disclosed feeling frightened or describing her mother as upset and crying at home.

2.24 Family members stressed the overarching belief within the wider family to keep "problems" to yourself. GG is quoted as saying – "the more I know about you, the worse it is for me." This appears to be the same belief that Mrs C Moon took when considering whether to discuss the violence in her marriage with others and certainly professionals.

2.25 In November 2012, a disclosure was made by Miss M at school which resulted in an assessment by Ealing Council Children's Social Care. Mrs C Moon described the situation to her father GG at the time. He described her as "furious" and extremely concerned that Miss M would be taken into care by Children's Services.

2.26 This intervention by Ealing Council Children's Social Care was discussed in some depth with the family who were clear that Mrs C Moon regarded the intervention as threatening; not necessarily because threats were made but because of her and her family's perception of how quickly the state would act if Miss M was thought to be unhappy or in an unsafe environment.

2.27 Brief instances with the police, the school and Ealing Council Children's Social Care reinforced the characterisation by the family that disclosure of domestic abuse would have caused more difficulties than improvements in Mrs C Moon's overall situation.

2.28 Mrs C Moon was popular at work. Although described as private, she was kind and well-liked. After her death, colleagues contributed a substantial amount for her funeral. They also attended a first memorial of her death.

2.29 Not all family members felt that Mrs C Moon was planning to separate from Mr AA at the time of the homicide. They perceived her to be unhappy but not planning to leave the relationship. She disclosed to her sister a few weeks prior to the homicide that she would like to leave due to Mr AA's excessive jealousy and surveillance about who she was communicating with over the phone.

Police

2.30 The only recorded incident between Mr AA and Mrs C Moon occurred in February 2005, in the year after Mr AA moved to the UK and three years after their marriage abroad in 2002. At the time of the incident, Mrs C Moon was 8 months pregnant with her daughter. Police recorded that the couple had an argument over household chores but when they arrived 31 minutes after the initial call, Mr AA was in bed asleep and no allegations were alleged or disclosed. Advice was given to both parties.

2.31 The incident was referred to Ealing Council Children's Social Care (reference number provided) in relation to the unborn child and an intelligence report was generated.

2.32 The incident was referred to the Community Safety Unit who contacted both parties independently to ascertain if further assistance was required, however no such help was requested. The report was correctly flagged with a "DV marker."

2.33 There were no other incidents reported to the police involving domestic abuse.

Ealing Community Services – Ealing Hospital NHS Trust

Context of Ealing Community Services

2.34 The Health Visiting Service is a workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family's future health and wellbeing. This service is led by health visitors and supported by a mixed skills team (National Health Visiting Specification 2014).

2.35 School nurses, with their teams, co-ordinate and deliver public health interventions for school-aged children. The nature of their work requires clinical input and effective leadership, which qualified school nurses are equipped to provide (Department of Health, 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).

Contact with Mr AA and Mrs C Moon

2.36 There is no record of information given to Ealing Community Services as a result of the police incident in the 8th month of Mrs C Moon's pregnancy.

2.37 The family were initially difficult to get in touch with to arrange the new birth contact after the birth of Miss M in 2005. The community midwife liaised with the health visitor and a new birth visit was completed when the baby was 15 days old.

2.38 The Ealing and Harrow Community Services New Birth Policy 2012 states that the new birth contact should be carried out within 10-14 days following the birth. If this was the case with the previous policy, then the new birth contact was outside the recommended timescale by a day.

2.39 The post-natal visit form completed by the health visitor indicates that domestic abuse was discussed as it is documented on the form that the answer was 'no.' The form used was a yes/no form and there were no follow-up questions if the mother had replied 'yes' when asked about domestic abuse.

2.40 Miss M attended child health clinic 5 times in the first year and then again at 17 months.

2.41 The records show that feeding and weight were the issues discussed as well as cradle cap. There is one entry which states 'strong personality – active toddler' but no elaboration or follow-up.

2.42 There is no evidence in the records that any developmental reviews at 8-9 months or 2-2 ½ years were carried out or offered. This is likely to have been due to staff capacity issues at the time. These contacts would have provided an opportunity for the health visitor to ask about any concerns or if there was any domestic abuse.

2.43 On 19th November 2012, the school nurse received a call from the social worker at Ealing Children's Integrated Response Service regarding a school health update.

2.44 Miss M had made a disclosure to a school teacher at Green End Primary School that she had been hit at home by a parent. The social worker was undertaking an assessment and would contact the school nurse if further input was required.

2.45 There is no evidence in the records that the school nurse and the social worker contacted each other again to discuss the outcome of the social worker's assessment.

2.46 It is not documented which parent had hit Miss M.

2.47 There is no documented evidence that the school nurse followed this up with the family by offering a health assessment or liaising in school.

2.48 An alert was not put on the child or mother's record following the information received by the social worker in 2012.

2.49 There is nothing documented on the mother's records of the liaison by the social worker.

2.50 The child was not placed in the Universal Partnership Plus caseload following the liaison from the social worker.

GP 1: Greenford Road Medical Centre

2.51 In 2005, all members of the family, Mr AA, Mrs C Moon and Miss M were registered at Greenford Medical Centre.

2.52 In February 2012, Mr AA and Mrs C Moon registered at another GP practice called Goodcare. Miss M remained registered at Greenford Road Medical Centre despite her parents transferring to another practice.

2.53 Miss M's medical appointments were related to usual expected childhood minor ailments, vaccinations and travel advice.

2.54 Miss M was not seen by the GP since February 2012 through to the date of the submission of the Internal Management Review (IMR) from the GP.

GP 2: Goodcare Practice

2.55 All three family members registered with this practice from 28th February 2012, when both Mr AA and Mrs C Moon were seen by the GP. Miss M was registered at this practice but not seen there for another three months in May 2012. It appears that she was registered at both Goodcare Practice and Greenford Road Medical Centre. However, she was only seen at Goodcare Practice from May 2012 which is in keeping with the transfer and practice of her parents.

2.56 All family members have had relatively minimal contact with the GP services at Goodcare Practice since early 2012 and appointments relate to minor illnesses, blood tests and foreign travel advice.

2.57 There were no disclosures of domestic abuse and nothing noted in medical files that would have indicated proactive screening by the GP.

Ealing Council Children's Social Care

Context of Ealing Council Children's Social Care

2.58 Ealing Council Children's Social Care provides a social work service to families and children. It comprises of a first point of contact called Ealing Children's Integrated Response Service (ECIRS), which responds to all new contacts and referrals regarding children under 18 years. Within ECIRS, there is a Multi-Agency Safeguarding Hub (MASH) staffed by CSC, police and health. Six locality social work teams provide a direct social work service to children in need including those in need of protection. The locality teams undertake assessment and child protection enquiries as does the specialist hospital team based in Ealing Hospital and the Children with Disabilities team which is part of an

integrated service for children with additional needs. There are also specialist teams for looked after children, children subject to court proceedings, unaccompanied minors, care leavers and fostering/adoption.

2.59 Early help is provided by Supportive Action Families in Ealing (SAFE) and the Children's Centres.

2.60 On 26th February 2005, the police notified CSC that unborn Miss M had come to their attention. The referral was a formal notification then referred to as a 'Form 78.' This is now known as a Police Merlin notification and is required to be forwarded to CSC for any child under 18 including unborn babies who come to police.

2.61 This notification was received by the Referral and Assessment Team based at the Greenford Office. The notification stated that no offences were reported or allegations made. The police had been called by Mrs C Moon in response to a verbal argument over household chores. A decision was taken by a manager in CSC that no further action should be taken. Practice at that time would have included checking any other records held by CSC to inform any response.

Referral to CSC in 2012

2.62 On 13th November 2012, a referral was made to the Emergency DutyTeam (out of hours service) by Green End Primary School concerning allegations made by Miss M that she was being physically harmed by her parents. Disclosure had come via a conversation Miss M was believed to have had with some older year 5 school pupils who then told a teacher.

2.63 The referral indicates that a member of school staff then spoke to Miss M who made a more detailed disclosure.

2.64 Miss M was spoken to in the presence of another staff member. She responded as follows; That she had ''a big stomach ache but that she didn't want to go to welfare as her Mum had said she had to stay in school and learn even if she did have a big stomach ache. The teacher then prompted about the year 5 pupils having spoken to her (without mention of what they had said) and Miss M repeated the concern about her stomach ache. The teacher asked if Dad could

help her remember. At that point Miss M got upset and said that Mum and Dad would get angry… they'd hit her with hands and a big stick on her arms, face, legs and privates. When asked if she had told anyone else at school Miss M said no because that would mean big trouble for her with Mum and Dad. Miss M asked if her parents would be told and she was informed that they would be spoken to but that she would be safe. Miss M's arms were checked but no marks seen. Miss M said this had last happened in September when they came back to school''.

2.65 The referral was made to CSC by a member of school administration staff as opposed to the designated teacher for safeguarding or another member of the senior leadership team which would be expected practice.

2.66 As the referral was sent outside of office hours it was not sent directly to ECIRS. EDT made a decision not to respond that evening but to pass the referral onto ECIRS the following morning. This decision was reached on the basis of the potential to increase the risk to Miss M by contacting the family in the evening when there are less protective mechanisms and services available.

2.67 The referral was accepted and responded to by ECIRS the following morning on 14th November 2012. It was allocated to a senior social worker who began the screening process by contacting the School Nurse on 19th November 2012. This was five days later.

2.68 The school nurse confirmed basic information including immunisation status and the GP surgery. The GP surgery does not appear to be included within the child's basic information on file. The senior social worker telephoned Mrs C Moon to discuss the referral and obtain her views. Mrs C Moon expressed surprise that Miss M had made an allegation stating that she "has never been hit and never needs to be as her behaviour is good''.

2.69 The Team Managers comments on 14th November 2012 on the electronic file (referred to as Framework) indicated that the referral was sent out by the Emergency Duty Team (i.e. after hours) as opposed to during office hours. The IMR author was unable to see how this had been followed up by ECIRS with the school. The referral was made by a member of school administration staff as

oppose to the Designated Teacher for safeguarding or another member of the senior management team which would be expected practice.

2.70 Mr AA contacted the senior social worker the following day to express his frustration about the referral believing that Green End School should have discussed this with him first. Generally, agencies are advised to seek consent and to inform those with parental responsibility that a referral is being made. The exception to this is where this will increase the risk to the child or in certain situations such as fabricated or induced illness or sexual abuse. Advice can be sought from ECIRS about disclosure as many agencies have anxiety about information sharing and consent issues. This would not have been possible in this case as the referral was made to EDT service and the referrer was not the designated teacher.

2.71 On 20th November 2012, the case was transferred by ECIRS to Northolt Locality Team as the threshold for an assessment had been met. A letter was generated to the referring agency confirming that an assessment would be undertaken as a result of the referral. This is referred to as an Enquiry Outcome letter.

2.72 The information contained within the referral details allegations of physical abuse. Miss M also talks of fear and anxiety about her parents' response. The referral is screened but not passed onto the Northolt Locality Team until 20th November 2012 which is a week after it was referred by Green End School.

2.73 Police were unaware of the details of the referral because it was not referred to the Locality for an S47 child protection enquiry but referred as Child in Need (CIN). The ECIRS Deputy Team Manager indicated that this may be revised when full contact was made with the child.

Northolt Locality Team Involvement

2.74 The first contact by the locality to begin the Child & Family Assessment (CFA) was on 21st January 2013. This was two months after the child's allegation of physical abuse. The child was seen alone and with her parents on 7th February 2013, nearly 3 months after the allegation was made.

2.75 Although ECIRS made screening enquiries with health, the social worker undertaking the CFA did not contact the GP, School Nurse or School.

2.76 Mrs C Moon and Mr AA's response to the concerns and allegation was that Miss M was making them up in order to be at home. They stated they had been firm with her about not pretending she had a stomach ache and believed that because the allegations originally came via other children her comments were taken out of context and misunderstood.

2.77 Mr AA stated that this had been discussed with school and appears to have been a misunderstanding. The social worker did not challenge Mrs C Moon and Mr AA with the details of the allegation that Miss M gave directly to an adult member of school staff as opposed to another pupil nor did the social worker seek to verify with the school Mr AA's account.

2.78 Miss M did not substantiate the allegations when spoken to but this has to be seen in the light of the time that had elapsed, her age and her being interviewed at home.

2.79 Although seen alone, Miss M would be aware that her parents were also being spoken to by the social worker. Observations of the family home were positive and Miss M was seen as a confident, outgoing child and no other concerns were identified.

2.80 The social worker does not refer to consent being discussed or a request to contact the GP being explored with the parents.

2.81 The social worker's report does not have sufficient multi-agency input to ensure it is comprehensive.

2.82 There is no record of updating health professionals (school nurse and GP) at its conclusion. It is unclear as to whether the GP was ever aware of the referral in 2012.

Green End Primary School – Miss M's School

2.83 Miss M started at Green End primary nursery in September 2009. She transferred to the reception class at Green End in September 2010.

2.84 Prior to 13th November 2012, there were no concerns regarding Miss M related to safeguarding. She was perceived to be a well-adjusted student with regular attendance. She was brought to school and picked up by one or the other of the parents and occasionally by an aunt.

2.85 Staff recall that they did not have any informal or unrecorded concerns. They had not heard anything unflattering about the family. Both parents are remembered as "pleasant and private people."

2.86 Miss M had good school attendance and did not have special education needs, behaviour difficulties or behaviours outside the normal range.

2.87 The school made a referral to Ealing Council Children's Social Care on 13th November 2012 when Miss M made a disclosure to her teacher that she was hit by her father. She went on to tell her teacher that mum and dad get angry with her and she was hit with a hand and a stick on the head and on the arms. She permitted staff to look at her arm but there was no sign of marks or injury.

2.88 The teacher reported the disclosure to the school's designated child protection teacher. She in turn referred the matter to Ealing Council Children's Social Care the same day.

2.89 On the same day, the designated teacher also contacted Mr AA to tell him about the referral. He came to school on 13th November 2012 and was initially cross that a referral had been made and that "the child was believed".

2.90 On 15th November 2012, following a minor telling-off at school, Miss M told her teacher that her mum would yell at her if she heard she was naughty and that her dad hit her with a stick when she was 3 or 4 years old. The school file does not indicate if this information was passed onto Ealing Council Children's Social Care. The file does show that the designated teacher asked the school

administrator to ring Ealing Council Children's Social Care on 15th November 2012 to see if there was any response to school's referral on 13th November 2012. However, the designated teacher at the time remembers passing the details on to Ealing Council Children's Social Care.

2.91 The school had no reply from Ealing Council Children's Social Care about the referral until 22nd January 2013 when social care asked for a school report on Miss M. Then, on 30th January 2013, the school had a letter from Ealing Council Children's Social Care saying that they were investigating the matter. There is no record at school of any further information or decisions being sent to school from Ealing Council Children's Social Care.

2.92 The School had no more concerns or incidents with the family until they learned of the homicide in late December 2013.

Post Office

2.93 Both Mr AA and Mrs C Moon had the same employer, although they worked on different teams and at different locations.

2.94 Both were perceived to be good employees who were reliable and well-liked by co-workers.

2.95 Much of the jealously demonstrated by Mr AA stemmed from his belief that Mrs C Moon was in contact with male co-workers via social media and at work.

2.96 No information given by co-workers at trial or to this Review Panel indicates that Mr AA's allegations were true. In fact, much of what was presented about Mrs C Moon by her colleagues depicted a friendly but private co-worker who did not disclose anything about her personal life at work.

Genesis Housing

2.97 Genesis Housing was the freeholder to the property owned by Mr AA and Mrs C Moon. They did not have any contact with Mr AA and Mrs C Moon, nor did they have any complaints from neighbours or residents about them.

Analysis

3.1 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.

3.2 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.

3.3 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.

3.4 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 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 being

threatened with a knife to her father and sister. 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.

3.5 Amidst this escalation there was a key intervention by Green End 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.

3.6 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.

3.7 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?

3.8 Anyone and everyone can help another identify that they are suffering abuse and assist them. Friends, family, employers and professionals need to be able to 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.

Family

3.9 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.

3.10 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.

3.11 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.

3.12 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.

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

Post Office

3.13 There is no indication that Mrs C Moon disclosed the abuse she was suffering at 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.

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

3.15 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.

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.

GP

3.16 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.

3.17 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).

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

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

3.20 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

Police

3.21 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.

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

3.22 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 a 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.

3.23 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.

3.24 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.

3.25 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.

3.26 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)

3.27 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.

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

3.29 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.

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

3.31 Research shows that another risk factor linked to domestic 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.

3.32 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.

3.33 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.

3.34 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).

3.35 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 or safeguarding supervisor. There is no evidence that this family were brought to supervision by the school nurse.

3.36 Safeguarding training is provided by Ealing Hospital NHS Trust as required by the Safeguarding Children and Young People: Roles and Competencies for Healthcare 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.

3.37 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.

Recommendations:

3. LNWHT should be assured professionals are undertaking a new birth visit and asking routine and follow-up questions around domestic abuse with evidence of risk assessment and any required support details.
4. All staff are trained to use the new assessment tool for domestic abuse.
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.
6. LNWHT should be assured around school nurses and health visiting record keeping skills.
7. LNWHT should ensure safeguarding children level 3 training is inclusive of domestic abuse and recommendations from this DHR.
8. LNWHT should review internal processes for creating alerts on electronic records in relation to domestic abuse.

Green End Primary School – Miss M's School

3.38 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 Miss M disclosure, or school's perception of the family that indicated actual or suspected domestic abuse.

3.39 The Department for Education and Pan-London child protection referral procedures were followed by the school.

3.40 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.

3.41 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.

3.42 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.

Recommendations:

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

10. 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.

11. To undertake an audit to ascertain if recommendations from this DHR have been embedded in practice.

Ealing Council Children's Social Care

3.43 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.

3.44 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.

3.45 At that time, the London Child Protection Procedures 2003, 2nd Edition was in place. In addition to Working Together to Safeguard Children 1999, this provided the guidance on practice for all London Boroughs.

3.46 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 (s47) 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).

3.47 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.

3.48 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.

3.49 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 the timeliness and quality of response within the team, particularly in relation to child protection referrals.

3.50 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.

3.51 Ealing Safeguarding Children Board (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.

3.52 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 Barnardo's DV Matrix training delivered to all CSC staff in 2011/12.
- Training on domestic abuse for school programmes 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.

Recommendations:

12. Ealing Council Children's Social Care produce good practice in domestic abuse guidance for social care staff.
13. Development of training for social work managers on risk management and decision making in domestic abuse cases.
14. To undertake audit to ascertain if recommendations from this DHR have been embedded in practice.

Recording and transmission of information between professionals

3.53 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

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

3.55 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 abuse flag put on the address is good practice.

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

Conclusions and Recommendations

4.1 Every professional that Mrs C Moon saw had the opportunity to ask her about her 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 CCR to domestic abuse and the care pathways to help, and without a broader understanding of their response to screen for domestic abuse and address barriers to seeking help.

Preventability

4.2 Mrs C Moon's reluctance to talk about the abuse, likely 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 are 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.

Summary of Recommendations

4.3 **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.

4.4 **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.

4.5 **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 should also be included.

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

4.7 **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.

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

4.9 **Recommendation 7:** LNWHT should ensure safeguarding children level 3 training is inclusive of domestic abuse and recommendations from this DHR.

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

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

4.12 **Recommendation 10:** The LSCB to ensure that training be delivered for school safeguarding leads and includes equipping schools with the knowledge/skills to understand the risks associated with domestic abuse contained in the CAADA Dash and Barnardo's 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.

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

4.14 **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.

Annex 1: Domestic Homicide Review Terms of Reference for Mrs C Moon

This Domestic Homicide Review is being completed to consider agency involvement with **Mrs C Moon**, her partner **Mr AA**, and their daughter **Miss M** following her death in December 2013. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose

1. Domestic Homicide Reviews (DHR) 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 Mrs C Moon and Mr AA during the relevant period of time: **01/01/2004 – her date of death.**
3. To summarise agency involvement prior to **01/01/2004**.

4. 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.

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

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

7. To commission a suitably experienced and independent person to:
   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.

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

9. On completion, present the full report to the Community Safety Partnership.

Membership

10. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Your agency representative must have knowledge of the matter, the influence to obtain material efficiently and can comment on the analysis of evidence and recommendations that emerge.

11. The following agencies are to be involved:
    a) Clinical Commissioning Groups (formerly known as Primary Care Trusts)
    b) General Practitioner for the victim and alleged perpetrator
    c) Local domestic violence specialist service provider e.g. IDVA
    d) Education services
    e) Children's services
    f) Adult services
    g) Health Authorities
    h) Substance misuse services
    i) Housing services
    j) Local Authority
    k) Local Mental Health Trust
    l) Police (Borough Commander or representative, Critical Incident Advisory Team officer, Family Liaison Officer and the Senior Investigating Officer)
    m) Prison Service
    n) Probation Service

o) Victim Support
p) Homicide case worker

12. Where the need for an independent expert arises, for example, a representative from a specialist BME women's organisation, the chair will liaise with and, if appropriate, ask the organisation to join the panel.

13. If there are other investigations or inquests into the death, the panel will agree to either:
    a) run the review in parallel to the other investigations, or
    b) conduct a coordinated or jointly commissioned review where a separate investigation will result in duplication of activities.

Collating evidence

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

15. Each agency must provide a chronology of their involvement with the **Mrs C Moon**, **Mr AA** and **Miss M** during the relevant time period.

16. Each agency must prepare an Individual Management Review (IMr), which:
    a) sets out the facts of their involvement with **Mrs C Moon**, **Mr AA** and/or **Miss M**;
    b) critically analyses the service they provided in line with the specific terms of reference;
    c) identifies any recommendations for practice or policy in relation to their agency, and
    d) considers issues of agency activity in other boroughs and reviews the impact in this specific case.

17. 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 **Mrs C Moon**, **Mr AA** or **Miss M** in contact with their agency.

Analysis of findings

18. In order to critically analyse the incident and the agencies' responses to the family, this review should specifically consider the following six points:
    a) Analyse the communication, procedures and discussions, which took place between agencies.
    b) Analyse the co-operation between different agencies involved with the victim, alleged perpetrator, and 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 training available to the agencies involved on domestic abuse issues.

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

19. Sensitively involve the family of **Mrs C Moon** in the review, if it is appropriate to do so in the context of on-going criminal proceedings. Also to explore the possibility of contact with any of the alleged perpetrator's family who may be able to add value to this process. The chair will lead on family engagement with the support of the senior investigating officer and the family liaison officer.

20. 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.

21. Coordinate with any other review process concerned with the child/ren of the victim and/or alleged perpetrator.

Development of an action plan

22. Establish a clear action plan for individual agency implementation as a consequence of any recommendations.

23. Establish a multi-agency action plan as a consequence of any issues arising out of the Overview Report.

Media handling

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

25. The CSP is responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

26. 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.

27. 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.

28. 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. Confidential information must not be sent through any other email system. Documents can be password protected.

Annex 2: Panel Agencies Represented

Organisation
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

Annex 3: Action Plan

The Panel is responsible for ensuring that all recommendations must be SMART (specific, measureable, achievable, realistic, time bound) and for the completion and implementation of the Action Plan.

The CSP will monitor the implementation and delivery of the Action Plan.

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
Theme 1 – Risk assessment					
LNWHT should be assured if professionals undertaking a new birth visit ask routine and follow up questions around DV. Evidence of risk assessment and any required support details. All staff are trained to use the new assessment tool	Review of LNWHT new birth policy should be standardised to include a health needs assessment tool to include routine questioning around DV, evidence of risk assessment and signposting for support services or MARAC/MASH referral.	Assistant Director of Professional standards. MS		December 2015	
Theme 2 – DV Policy					

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
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.	To review LNWHT DV policy to ensure it captures the importance of seeing victims alone. To ensure staff are aware of the policy.	Associate Director Safeguarding children LT	LNWHT DV policy in line with DV NICE recommendations. IDVA appointed and working from both A+E departments. Policy launch workshops attended by ECS.	December 2015	
Theme 3 – Record keeping					
LNWHT should be assured around school nurses and health visiting Record keeping skills.	School nurses and health must record on child and mother electronic records. Review record keeping in progress notes. When an alert should be added to flag universal or partnership plus caseload, ensure appropriate use of alerts and that they	MS	All teams are expected to undertake their own record keeping audit. Evidence of audit required.	January 2016	

Recommendation	Action to take	Lead	Key milestones achieved in enacting recommendation	Target Date	Date of completion and outcome
	are added correctly. Documentation should contain clear plan for follow up.				
Theme 4 – Safeguarding training					
LNWHT should ensure safeguarding children level 3 training is inclusive of DV and recommendation from this DHR.	Training must be inclusive of screening, asking questions, follow up questions risk assessment.	Chief Nurse	Level 3 training is inclusive of risk assessment, tools, appropriate questioning	November 2015	
Theme 5 – DV Alerts					
Review of internal processes for creating alerts on electronic records in relation to DV.	Review internal systems for creating and reviewing alerts and updating processes.	Chief Nurse		November 2016	