DOMESTIC HOMICIDE REVIEW

London Borough of Barnet Community Safety Partnership

Report into the death of Duncan October 2018

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Contents

DOMESTIC HOMICIDE REVIEW (DHR) OVERVIEW REPORT INTO THE DEATH OF DUNCAN, OCTOBER 2018

Preface

The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the death of Duncan[1], and offer their sincere hopes that they are recovering from the shock.

The Review Chair thanks the Panel for their thoughtful deliberations both in the form of reports and Panel discussions in reviewing the conduct of local agencies.

1. Introduction

1.1 Domestic Homicide Reviews came into force in April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship or

(b) A member of the same household as himself;

with a view to identifying the lessons to be learnt from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence', and the report uses the cross-Government definition as issued in March 2013. This can be found in full at Appendix B.

1.2 The purpose of a DHR 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 these lessons to service responses including changes to inform national and local policies and procedures as appropriate
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

[1] Not his real name

1.3. This Domestic Homicide Review examines the circumstances leading up to the death of Duncan who was killed in October 2018.

The decision to undertake a DHR was made by Barnet Community Safety Partnership (CSP) in November 2018 in consultation with local specialists. The Home Office and family of the victim were duly informed. An independent Chair was appointed in April 2019 and the Panel met for the first time in May 2019 where Independent Management Reviews (IMRs) were commissioned, and agencies advised to implement any early learning without delay. Two further 'in-person' meetings were subsequently held and thereafter, switched to virtual meetings as a consequence of the pandemic.

1.4. The Barnet Safer Communities Partnership ('BSCP' or 'the Partnership') are responsible for overseeing the development and implementation of an overall strategy for reducing crime and anti-social behaviour; this includes Domestic Abuse (DA) and Violence Against Women & Girls (VAWG). The priorities and aims of DA and VAWG are set out in the BSCP's Domestic Abuse & VAWG Strategy for 2022-2025 which includes the partnership's commitment to working together to prevent and tackle all forms of VAWG.

1.5. London Borough Barnet has a number of specialist domestic abuse services. These include Jewish Women's Aid, an advocacy and advice service run by Solace Women's Aid and an Independent Domestic Violence Adviser (IDVA) service provided by Victim Support. In addition to this, Solace also provides the advocate-educator for IRIS[2] trained GP practices and a local community interest company – Rise Mutual – delivers perpetrator interventions. Also of particular relevance to this DHR, Operation Encompass[3] has been rolled out across the Borough since the events in this DHR took place. Operation Encompass ensures that schools are notified prior to the start of the next school day if police have attended a domestic abuse call-out to a home where school aged children live.

2. Overview

Persons involved in this DHR

Name	Gender	Age at the time of the murder	Relationship with victim	Ethnicity
Duncan	M	47	Victim	White British
Lillian[4]	F	43	Wife and perpetrator	White British

Duncan and Lillian had two children who were young adults at the time of his death: Lola (23) and Greg (21)[5]. Greg still lived in the family home (address 1), but Lola had moved out to a flat a couple of miles away.

[2] IRIS is Identification and Referral to Increase Safety, a primary care practice model; for responding to domestic abuse. Further detail is available here: https://irisi.org/
[3] Further details can be found here: https://www.operationencompass.org/
[4] Not her real name
[5] Not their real names.

2.1. Summary of the incident

2.1.1. In late October 2018 police received a call from Greg informing them that his father, Duncan, was on the floor and that Greg believed his mother, Lillian, may have stabbed him.

2.1.2. Earlier in the day Greg and his mother had been seen on Close Circuit Television (CCTV) buying large quantities of alcohol at a local Co-op; later that evening Greg and his father returned to the same shop to buy more.

2.1.3. According to Greg, he had been upstairs in his bedroom playing Fortnite, an online computer game, on a PS4 console, when he became aware of a disagreement taking place downstairs. He messaged the friend he was playing with, Steve, using the PlayStation's chat function. He texted *'it's kicking off'* and then added that he was trying to ignore the commotion. Greg's older sister Lola was living with Steve at the time and was aware of the chat between them.

2.1.4. Some minutes later Greg heard his father shout, '*she's just stabbed me!'* and, on coming downstairs, found his father lying on the floor bleeding in the kitchen and his mother, Lillian, sitting on the floor beside him. She was unable or unwilling to tell Greg what had happened nor where the phone was.

2.1.5. Greg messaged Steve and Lola via PlayStation to relay what had happened and begged them to call the police. Lola immediately hurried over to her parents' house. In the meantime, Greg located the phone and called the police himself.

2.1.6. The police arrived around 11.40 pm to find Duncan on the floor, injured by a single stab wound to the upper chest which had pierced his lung. Despite emergency care being provided, this wound proved fatal, and Duncan died shortly after midnight.

2.1.7. Police initially arrested Lillian, Greg and Lola at the scene, but Greg and Lola were shortly thereafter released without charge. As Greg was regarded as vulnerable due to a history of mental health problems, an appropriate adult was arranged for his interview. He was then referred to the Adult Urgent Response Team due to his vulnerability and safeguarding concerns regarding domestic and psychological abuse.

2.1.8. Lillian was subsequently charged with murder. She claimed at trial that by late 2018 she was spending most of the household money on alcohol and cannabis and that she could not remember anything about the fatal incident nor the events leading up to it.

2.1.9. In April 2019, Lillian was found guilty of murder and sentenced to life imprisonment with a minimum sentence of 15 years.

3. Parallel reviews

3.1. An inquest was opened by Her Majesty's Coroner and was adjourned pending the outcome of the criminal trial. It has not been re-opened.

3.2. There was a criminal trial which concluded in April 2019.

3.3. There were no other parallel reviews.

4. Domestic Homicide Review Panel

The DHR Panel was comprised of the following:

Name	Position & Agency
Davina James–Hanman	Independent DHR Chair
Karen Morrel	Head of Mental Health, Adult Social Care
Ruth Vines	Head of Safeguarding, Barnet Enfield and Haringey Mental Health Trust, NHS
Stuart Coleman	Head of Housing Management, Barnet Homes
Liz Gaunt	Detective Sergeant, Serious Case Review Group (SCRG) Metropolitan Police Service
Kate Aston	Adult Safeguarding, Mental Capacity Act & and Prevent Lead, Central London Community Healthcare NHS Trust
Heather Wilson	Adult Safeguarding Lead, Barnet Clinical Commissioning Group, NHS
Monica Tuohy	Senior Manager, Solace Women's Aid
Aneta Mularczyk	Area Manager, Hestia Housing and Support
Mark Cranwell	Detective Sergeant, Specialist Crime Review Group, Metropolitan Police Service
Radlamah Canakiah	VAWG Strategy Manager, Community Safety Team
Matthew Hutchins	Data Analyst Apprentice, Community Safety Team (Minutes)
Julie Carpenter	Safeguarding Specialists for Adults, London Ambulance Service
Kamini Kaur	Community Safety Project Officer (Minutes)
Helen Swarbrick	Head of Safeguarding, Royal Free London NHS Trust

5. Independence

The author of this report, Davina James-Hanman, is independent of all agencies involved and had no prior contact with any family members. She is an experienced DHR Chair and is also nationally recognised as an expert in domestic violence, having been active in this area of work for over three decades. Further details are provided in appendix C. She has completed one previous DHR in Barnet.

All Panel members and IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had

had direct contact.

6. Terms of Reference and Scope

6.1. The full terms of reference can be found at appendix A. A draft version of the key lines of enquiry were discussed at the first Panel meeting and amended accordingly in light of the findings from the initial scoping. The key lines of inquiry were as follows:

1. Each agency's involvement with the following family members between January 2004 and the death of Duncan in October 2018 both resident at address 1:

(a) Lillian
(b) Duncan

and (for education and Children's Social Care only)

each agency's involvement with the following family members, both resident at address 1:

(a) Lola (between January 2004 and May 2013)
(b) Greg (between January 2004 and August 2016)[6]

Any involvement outside the timeframe should be summarised.

2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Duncan:

(a) Communication between services

(b) Information sharing between services regarding the safeguarding of children

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Duncan or Lillian concerning domestic violence or other significant harm from January 2004. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons.

5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

6. Was anything known about the perpetrator? What support was offered to Lillian in respect of managing her son and his challenging behaviour? What was known about her substance

[6] Neither Lola nor Greg agreed to their information being shared. Thus the Panel decided that the end of their childhood should be the cut-off date.

use and what actions were taken? Were Greg and Lola adequately protected? Was the transition from childhood to adulthood appropriately and adequately managed?

7. How accessible were the services for the victim and perpetrator?

8. The training provided to staff and whether this was taken up and refresher training provided as needed.

9. Whether practices by all agencies were sensitive to the nine protected characteristics[7] of the respective family members and whether any special needs on the part of either of the parents or the children were explored, shared appropriately and recorded.

10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

11. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

7. Confidentiality and dissemination

7.1. The findings of this Overview Report are restricted. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved for publication by the Home Office Quality Assurance Panel. Members of the victim's family have also been provided with a copy of the report.

7.2 As recommended within the 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' to protect the identities of those involved, pseudonyms have been used and precise dates obscured.

7.3 The Executive Summary of this report has also been anonymised.

7.4 This has not prevented agencies taking action on the findings of this Review in advance of publication.

7.5 Subsequent to permission being granted by the Home Office to publish, this report will be widely disseminated including, but not limited to:

- Barnet VAWG Delivery Group
- Barnet Safer Communities Partnership Board
- Barnet Community Leadership and Libraries Committee
- Barnet, Enfield and Haringey Mental Health Trust
- Barnet Clinical Commissioning Group, NHS
- Solace Women's Aid
- Metropolitan Police Public Protection Investigations, Northwest Basic Command Unit
- Specialist Crime Review Group, MPS
- Jewish Women's Aid
- Royal Free London NHS Trust
- Barnet Community Safety Team
- London Ambulance Service

[7] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

- Mayor's Office of Policing & Crime
- Domestic Abuse Commissioner

7.6 A number of learning events have been planned to ensure that the lessons are disseminated as widely as possible; the first of these will be a confidential briefing to key local partners which will share the critical learning from this DHR. Once permission is granted by the Home Office to publish, this report will be more widely disseminated to the local professional networks including Barnet VAWG Delivery Group and VAWG Forum. Learning will be further incorporated into local domestic abuse training. All DHRs are published on a permanent hyperlink on LB Barnet's website
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8. Methodology

8.1. Chronologies were provided by seven agencies. In each instance, the Panel scrutinised these and asked further clarification questions. As contact was minimal for all the agencies and none was directly related to abuse, it was felt that a full IMR was not required although information from each appears in this report.

8.1.1. A further 16 agencies advised they had not had any contact with the subjects of this DHR.

8.2. Agencies completing chronologies were asked to provide accounts of any contact with Duncan, Lillian, Lola or Greg prior to the homicide. As consent was not forthcoming from the adult children, information about them was only shared until they reached their respective 18th birthdays. The recommendations to address lessons learned are listed in section 13 of this report and action plans to implement those recommendations are included in Appendix D.

8.2.1. The Review Panel has checked that the key agencies taking part in this Review have domestic violence policies and is satisfied that where these exist, they are fit for purpose.

8.2.2. The Panel and Individual Management Review (IMR) Authors have been committed, within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, and have ensured that the Review has been conducted in line with the terms of reference.

8.3. This report is an anthology of information and facts gathered from:

- Agency chronologies
- The Police Senior Investigating Officer and Family Liaison Officer
- The criminal trial and associated press articles
- A Psychiatrist's report prepared for the trial
- DHR Panel discussions
- Information from the victim's sister

8.3.1. In preparation for the criminal trial, the Metropolitan Police took a number of statements from witnesses and family members. A summary of each of these statements was made available to the Panel.

8.4. Barnet Community Safety Partnership is responsible for monitoring the implementation of the action plan (appendix D).

8.5. Involvement of family and friends

8.5.1. The sister of the victim and his adult children were informed about the commencement of the DHR and invited to participate. Prior to meeting (whilst the criminal investigation was still on-going) contact was made through the Family Liaison Officer (FLO) which allowed them an opportunity to comment on the terms of reference although none responded. Home Office leaflets and details of specialist advocacy services were provided.

Once criminal proceedings had concluded, the Chair contacted all the family members for a second time, inviting their participation. No responses were received.

8.5.2. Following the intervention of the FLO who had built a positive working relationship with all parties, the victim's sister indicated that she was willing to speak to the Chair. A lengthy telephone conversation took place where very useful background information was provided which is included in the report.

8.5.3. A copy of the draft report was sent to her prior to submission to the Home Office and her comments and views have been incorporated into subsequent versions.

8.5.4. Contact was also made with the perpetrator and her mother. Neither replied. A second contact through her solicitor revealed that an appeal was planned and participation in the DHR would not be forthcoming.

8.5.5. Once the trial had concluded, contact was made with those who had given statements to the police. None wished to participate in the DHR but did consent to their statements being shared.

8.6. Equality and diversity

8.6.1. All nine protected characteristics[8] in the 2010 Equality Act were considered by the Review Panel along with consideration of other vulnerabilities which may have impacted on their circumstances. There were no grounds for assuming that age; gender reassignment; marriage; pregnancy, race or sexual orientation played a role in this case. There is no record of any formal religious affiliation or faith for either Lillian or Duncan.

8.6.2. Two protected characteristics were found to have potential relevance. These were sex and disability.

8.6.3. Sex was found to be potentially relevant as men are much less likely to be considered by professionals to be a victim of domestic abuse and male victims are significantly less likely to seek external help[9]. The reasons for this are varied but two of the most common are not naming the experience as abuse and because the abuse did not cause them to feel fear. Greg told police that when Lillian used physical violence against him, he would often *'laugh in her face'*. It is possible that Duncan was equally dismissive of the seriousness of Lillian's violence. Indeed, Lola told police that she had seen her mum hit Duncan and added *'If she hit him just once or twice, he would push her away but if it was numerous times, he would hit her back once.*'

8.6.4 It also seems that Lillian was only physically violence when intoxicated which provided all family members with a lens through which to make meaning of Lillian's violence, namely that it was behaviour fuelled by alcohol rather than being seen as abuse. It should be noted

[8] These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

[9] Moore, T. Suggestions to improve outcomes for male victims of domestic abuse: a review of the literature. *SN Soc Sci* **1**, 252 (2021). https://doi.org/10.1007/s43545-021-00263-x

that most research shows that whilst alcohol can be disinhibitory, it is not in itself a cause of violence or abuse. Indeed, research suggests that a person's belief about the effects of alcohol is a greater determinate of what behaviours result than the consumption of alcohol.[10]

8.6.5. Duncan had a number of health appointments where he disclosed low mood. He attributed this to the stresses of coping with Greg and later, to having been made redundant and experiencing a period of unemployment. There is nothing on record to suggest that Duncan was asked if there were any other stressors in his life, such as domestic abuse. It is possible that this did not occur because a reasonable cause had already been disclosed but it is also possible that the GP did not consider domestic abuse because of Duncan's sex. It is also possible given what we know about Duncan's age, and how he viewed himself as a provider for the family, suggesting a belief in traditional gender roles, that even had he been asked about domestic abuse he would not have disclosed it or even perceived his experience as warranting the label. Many male victims of domestic abuse struggle to name or disclose their experiences as it sits at odds with their self-perception of being able to take care of themselves / being the strong one.[11]

8.6.6. Disability was also considered as potentially relevant. Although Lillian did not have a formal diagnosis, several people have provided evidence that she was a virtual recluse and rarely left the house. We also know that she had attempted suicide in the past. Whether she did indeed have mental health issues of sufficient durability to 'count' as a disability is, of course, speculation, but if she did, then there is also evidence that it had a significant impact on her day-to-day life.

8.6.7. The above is a summary of Panel discissions. However, the Panel ultimately concluded that no protected characteristics could be definitively said to have impacted on the circumstances of this case.

8.8.8. In considering other vulnerabilities, however, the Panel felt that two factors did play a significant role: excessive drinking on the part of both Lillian and Duncan and the stresses arising from coping with a child with behavioural issues.

9. Key events

9.1. Although there were two brief contacts with a GP involving Lillian in 1987 and 1995, January 2004 was chosen as the start date for the DHR as this is when outside agencies, including police, education, health and social work first began to become consistently involved with the family. It was also felt that the two earlier incidents were so far in the past that it was unlikely useful lessons could be learned. These agency contacts can be divided into three distinct phases with little or no known agency contact during the intervals between phases:

9.2. **2004-2005:** This mainly involved issues arising out of Greg's behaviour at school, but also includes two domestic abuse incidents where the police became involved.

9.3. **2008-2013:** Covers the period where both children became teenagers and the stresses of home, school and work were more difficult to handle by all family members.

9.4 **2015-2016**: Mostly health-related contacts for both Duncan and Lillian, but also includes two separate incidents with Lola and Greg where the police became involved.

[10] Steele CM, Southwick L. Alcohol and social behavior I: The psychology of drunken excess. J Pers Soc Psychol. 1985 Jan;48(1):18-34. doi: 10.1037//0022-3514.48.1.18. PMID: 3981386.

[11] '*Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis',* Huntley et al, 2019 BMJ Open

9.5. There then follows a near two-year absence of agency contact until shortly before the murder.

9.6. Background information about Duncan

9.7. Duncan was originally from Irvine in North Ayrshire and retained strong ties to the west of Scotland even after moving down to London as a young adult. He had a sister and two brothers and returned as often as possible to see family and a wide circle of friends and maintained a lifelong passion for Celtic football club.

9.8. His sister recalls a happy childhood with Duncan. He was the 'happy-go-lucky joker' in the family, and he continued to make friends easily even after moving down to London. She said others who knew him well described him as a '*loveable rascal'*.

9.9. Duncan took his responsibility as the financial provider for the family very seriously and was known as a hard worker. After working at a bingo hall, where he met Lillian, Duncan got a job with an American global technology distributor and rose to become a sales executive. Intermittently, however, he was overwhelmed by the pressures of work and home and complained of stress, anxiety and depression. He often linked these feelings, at least in part, to the difficulties of dealing with his son, Greg.

9.10. In the spring of 2008, Duncan had to take two weeks off work due to stress, but on returning to work, immediately had a panic attack. A long consultation with his GP ensued and he was referred on to a counsellor. Six weeks later he was again complaining of anxiety and depression and was prescribed anti-depressants.

9.11. Once this crisis passed, Duncan seems to have coped without seeking outside help for some time. However, when he changed GPs and went for a new patient screening in early 2011, he talked about 'family pressures' centred around Greg and admitted that he sometimes drank a lot as a means of 'coping and unwinding'.

9.12. In late 2015, Duncan was made redundant, which hit him very hard as it cut to the core of his self-worth and self-image as family provider. By the summer of 2016 he was back at the doctor's reporting feeling low since losing his job at the end of the previous year. He said he was now drinking every day and admitted to consuming 47 units per week. He was offered both general and alcohol counselling but declined both.

9.13. Over the same period, Duncan also had some physical health problems which entailed appointments with a physiotherapist, ENT and an ophthalmologist. While individually these appear to have been minor, they cannot have helped to lighten his depression.

9.14. In May 2018, a few months before his death, Duncan went to Scotland with Lillian to join other family members and friends in celebrating his mother's 80th birthday. According to his sister, it was an 'absolutely fabulous weekend'. He also obtained a new job which he began about a month before his death.

9.15. Background information about Lillian

9.16 According to Lillian's interview with the court-appointed psychiatrist, she had a happy childhood with no traumatic episodes. Her parents separated before she was five and her mother later remarried. This is contradicted by GP notes from 1987 (see below) which suggested that her parents were separating when she was 13; the Panel were unable to confirm which version was correct as Lillian was the source for both versions. Lillian said she had a good relationship with both her stepfather and her mother, although the two women were later estranged for a period of about two years after disagreements over the parenting of Lola, Duncan and Lillian's eldest child.

9.17. Lillian was aware that her birth father had been abusive towards her mother although she denied that she had suffered any direct abuse herself. It does, however, seem that Lillian was affected by this environment; GP notes from 1987 detail that she was going through a difficult stage as a teenager, including truanting, smoking and shoplifting.

9.18. Lillian said she liked primary school but began to go off the rails when she went to firstly an all-girls secondary school and then a mixed school. She experienced bullying, truanted often and was involved in some minor delinquency. She left school at 16 without any qualifications and had a few brief jobs before ending up working at a bingo hall at 18, where she met her future husband, Duncan. Two years later she gave up work when her daughter Lola was born. Later she worked briefly in Argos but had to quit to look after Greg after his diagnosis.

9.19. Lillian reported to the psychiatrist that initially Duncan and herself had a 'content and supportive relationship' and enjoyed going on holiday together. However, over time they had increasingly pursued separate interests, communicated little and 'fought for years'.

9.20. In 1995, GP records show that Lillian, now a mother herself, was suffering from some degree of post-natal depression, likely exacerbated by unspecified 'housing problems'. Her GP gave her letters of support to give to the housing department.

9.21. In October 2013 Lillian took an impulsive overdose of medication and Duncan called an ambulance. She stated that she had done this before a few times, without knowing why and always when she had been drinking, but without needing hospital care. She also admitted to self-harming by scratching her face and cutting. She was noted to have scars on both forearms. There is no evidence of any follow-up appointments after this suicide attempt.

9.22. In early 2017, Lillian was hospitalised with a stroke at Northwick Park Hospital. She stated afterwards that she did not know how she had got to this point with her drinking. The stroke was not noted in her defence at trial. This event happened at about the same time that Lillian fell out with both her own mother and her daughter, Lola.

9.23. The relationship between Lillian and Duncan

9.24. Lillian and Duncan first met at the bingo hall where they both worked when she was 18 and he was 21. They started going out together and Lillian gave birth to Lola when she was 20. Theirs was a long-standing, if volatile, relationship which had lasted for over 25 years (nearly 19 years of them married) by the time of the homicide. Indeed, a friend and former colleague of Duncan's described them as sometimes having '*a bit of a barney but nothing serious. Everyone has their ding-dongs — him and Lill were no different……. Duncan was always sorting things out, always on the phone to Lill. They loved each other.*' This perspective is confirmed by Duncan's sister who gave as a recent example, a positive report of their mother's 80th birthday celebrations, which both Duncan and Lillian attended (see above).

9.25. On the other hand, Lola describes her parents' relationship as 'toxic', marked by heavy drinking, especially at weekends, and constant arguing. She thought Lillian was a recluse who never left the house and sometimes hit her father. Lola said: *'If she [Lillian] hit him just once or twice, he would push her away but if it was numerous times, he would hit her back once. My brother and I used to try and get in the way to separate it. At the end of the day, they were both as bad as each other'*. Lola had told them for years they should split up and also believes that they had a better relationship with Greg because they could get money for him, but not her.

9.26. Greg also reported their heavy drinking and said that it could lead to either all loving or arguing and fighting, the latter sometimes involving Greg as well. He comments that both would hit him, and he just took it and never hit them back. He says, *'When Mum was drunk,*

she struggled to control herself and used to punch me properly to the head'. He described his mum as '*broken'* and said he believed she had underlying mental health issues for which she had never sought help.

9.27. Two factors appear to have been particularly significant in shaping the course of their relationship.

9.28. Firstly, their drinking, which was reported as '*heavy and regular'* and often led to, or exacerbated, fierce and protracted arguments, which sometimes escalated into both using physical violence. This became such a pattern that Friday nights, when they would both drink more heavily, was referred to by their children as '*fight night'*. According to Greg they would only drink beer and wine during the week, but also drank spirits at the weekend. After extensive research, Johnson[12] (2006) identified three typologies of intimate partner violence: *the intimate terrorism, violent resistance* and *situational couple violence* (sometimes referred to as bi-directional abuse). Intimate terrorism is where one person exerts control over a partner to achieve total dominance. Violent resistance is when a victim of domestic abuse behaves violently in self-defence or for self-preservation. Finally, *situational couple violence* is a term coined to describe toxic relationships in which there is violence, but this is not about gaining power and control over the other person. three factors would suggest that situational couple violence was the most likely. Firstly, neither party ever expressed concern or fear to anyone about the violence and nor did they ever name their experience as such; secondly, those who witnessed physical assaults did not perceive either one to be principally the victim or perpetrator and finally the physical assaults only seemed to take place when both parties had been drinking heavily, that is, it was confined to a specific set of circumstances rather than infusing all of their relationship. The Panel wishes to stress that this conclusion is both tentative and speculative, based as it is on limited information.

9.29 At various times both Duncan and Lillian reported to their GP that they were, or had been, drinking excessively although neither were ever very consistent about just how much they were actually consuming when reporting to doctors. From interviews with a psychiatrist while awaiting trial, Lillian claimed that she usually consumed about four cans of beer, a bottle of wine and vodka shots every day and that Duncan consumed a similar amount. Additionally, she stated that they would spend about £240 per week on skunk[13] and that both would smoke several joints in the evening. This rate of consumption (alcohol + skunk) seems very unlikely in terms of cost and daily functioning, and it is more likely that Lillian was referring to their typical daily consumption at the weekend.

9.30. Secondly, Greg's severe ADHD impacted family life. This seems to have been initially diagnosed when he was six years old. Different combinations of medications were tried but were only partially successful according to his mother. At various times, those involved with Greg speculated that he might have had further difficulties, such as autism, but no diagnosis of any other condition seems to have been made. His behaviour was obviously challenging and much of the burden appears to have fallen on Lillian, as his full-time carer.

9.31. Lillian said to the psychiatrist that marital arguments increased after they moved into a new council house because it was in a poor condition, but also admitted that they had done little to improve it and it remained in an '*unsatisfactory state'*.

9.32. Over the years Duncan seems to have spent an increasing amount of time at work, perhaps in part as an escape from the fraught atmosphere at home. Certainly, this is very

[12] '*A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence'* Michael P. Johnson 2008

[13] A particularly potent form of marijuana. The local drug service advised the DHR Panel that this seems an unrealistic amount; half of this would be considered excessive use.

likely to have increased the pressure on Lillian, who spent more and more time at home, may have become somewhat agoraphobic and clearly struggled to cope.

9.33. Lillian claimed that she often had blackouts as a result of her drinking and there had been incidents of physical violence where one or both of them would have injuries resulting from some physical altercation without necessarily remembering how these had been inflicted. Lillian accepted that they had both had been aggressive towards each other – always when they had been drinking.

9.34. Neighbours reported regularly (every 2-3 weeks) hearing noise and disturbances. However, they were aware of Greg's diagnosis and attributed what they heard to Greg having an 'episode'. Neighbours said they thought the family were 'close' and reported getting on well with them. They were unaware of any other friction, issues or violence within the family.

9.35. Background information about Greg

9.36. According to his mother, Greg was diagnosed with ADHD when he was six years old and prescribed a variety of medications over the years with only partial benefits. He attended a variety of schools, was often excluded for behavioural reasons and even had a period of home tutoring. His final five years of schooling were at a special school where he achieved 'relative stability'. He then worked briefly at Waitrose but resigned as he found the commute too stressful. When he was 18, he stopped taking all ADHD medication.

9.37. In June 2005, when Greg was eight years old, his school began to express concerns about his behaviour. He was referred to CAMHS (Child and Adolescent Mental Health Services). They began a screening and assessment procedure. Both the school and family appeared to be happy to participate in this process, but nothing seems to have happened over the summer holiday period.

9.38. The headmaster had a detailed discussion with a Social Worker about Greg's presentation (disruptive and aggressive behaviour, sexualised language, depressed and possible self-harm) and signalled his belief that there was possible physical abuse. There had been two incidents at school where Greg had been physically violent, including headbutting another pupil.

9.39. However, despite never completely ruling it out, Children's Social Care (CSC) decided (after liaising with the Police Child Abuse Investigation Team) that the school should discuss their concerns with the parents, but no further police investigation was merited. A key factor in reaching this decision was that Greg was not alleging that he had been physically abused.

9.40. The school remained unhappy about what they appeared to see as inaction and finally a home visit was arranged.

9.41. Both children were interviewed separately and said they were happy at home and had no difficulties with their parents. Lola did say Greg was the cause of problems at home.

9.42. Duncan and Lillian were seen together; Duncan was described as '*quiet and reflective'* and Lillian as '*anxious.'* Both stated that Greg's problems were related to the school and not at home. However, it had previously been agreed that the parents were to be seen separately and asked about the domestic abuse notification in June (see paragraph 9.53 and 9.54 below). There is no record of this being done.

9.43. The Social Worker recorded a conversation with the school that a Statement of Educational Needs was required and queried if Greg possibly had autism and was being screened by CAMHS. Parenting capacity and possible risks to Greg within the home were

not identified or explored in more detail which would have been expected and is now routine practice.

9.44. A meeting between professionals in October concluded that despite Greg's ADHD and other behavioural difficulties, there were no child protection issues and a parenting partnership approach was merited. The headmaster strongly disagreed and expressed his view that there was child abuse occurring. He was not supported by any of the other professionals present and CSC records that the headmaster does not appear to understand the context of neurological challenges.

9.45. A second fraught meeting was held a week later at the school with both parents, CAHMS and a Social Worker present. Duncan thought the school needed to be more constructive in dealing with Greg and that merely restraining him did not work, Lillian became upset and left, and then the headmaster had to leave to deal with Greg's behaviour.

9.46. The case was finally closed in November with an initial assessment that Greg was not a 'child in need', that the parents had been observed to be affectionate towards children, and that there were no concerns about Lola. It was noted that the parents had been together for ten years with two minor incidents of police call outs for domestic abuse, but that this was no longer an issue. There is no explanation as to why domestic abuse was no longer considered an issue. Lillian was assessed as providing good basic care for the children.

9.47. Greg describes himself as a loner with no friends who plays computer games constantly and does not go further than the local shops because of anxiety issues. He also talks about anger issues and how he would get angry and shout as well as hitting out at walls and doors punching or headbutting them but does not usually get violent towards people. He disclosed that he had never hit his dad, but on one occasion he did slap his mum when she was *'clawing at his neck'*. On another occasion, he spat in Lillian's face and another time, tried to head butt her during a drunken argument. Greg reported that his mum would use her hands to hit him and most of the time he would just tolerate it, or even laugh in her face.

9.48. Background information on Lola

9.49. Apart from the three incidents involving the police outlined below (in two of which, she was the victim), there was very little agency involvement with Lola individually.

9.50. When Lola was 15 (2010), she had *'significant conflict'* with her mother which resulted in her going to live with her grandmother. This caused a period of estrangement between Lillian and her own mother for approximately two years.

9.51. Police involvement with the family

9.52. At various points, the police were involved with all members of the family, either individually or collectively.

9.53. In late 2004, police responded to an abandoned 999 call from the family's home. Lillian and Duncan said they had been going through '*a bad patch'* and had been arguing vehemently. Both had been drinking and Duncan was described by the police as '*aggressive'*, although neither admitted to any criminal offences. The children had witnessed the argument. Lillian and Duncan were spoken to by the police and later sent information about support services.

9.54. About six months later, the police were again called to the same address where both Lillian and Duncan claimed to have been assaulted by the other. Both had been drinking. Duncan had a bleeding nose, allegedly as a result of a slap, but declined to make a formal allegation. Lillian did make an allegation that Duncan had hit her although she had no visible

signs of injury. Duncan was arrested for common assault and given an adult caution; an officer present, however, noted that *'she seemed to be the aggressor'*. The children were not aware that the alleged assaults had taken place. The incident was notified to Children's Social Care (CSC), but no further action was triggered.

9.55. In the autumn of 2009, police were called to a fight in a pub and Duncan was arrested at the scene in possession of a hammer and a Stanley knife. At interview he claimed that he had been hit on the head with a chair following an argument between his wife and another woman. He had taken Lillian home then returned to the pub armed. He was subsequently charged with being in possession of an offensive weapon and received a community order of 18 months, overseen by the Probation Service.

9.56. Although there were a number of incidents involving his school and CSC arising from his disruptive and sometimes violent behaviour during 2005, Greg did not come to the attention of the police directly until a few years later when he was a young teenager.

9.57. Between 2010 and 2013 there were four relatively minor incidents involving Greg which came to the police's attention. These were: riding his bicycle dangerously in traffic, an unspecified stop in the street, a play fight which Greg claimed, '*got out of hand'* and anti-social behaviour aboard a bus. In all these incidents Greg was spoken to by the police, but no further action was taken.

9.58. More seriously, in 2016, when Greg was 18, a girl aged 14 reported to the police that Greg had been sending her photos of his penis via Snapchat. The girl and her mother did not substantiate their allegations and only wanted him spoken to as they were all family friends. Apparently, Lola had also been sending messages to the girl saying she was not telling the truth about the images. Greg was issued with a Harassment warning; the police did not speak with Lola.

9.59. Lola herself had some direct and indirect involvement with the police over a similar period, the first two of which were as a victim in more serious incidents.

9.60. In early 2009, when Lola was 13, she was punched in the face by a boy. Police spoke to Lola and Duncan who wanted the boy spoken to; the suspect was warned by the Schools Liaison Officer.

9.61. In 2013, police were called by Duncan to report a sexual assault against his daughter. Lola claimed that she had been touched inappropriately by a boy she knew vaguely from school. However, neither she nor Duncan were prepared to make a formal statement and although a suspect was identified, no further action was taken.

9.62. In 2015 a friend of hers claimed that Lola had taken her phone and was using it. The alleged victim later decided not to give a statement, so Lola was never spoken to by the police. The girl later informed the police that Lola had returned the phone.

9.63. Ten days leading up to the homicide

9.64. In October 2018, Lillian had her left ankle x-rayed in hospital following a fall, having been referred by her GP. It would later be claimed that the injury had occurred when Lillian was drunk and had fallen off a table she was dancing on. She was in pain and swelling/bruising was visible, but the ankle was not broken. Since she had not come through A&E, no questions were asked by them about how the injury had occurred.

9.65. Ten days later Greg called the police to inform them that he believed his mother, Lillian, had stabbed Duncan, his father, who was lying on the floor.

10. Analysis

This section will focus on the conclusions and findings, organised according to the terms of reference.

10. 1. Each agency's involvement with the following family members between January 2004 and the death of Duncan in October 2018 both resident at address 1:

(c) Lillian
(d) Duncan

and (for education and CSC only)

each agency's involvement with the following family members, both resident at address 1:

(c) Lola (between January 2004 and May 2013)
(d) Greg (between January 2004 and August 2016)

Any involvement outside the timeframe should be summarised.

Agency involvement is detailed in the chronology above and is not repeated here except to note that agency involvement with the family was relatively limited, especially in the years immediately prior to the homicide.

However, there was some contact with the housing department in 2013 which is not detailed in the chronology above, but which is summarised below.

Duncan and Lillian moved to a different council property in early 2011 (where they were living at the time of the homicide). Housing reported that there were some issues with access to the property for gas checks and repairs, including a forced entry in 2016 for the annual gas check. There was a series of rent arrears during the period when Duncan was unemployed, which the couple struggled to clear. The property was generally neglected, and housing officials perceived a lack of engagement from Lillian (who usually dealt with the housing department as she was at home full-time). It seems probable that some of the damage to the property was caused by Greg as others reported he had a tendency to hit his head on walls and doors, sometimes also punching and kicking them.

10.2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Duncan:

(a) Communication between services
(b) Information sharing between services with regard to the safeguarding of children

The limited amount of agency contacts with the family – especially in the years leading up to the homicide – means there were scant opportunities for communication and information sharing between agencies.

With the benefit of hindsight, we can now see that raising Greg had many challenges and Lillian may never learned to best respond to these. When multi-agency interventions were triggered in 2005, the outcome did not seem to encourage Lillian and Duncan to seek further help even as the situation at home continued to deteriorate.

10.3 Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

As noted elsewhere, the response from CSC in 2005 could have been more robust but there have been significant changes in practice since then. Nevertheless, policies and protocols in place at that time were followed.

Changes include the introduction of a number of checks and balances such as regular audits which helps keep a close eye on practice and early identification of any areas for improvement. These changes have been verified through Ofsted inspections; the most recent SEND inspection[14] identified a range of strengths that address all of the weaknesses identified in responses to Greg and his parents. The Panel is satisfied, therefore, that recommendations to address these are not required.

10.4. The response of the relevant agencies to any referrals relating to Duncan or Lillian concerning domestic violence or other significant harm from January 2004. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons.

There were no referrals about domestic abuse other than the original police notification to CSC when they attended a domestic abuse incident in 2004 and 2005. Neither of these incidents led to any arrests or charges and CSC determined they would take no further action albeit that this period also coincided with concerns being raised by Greg's school about his behaviour.

When CSC made a home visit to discuss these concerns, Duncan and Lillian were seen together. Duncan was described as '*quiet and reflective'* and Lillian as '*anxious'*. Both stated that Greg's problems were related to the school and not at home. However, CSC had received a recent notification about an incident of domestic violence (June 2005), and it had previously been agreed that the parents were to be seen separately. There is no record of this being done, showing a lack of challenge and professional curiosity. However, both children were seen separately and neither reported anything that raised concerns.

10.5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

Duncan was only known as a possible victim of domestic abuse in 2005: thirteen years prior to his death. He was provided with information about support agencies.

10.6. Was anything known about the perpetrator? What support was offered to Lillian in respect of managing her son and his challenging behaviour? What was known about her substance use and what actions were taken? Were Greg and Lola adequately protected? Was the transition from childhood to adulthood appropriately and adequately managed?

[14] https://files.ofsted.gov.uk/v1/file/50179970

Lillian was only known as a possible perpetrator of domestic abuse in 2005: thirteen years prior to the fatal incident death.

Greg was diagnosed with ADHD when he was six years old and prescribed a variety of medications over the years which were not very effective. His behavioural issues led to him being excluded from school on several occasions and at one point he was home tutored. This is highly likely to have put a huge strain on the marriage and although Duncan was an involved father and tried to attend any meetings about his son, much of the caring burden fell on Lillian.

There is extremely limited information in the records regarding what help and support was offered to Lillian to help her cope with Greg. Indeed, the gaps in the records tell a kind of story of their own: Greg's early exclusions from school did not generate any records of plans for him to return or of alternatives offered. When CSC undertook a home visit, parenting capacity and possible risks to Greg within the home were not identified or explored in more detail. As a consequence of focusing only on Greg's needs, CSC closed the case without seemingly ever considering if Lillian needed support. There are no records relating to support being offered when Lilian was home schooling. There are no records relating to any support offered when Greg stopped taking his medication aged 18 even though he was still living at home And Lillian was his full-time carer. Even Lillian's impulsive suicide attempt did not seem to generate any offers of support.

Lillian's drinking and drug use was known to her GP who offered to refer her to support services which she declined. This information was not shared with any other agency. However, Lillian was not wholly honest or consistent in her disclosures of drinking and cannabis consumption. Had the full extent been known, this would have escalated safeguarding concerns for Greg and Lola.

There is very limited information about the management of Greg from childhood to adulthood; systems and practice have substantially changed since then so no recommendations are made on this issue.

10.7. How accessible were the services for the victim and perpetrator?

There is no evidence that either Lilian or Duncan found it difficult to access services: rather it seems that agency involvement in their lives was not something they generally welcomed and with the exception of some health services, both tended to disengage as soon as they could. This, of course, raise the question of whether the services being offered were appropriate and experienced by them as supportive. Both, for example, disclosed excessive drinking to health professionals but neither wished to avail themselves of support with this. It is possible they felt judged, and in earlier years at least, harboured fears about others intervening with respect to their children if the true extent of their drinking was known. That these are common fears is well-established although it cannot be substantiated that they applied in this case. The learning, however, is that further probing should have taken place when Duncan and Lillian disclosed their alcohol intake to try to identify what issues underpinned their excessive consumption. Similarly, when Greg's behaviour triggered CSC involvement, it does not appear that support was offered to the parents and the involvement of professionals may not, therefore, have been perceived as helpful.

It is also possible given what we know about Duncan's age, and how he viewed himself as a provider for the family, suggesting a belief in traditional gender roles, that even had he been asked about domestic abuse he would not have disclosed it or even perceived his experience as warranting the label. Many male victims of domestic abuse struggle to name

or disclose their experiences as it sits at odds with their self-perception of being able to take care of themselves / being the strong one.[15]

10.8. The training provided to staff and whether this was taken up and refresher training provided as needed.

The Panel is satisfied that the availability, uptake and quality of domestic abuse training is sufficient in each participating agency in respect of understanding the issues and responding effectively to victims. Training is regularly reviewed, and new and emerging issues are incorporated, including learning from DHRs.

10.9. Whether practices by all agencies were sensitive to the nine protected characteristics[16] of the respective family members and whether any special needs on the part of either of the parents or the children were explored, shared appropriately and recorded.

The issue of protected characteristics is explored in section 8 above and the information is not repeated here.

See also 10.6 above.

10.10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

There were no domestic abuse issues that warranted escalation.

10.11. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

No agency reported any issues relating to organisation change or capacity. However, it is worth noting that in the time period covered by this review, practice on domestic abuse has considerably improved across the board.

11. Good practice

No examples of good practice were noted.

12. Key findings and lessons learned

- Lack of support for parents with Greg's diagnosis

The Panel found the decision by CSC that Greg did not qualify as a 'Child In Need' surprising: he had a diagnosed mental health issue which caused behavioural issues of sufficient severity for him to be excluded from school on more than one occasion and which caused him to self-harm and cause regular damage to the family home. After a single home

[15] '*Help-seeking by male victims of domestic violence and abuse (DVA): a systematic review and qualitative evidence synthesis',* Huntley et al, 2019 BMJ Open

[16] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

visit, it was concluded that as Lillian and Duncan seemed to love and care for him, there was nothing more to be done.

- Inability to see events through the eyes of the carer

Services that were offered must not have seemed very helpful to Lillian given that she generally declined them. She ended up self-medicating with cannabis and alcohol and subsequently declined help with this issue as well. No-one seems to have taken the time to explore what Lillian might have found helpful. The 2014 Care Act came a little too late to be of use to Lillian, but the Panel received assurances that changes since then would mean a very different approach would be taken today.

- Lack of professional curiosity

The Panel considered whether Greg's behaviour - which resulted in a diagnosis of ADHD - could be explained, at least in part, by neglect or him growing up in an unsafe environment. However, there is nothing in any agency records to show if this was ever considered. Professionals must be mindful that few of the issues with which they deal will have a single cause and should actively seek to definitively rule out other likely causes. Similarly, they seemed to be a lack of probing regarding the underlying cause of drinking. It is on record that Duncan was asked and spoke of *'family problems'* but no further detail is recorded. Lillian does not appear to have been asked until after the homicide when speaking to the psychiatrist in preparation for trial.

- Lack of involvement with services / services not assertively offered

Both Lilian and Duncan chose to deal with their problems by excessive drinking and mostly declined services offered to them. Further probing should have taken place to try to identify what issues underpinned their excessive consumption.

Other than this – and even with the benefit of hindsight – there were few clues to help agencies identify any warning signs. The knowledge of Greg's disorder meant that his behaviour at school was seen through that lens rather than raising concerns about what might be happening at for him home. Appropriate meetings took place involving Lillian and Duncan who presented as co-operative and concerned for their son. Similarly, some noise or anti-social behaviour complaints would have seemed likely, but Lillian and Duncan had good relationships with their neighbours and any noise disturbances were attributed to their son Greg having an 'episode'. Consequently, no complaints were made.

The exception to the above was the way that the two reports of domestic abuse seemed to fall off the radar of CSC professionals but even here, these concerned incidents which occurred thirteen years before the homicide.

13. Recommendations

In many instances where recommendations might have been made, practice has already changed since the events in question occurred.

Single agency recommendations

North Central London Integrated Care Board to ensure that Primary Care Practitioners are aware of the alerts and flags for vulnerability that are within the EMIS patient record system and are taking these into account within their assessments and decision making.

North Central London Integrated Care Board to assure itself that GP training supervision and appraisals include managing disclosures of the problematic use of alcohol and other substances and the familial, psychological and psychosocial factors that are impacting on the patient.

Multi-agency recommendations

Barnet CSP to reassure itself that all member agencies have effective engagement strategies in place, with escalating efforts when services are repeatedly declined. At the very least, a conversation should take place to try to identifiy what support the client / patient would like to receive and the results of this to be fed into subsequent service planning / service specifications.

When carrying out Child Protection Investigations all agencies to consider who needs to be interviewed and how this is to take place, remaining curious about risks of domestic abuse, coercive and controlling behaviour.

Review multi-agency domestsic abuse training to ensure that the need for a trauma informed response and professional curisoity are appropraitely foregrounded.

Appendix A: Terms of Reference

DOMESTIC HOMICIDE REVIEW (DHR)
INTO THE DEATH OF DUNCAN

TERMS OF REFERENCE

Overarching aim

The over-arching intention of this review is to learn lessons from the homicide in order to change future practice that leads to increased safety for potential and actual victims. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not to apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners. The purpose is not just to assure ourselves that roles were appropriately performed but to question whether the appropriate roles were in place to provide the required support.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy with the victim's voice at the heart of the process.
3. Asking questions, to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Key lines of inquiry

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with the following family members between January 2004 and the death of Duncan in October 2018 both resident at address 1:

(e) Lillian
(f) Duncan

and (for education and CSC only): each agency's involvement with the following family members, both resident at address 1:

(b) Lola (between January 2004 and May 2013)
(c) Greg (between January 2004 and August 2016)

Any involvement outside the timeframe should be summarised.

2. Whether, in relation to the family members, an improvement in any of the following might have led to a different outcome for Duncan:

(a) Communication between services

(b) Information sharing between services with regard to the safeguarding of children

3. Whether the work undertaken by services in this case was consistent with each organisation's:

(a) Professional standards

(b) Domestic violence policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Duncan or Lillian Welsh concerning domestic violence or other significant harm from January 2004. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons.

5. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

6. Was anything known about the perpetrator? What support was offered to Lillian in respect of managing her son and his challenging behaviour? What was known about her substance use and what actions were taken? Were Greg and Lola adequately protected? Was the transition from childhood to adulthood appropriately and adequately managed?

7. How accessible were the services for the victim and perpetrator?

8. The training provided to staff and whether this was taken up and refresher training provided as needed.

9. Whether practices by all agencies were sensitive to the nine protected characteristics[17] of the respective family members and whether any special needs on the part of either of the parents or the children were explored, shared appropriately and recorded.

10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

11. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

Panel Membership

The Panel will consist of:

- Barnet Clinical Commissioning Group
- Barnet Homes
- BEH-MET, NHS
- Central London Community Healthcare NHS Trust
- Children's Social Care
- CLCH Care Trust

[17] These are: age; disability; gender reassignment; marriage or civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

- Hestia Housing and Support
- LBB Adult Social Care
- LBB Community Safety
- London Ambulance Service
- Metropolitan Police
- Royal Free Hospital
- Solace Women's Aid
- Victim Support

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family are able to respond to this review endeavouring to avoid duplication of effort and without undue pressure.

Contact with the family and other members of their social networks will be led by the Chair.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal investigation is running in parallel to this DHR, therefore all material received by the Panel must be disclosed to the SIO and the police disclosure officer
- The criminal investigation is likely to result in a court hearing. Home Office guidance instructs the Overview Report will be held until the conclusion of this case. Records will continue to be reviewed and any lessons learned will be taken forward immediately.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by a pseudonym.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be disclosed in the public interest.

Media strategy

All media enquiries should be directed to the Chair until the report is submitted to the Home Office for quality assurance. Thereafter media enquiries should be directed to Barnet Community safety Partnership. Individual Panel Members should not speak to the media about this case, and this includes self-generated publicity such as press releases or tweets. Panel members should remember that they are representing their agency and that this media ban also applies to other staff from their agency.

Appendix B: Cross-Government definition of domestic violence[18]

The cross-government definition of domestic violence and abuse is:

any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

[18] This is the definition which applied at the time of the events described in this report. It is acknowledged that a new statutory definition has since superseded this one.

Appendix C: Further information about the chair and report author

Davina James-Hanman is an independent Violence Against Women Consultant. She was formerly the Director of AVA (Against Violence & Abuse) for 17 years (1997-2014), which she took up following five years at L.B. Islington as the first local authority Domestic Violence Co-ordinator in the UK (1992-97). From 2000-08, she had responsibility for developing and implementing the first London Domestic Violence Strategy for the Mayor of London. A key outcome of this was a reduction in domestic violence homicides of 57%.

She has worked in the field of violence against women for over three decades in a variety of capacities including advocate, campaigner, conference organiser, crisis counsellor, policy officer, project manager, refuge worker, researcher, trainer and writer. She has published innumerable articles and three book chapters and formerly acted as the Department of Health policy lead on domestic violence (2002-03). She was also a Lay Inspector for HM Crown Prosecution Service Inspectorate (2005-10). Davina has authored a wide variety of original resources for survivors and is particularly known for pioneering work on the intersections of domestic violence and alcohol/drugs, domestic violence and mental health, child to parent violence, developing the response from faith communities and primary prevention work.

She acted as the Specialist Adviser to the Home Affairs Select Committee Inquiry into domestic violence, forced marriage and 'honour' based violence (2007-08) and Chairs the Accreditation Panel for Respect, the national body for domestic violence perpetrator interventions. From 2008-09 she was seconded to the Home Office to assist with the development of the first national Violence Against Women and Girls Strategy. Davina was also a member of the National Institute of Health & Care Excellence group which developed the domestic violence recommendations and subsequent Quality Standards. She remains an Expert Adviser to NICE.

Davina is a Special Adviser to Women in Prison and a Trustee of the Centre for Women's Justice.

Appendix D: Recommendations and Action Plan

Recommendation	Scope	Action	Lead Agency	Target date	Completion date and outcome
North Central London ICB to ensure that Primary Care Practitioners are aware of the alerts and flags for vulnerability that are within the EMIS patient record system and are taking these into account within their assessments and decision making.	Local	Incorporation into GP training and learning events. DHR briefing for ICB staff and Primary Care to be part of the system learning workstream	NCL ICB Safeguarding Team NCL training and system learning sub-group.	December 2023	Completed December 2023. The EMIS system use by the GPs enables them to code specific concerns which are then reflected in the patient notes as a presenting problem; there is also a 'flag' system for safeguarding concerns.
NCL ICB to assure itself that GP training supervision and appraisals include managing disclosures of the problematic use of alcohol and other substances and the familial, psychological and psychosocial factors	Local	For the NCL ICB named GPs to include in their work plan for 2023	NCL ICB Safeguarding Named GP forum	December 2023	Completed December 2023. This is part of routine GP consultations and NCL ICB Designated Professional for Safeguarding

that are impacting on the patient.					Adults (Barnet),Chief Nurse's Directorate is satisfied this would be considered as being business as usual. [19]
Barnet CSP to reassure itself that all member agencies have effective engagement strategies in place, with escalating efforts when services are repeatedly declined. At the very least, a conversation should take place to try to identifiy what support the client / patient would like to receive and the results of this to be	Local	CSP chair to write to all member agencies inviting them to share their engagement strategies. Barnet Family Services to subsequently analyse these with a view to making recommended changes to improve engagement.	Barnet CSP / Barnet Family Service	All agencies to share their engagement strategies and approach the partnership to seek further support – Best practice examples will be encouraged The findings of the analysis of the engagement strategies and changes to improve engagement will	February 2023 Completed and ongoing review ongoing

[19] There is annual safeguarding training in Barnet to the new cohorts of GPs-this is delivered by the designated professionals (for adults, and the nurse for children) alongside the named GPs and designated Dr. As part of this training we highlight the importance of formulating and responding to psychosocial concerns and challenges, along with the longer term impact of ACEs into adulthood , and this is also emphasised by medical colleagues at the training.

fed into subsequent service planning / service specifications.				be shared to all partners	
When carrying out Child Protection Investigations all agencies to consider who needs to be interviewed and how this is to take place, remaining curious about risks of domestic abuse, coercive and controlling behaviour.	Local		Barnet Safeguarding Children Partnership	On going	Ongoing and involving VAWG Partnership
Review multi-agency domestsic abuse training to ensure that the need for a trauma informed response and professional curiosity are appropriately foregrounded.	Local		LBB	Ongoing	31.01.2023 Completed and ongoing review